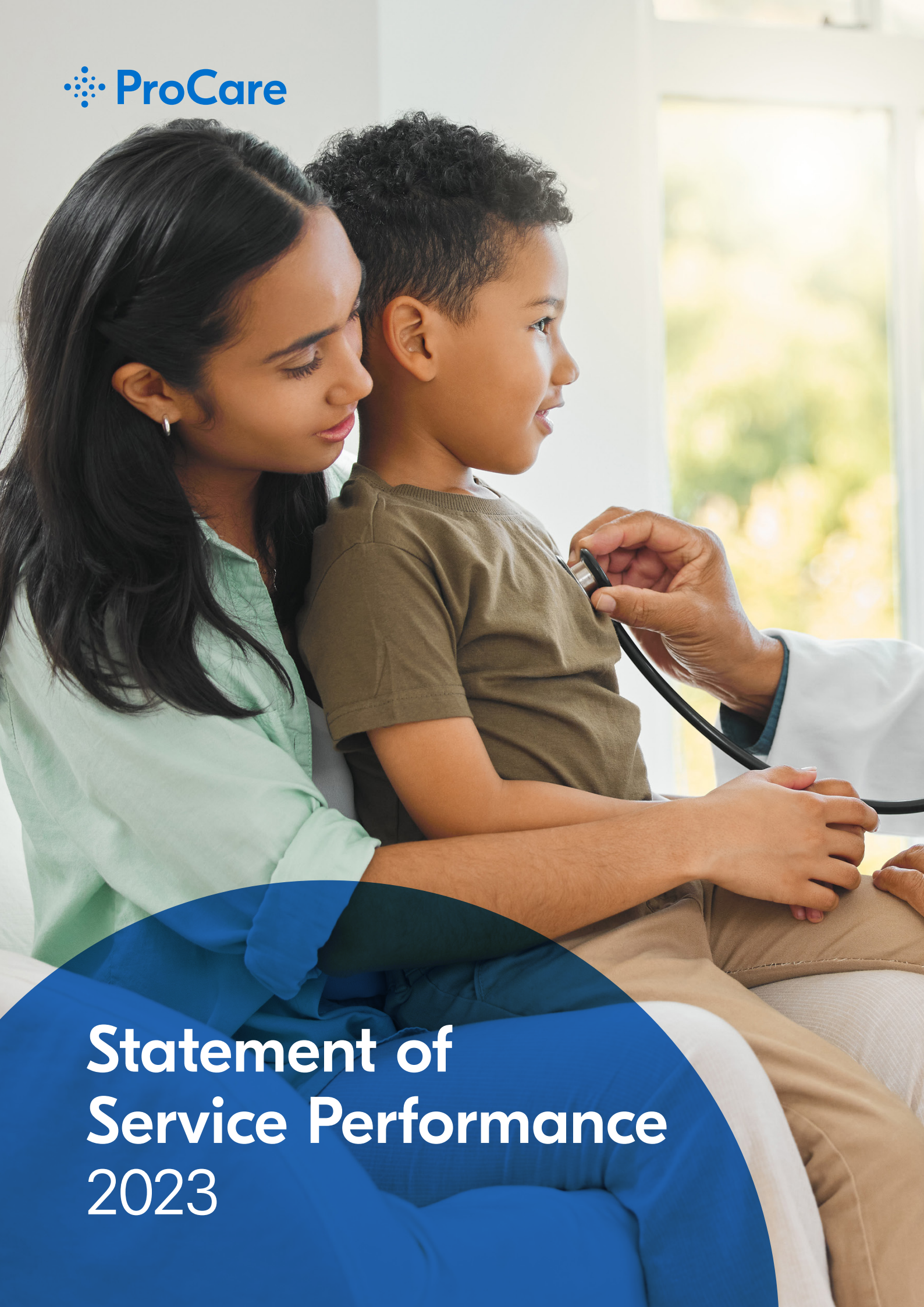
ProCare



Statement of Service Performance 2023

Our purpose

Our reason for being

Supporting and uplifting the health and wellbeing of the people of Aotearoa New Zealand.

Our mission

How we act on our purpose

Together we are reimagining healthcare to deliver the most progressive, pro-active and equitable health and wellbeing services in Aotearoa New Zealand.

Our vision

What the world will look like when we've completed the mission

An Aotearoa where all people, across all life stages are enabled to meet their full potential.

Our te ao Māori values

Kotahitanga

Mana motuhake

He tāngata

Haerenga tahi

Tikanga

He whakataukī

He ika kai ake i raro, he rāpaki ake i raro
Committing to a journey begins with the first steps

Who we are

As an organisation we exist to fund, organise and support trusted, quality primary healthcare for the population of Auckland and strive to improve equity of access and outcomes for Māori, Pacific and at-risk communities.

Total enrolled population: 848,951

ProCare is New Zealand's largest and most diverse co-operative of healthcare professionals and serves the largest Pacific and South Asian populations enrolled in general practice in New Zealand as well as the largest Māori population in Tāmaki Makaurau.

We are committed to improving the health of the community with a local and personal approach to delivering world leading health services which are backed by clinical excellence and put whānau at the centre of all care.

As an organisation, we are committed to partnership and innovation to deliver quality healthcare which improves equity of access and outcomes for Māori and Pacific whānau.

The ProCare team includes clinicians, advisors skilled in quality improvement and change management, as well as portfolio managers focused on the delivery of clinical services.

Statement of Service Performance Reporting

ProCare has been established as a primary health organisation and operates exclusively for the charitable purposes set out in the Statement of Service Performance Reporting.

In compiling the Company's Statement of Service Performance report, management has made judgements in relation to which outcomes and outputs best reflect the achievement of our performance for the Company's mission. This is exemplified by the implementation of the Company's population health strategy that aims to empower whānau to be well through five key goals that span all the ages of our lives, to help achieve our vision that, 'An Aotearoa where all people, across all life stages, are enabled to meet their full potential'.

Outputs and outcomes are aggregated from information reported across the Auckland and Northland region.

What we do

1 July 2022 – 30 June 2023

The health needs of **848,951 people** are supported by:
(2022: 788,190)

172
Practices
(2022: 167)

874
General Practitioners
(2022: 853)

731
Nurses
(2022: 709)

88
Healthcare Assistants
(2022: 71)

Collectively providing:

2,074,558
GP consultations
(2022: 2,129,390)

25,010
HPV vaccines
(2022: 27,619)

185,556
Flu vaccines
(2022: 177,935)

68,938
Cervical screens
(2022: 61,764)

21,127
Mental health referrals
(2022: 11.966)

Our Population Health Strategy

A population approach to improving health.

Our Population Health Strategy is a direct response to the health gaps identified in 'Our Picture of Health', a comprehensive health needs analysis, completed in 2018, using aggregated health data of approximately 800,000 enrolled patients across the ProCare network.

The ProCare Population Health Strategy is a five year programme of work, and guides clinical care and practices until 2024, with 2022-23 being Year Four. To deliver the strategy, ProCare is leading the way by shaping systems and new models of care encompassing acute, chronic disease, mental health and care planning, all of which support our practices to improve the health and wellbeing of their patients.

The strategy aims to improve health outcomes, experience of care and address equity across the ProCare network, especially for Māori and Pacific people.

A commitment to Te Tiriti o Waitangi ensures a strong pro-equity stance and directs our activities to those groups who have been identified by ProCare's health needs assessment as having the most to gain.

The strategy uses a life course approach to prioritise population health efforts across five goals, each covering a life stage, to help achieve our vision: An Aotearoa where all people, across all life stages, are enabled to meet their full potential.

Looking forward with the uncertainty of the primary healthcare landscape, with the health reforms and their development, this has made it more difficult to plan out the future of the Population Health Strategy beyond Year 5 (2023-2024).

Population health goals

We aim to empower whānau to be well through five key goals that span all the ages of our lives.

Children to have a healthy start to life (0-4 years)

This goal aims to address the stark differences in the health of infants and children by population group as measured by Ambulatory Sensitive (avoidable) Hospitalisation (ASH) rates; acute admissions to hospital that are considered potentially reducible through preventative or therapeutic care provided in the community.

Youth to increase engagement with primary care (15-24 years)

This goal recognises the specific health needs of youth aged 15-24 years as they move through adolescence into adulthood.

The aim is to support youth engagement with general practices so that health issues they face can be addressed such as: substance and alcohol use, contraception, sexually transmitted diseases, depression, psychosocial stress and other mental health disorders.

All people in a whānau are engaged and enabled to improve wellbeing

This goal uses a resilience and strengths-based approach to positively impact lifestyles and effective behaviour change for mental health, smoking, and harmful alcohol and other substance use.

ProCare advocates on behalf of its enrolled population for health, social and environmental policy change which supports improved wellbeing.

Improved quality of life for people living with long term conditions

Long term conditions account for around 70% of general practice visits and are the leading cause of hospitalisations and preventable deaths.

We aim to improve the quality of life for people with long term conditions focusing on improving care processes and reducing inequities for long term conditions such as diabetes, primary and secondary prevention of cardiovascular disease, heart failure, chronic obstructive pulmonary disease and gout.

Older people to have improved quality of life

This goal is focused on Māori and Pacific people aged 65 years or older, and all others aged 75 or older. Transforming services for older people requires a fundamental shift towards care that is co-ordinated around the full range of an individual's needs (rather than care around single diseases) and truly prioritises prevention and support for maintaining independence.

A planned approach to improving population health

Goals	Children to have a healthy start to life (0-4 years)	Increase Youth engagement with primary care (15-24 years)	Whānau are engaged and enabled to improve wellbeing	Improved quality of life for people with long term conditions (LTCs)	Older people to have improved quality of life

Outputs	• Adopt a systematic health and social needs assessment tool for pregnant women and devleop pre and post natal plans of care
	• Develop resource and referral options through multi-sectoral coordination (e.g. housing, PPP)
	• Pilot LMC and social work virtual hubs linked to practices
	• 8-month and 2-year immunisations
	• Flu vaccinations for children after respiratory hospitalisations
	• Increase maternal immunisations during pregnancy (Flu and Boostrix).
		• Stocktake primary care youth services
		• Stocktake practice youth freindly changes
		• Update and implement Youth Toolbox and youth health e-checkers after youth co-design prcoesses including:
		  • Sexual and reproductive needs
		  • Mental health and wellbeing
		  • Alcohol and drug related harm
		  • Youth appropriate digital tech
		• Evaluate Te Tumu Waiora on (Māori, Pacific, Q5) youth access and effectiveness
		• Develop metrics for youth engagement and health issues (mental health, pregnancy, STIs).
			• Continue Te Tumu Waiora and if funded, expland model to high needs (Māori, Pacific, Q5) practices
			• Develop FACT and health coach training
			• Increased referral to smoking cessation services (especially for Māori/ Pacific, LTCs and pregnant mothers)
			• Establish baseline alcohol screening dashboard and review as well as CMH alcohol brief advice (ABC) pilot
			• Collate community wellness directories
			• Investigate and pilot digital technologies to enable access to wellbeing services and supporting behaviour change.
				• Audit of management of microalbuminuria (Diabetes)
				• Address Read coding gaps for LTCs
				• Optimisae LTC management via care bundles, addressing inequalities
				• Collate Care Plans (eg. LTC Care, Back to Work, Acute Care & Advance Care Plans)
				• Identify practice implementation strategies
				• Further implement Healthcare Home model
				• Implement updated CVD risk assessment (focus on Māori men)
				• Pilot and evaluate shared medial appointments
				• Evaluate ProCare organisation as 'health literate' and make changes.
					• Systematic e-assessment with care plan, care co-ordinator and referal pathways
					• Vaccination programme (flu, zoster)
					• Scope hospital to home transtions and identify quick wins
					• Co-design care pathways for common problems e.g. constipation, continence
					• Dashboard enhancements
					  • Falls prevention screening
					  • Advance Care Plan and Care Plan
					  • Name of care co-ordinator
					  • Risk score
					  • Polypharmacy
					  • Isolation.

Outcomes	• Systematic assessment • Practice interventions and referral pathways implemented • 95% 8-month and 2-year immunisations • Increased flu vaccinations for at-risk children • Increased maternal immunisations • Increased referral for hapu mama to smoking cessation.	• 5% practices have completed self-audit tool and identifed youth friendly goals • Increased partnership with other primary care youth services • 20% enrolled youth with portal registration • Increased access to contraception • Increased STI testing (e.g. Chlamydia).	• Te Tumu Wairoa evaluated and scale up plan developed if funded (Māori, Pacific, Q5) • Alcohol ABC/dashboard screening increased • Reduction in smoking rates and inequities • Integration of approved digital technologies to support behaviour change.	• Improved identification of LTCs • Implemented LTC bundles and metrics • Shared medical appointment evaluated • Health literacy evaluated and changes made • Improvement in CVD and diabetes indicators with reduction in inequities	• Increased flu, zoster vaccination • Care pathways implemented • LTC care bundles implemented • Dashboard enhancements completed • Planned pro-active care, integrated into practice workflows.
KPIs	• Reduced ASH rates for 0-4 year olds and ASH inequities • 80% pregnant women (earlier KPIs for Māori, Pacific and high needs) have a systematic assessment for health and social determinants and have plans in place for unmet current and postpartum needs.	• Increased and equitable access for youth to primary care • 50% practices implemented youth friendly changes • Increased and equitable access for youth to primary healthcare (incl 80 - 90% have visted a GP in the last 2 years) • Reduced teen pregnancies & STIs • Improvement in youth experience.	• Increase in equitable access to effective behaviour change services • Improvement in patient experience • Reduced suicide rates and inequities by population group.	• Reduction in ASH rates attributable to CVD, heart failure and diabetes and ASH inequities • Improvement of care processes for primary and secondary prevention of CVD, diabetes, heart failure, COPD, gout and reduction in inequities.	• Reduction in ASH rates for older population and ASH inequalities • 80% of target population received holistic assessment • Equitable optimisation of medical management • Improvement in patient experience • Improved communications and co-ordination of care via shared care plans and care co-ordinators.
Long Term Outcomes	Improved quality, safety, equity & experience of care Improved sustainability of the health system		Improved clinical outcomes and reduced acute demand Engaged, happier providers		

Our approach for Year 4

Board endorsed KPIs for 2022-2023

Due to post-covid healthcare complexities and the workforce pressures that our practice network is under, both the ProCare Health (PHO) Limited and the ProCare Network Limited (Co-Op) Board agreed to focus efforts on the areas in the table below, during Year 4.

The Boards endorsed the following 14 indicators with an overall KPI for the executive management team to achieve 9 of the 14 in the 2022-2023 financial year.

KPI Description	Goal	Achieved	KPI Target	Māori	Pacific	Total Pop
8-month Immunisation rates for Māori and Pacific Children*	●	Yes	85%	85%*		89%*
2-year Immunisation rates for Total Population*	●	Yes	90%	82%*	83%*	90%*
Pregnancy Register - identify 1,642 pregnancies	●	Yes	1,642	2,648		-
Increase Māori and Pacific Youth Engagement for top 20 practices	●	Yes	64%	66%	64%	65%
Alcohol Screening Rate	●	No	50%	43%	45%	39%
Reduce high grade overdue smears by 30% to 2,114	●	No	2,114	2,614		-
Increase Māori/Pacific smoking cessation service referrals top 12 practices	●	Yes	438	270	198	-
Cardiovascular disease management - triple therapy*	●	Yes	70%	69%	75%	70%*
Cardiovascular disease risk assessment - new cohort	●	Yes	60%	58%	63%	63%
Cardiovascular disease risk assessment - old cohort	●	No	90%	84%	87%	81%
Increase management of microalbuminuria with ACE/ARBs	●	No	85%	75%	76%	77%
Increase diabetic eligible GLP1/SGLT2 prescribing rate	●	Yes	50%	57%	57%	51%
Māori and Pacific 55-64 flu vaccine	●	No	50%	44%	47%	46%
Aged 65+ flu vaccine overall and for Māori and Pacific	●	Yes	70%	71%	69%	74%

Legend

- Healthy Start
- Youth
- Wellbeing
- Long-term Conditions
- Older People

The above results are only for those general practices that have been a member of ProCare's PHO for the full year, and therefore participated with the full year programmes, promotions, and training. These targets are complex and require partnership between the patient and general practice, and some are impacted by patient choice or by an inability for a patient to take a specific medication.

* We have excluded decliners (8-month and 2-year immunisations) and patients who have been reviewed (triple therapy X coded) from the eligible (denominator) population. This is slightly different metric logic from the OPOH figures on page 23.

Children to have a healthy start to life (0-4 years)

Our 5 year targets

- Reduced ASH (Ambulatory Sensitive (avoidable) Hospitalisation) rates for 0-4-year-olds and ASH inequities
- 80% of pregnant women (earlier KPIs for Māori, Pacific, and high needs) have a systematic assessment for health and social determinants and have plans in place for unmet current and postpartum needs.

Milestones achieved

- Continued to promote and monitor the use of pregnancy assessment tool by GPs and nurses
- Monitored pregnancy immunisation rates via the pregnancy assessment tool
- Developed a Pregnancy Register to monitor hapū māmā and their health outcomes e.g. immunisation rates
- Provided Māori and Pacific hapū māmā with pēpē packs via practices (containing a Pregnancy Road Map and helpful products for māmā and pēpē)
- Started work with the Northern Region Newborn Enrolment working group, advocating for a smoother process for practices in accepting newborn enrolments. Ensuring newborn enrolments are accepted by practices in a timely manner, getting pēpē into the practice's enrolled population allowing timely immunisation recalls and better health outcomes
- Supported practices with the highest cohort of Māori and Pacific patients to develop closer relationships with iwi, marae, community health and social support agencies to collectively support whānau
- Introduced childhood immunisation data to the data share agreements between ProCare and Manurewa Marae and Papakura Marae
- Supported practices to run an initiative to provide $50 PAK'nSAVE vouchers to whānau who brought in their tamariki for immunisations using the national prioritisation matrix
- Gifted Whare Kākahu taonga to one practice in each district to acknowledge and celebrate innovative practices working with their Māori Whānau
- Worked with practices to recall patients who were overdue for immunisations
- Assisted practices with entering immunisations correctly into the PMS, especially with the schedule change from PCV-10 to PCV-13 in late 2022
- Tidied up immunisation data through regular data deep dives, comparing NHI lists with the NIR to ensure our immunisation data is as accurate as possible
- Identified key issues affecting the health and wellbeing of hapū māmā and 0-4-year-olds, and provided advocacy accordingly
- Outreach childhood immunisations and health checks completed by Ara Hauora.

Ongoing activities [1]

Suspended: Create reports for child oral health (i.e. dental care)

This was previously put on hold due to difficulty getting the data from Te Whatu Ora (TWO) Waitematā who run the regional dental service. We also had to prioritise our data analytics team's work and during year 4 the pregnancy register took precedence. We will not be proceeding with reporting on dental outcomes for the foreseeable future.

Develop improvements for childhood immunisations and reporting

Our data team, along with the portfolio manager and immunisation coordinators are working together to improve the data and reporting for childhood immunisations available to the network to assist with improving childhood immunisation rates.

Youth to increase engagement with primary care (15-24 years)

Our 5 year targets

- 50% of practices implemented youth friendly changes
- Increased access for youth to primary healthcare (incl. 80-90% have visited a GP in the last 2 years) with a specific focus on Māori and Pacific
- Reduced teen pregnancies and STIs
- Improvement in youth experience.

Milestones achieved

- Provided 12 practices with lowest engagement funding to offer free visits to rangatahi Māori and Pacific youth that haven't visited a practice in more than 12 months
- Provided 20 practices with the lowest engagement levels vouchers as incentives to encourage rangatahi Māori and Pacific youth that haven't visited a practice in more than 12 months
- Continued promotion of the youth-friendly audit to the 20 identified ProCare practices with the lowest engagement and supported them to complete these
- Followed up youth friendly audits with suggestions, support, and resources
- Distributed rainbow stickers, posters, and youth manuals to the 20 practices with the lowest youth engagement
- Created a flyer with input from the Youth Advisory Group (YAG) for youth, promoting youth health in primary care
- Promoted privacy and confidentiality through posters and a youth flyer
- Encouraged practices to contact youth turning 16-years-old to re-enrol, using text suggestions codesigned with the YAG
- Developed an online portal on LEARN to promote youth professional development
- Worked closely with practices to support best practice youth health care delivery, including sharing patient management system resources such as screening and competency assessment tools

Milestones continued

- Participation and Primary Care representation at regional youth hui including Sexual Health and Mental Health working groups
- Worked closely with Health Improvement Practitioners and Health Coaches to engage youth in practices
- Improved partnerships with mental health providers who support youth (i.e. Te Tumu Waiora, Fresh Minds etc.)
- Developed reporting to more accurately capture youth nurse visits
- Engaged with practices with low engagement and no focus on youth health, to create a plan to deliver best practice youth healthcare
- Identified key issues affecting the health and wellbeing of youth and provided advocacy
- Held Te Pou Tautoko Rangatahi, ProCare's Youth Health Forum and developed recommended approaches from a youth perspective on youth mental health and addictions.

Ongoing activities [1]

Continue to promote the top tips for youth health service delivery

We will continue to promote the top tips that came from the youth collaborative across the network including sharing resources such as posters and flyers and promoting professional development.

Continue to promote practices' completion of the youth friendly audit tool

We will continue to promote this tool to all ProCare practices, with specific focus on those with the highest cohort of Māori and Pacific youth patients, with the lowest youth visit rates.

Re-enrolment

We will continue to encourage practices to contact youth turning 16-years-old to re-enrol, using text suggestions co-designed with the Youth Advisory Group.

Sexual health

We will share best practice, screening tools and sexual health nurse competency assessments.

Partially completed: Develop reporting on long-acting, reversible contraceptives for practices

Work was completed to scope changes to the query build which can be completed at each practice site. This was then tested and improved. No further reporting development will be scheduled for Year 5.

Partnerships

We will continue to build partnerships with youth services and continue to strengthen the connection between ProCare, Fresh Minds, and Te Tumu Waiora.

Reporting

The data analytics team will use the more accurate youth health reporting revised for the 20 practices in the youth health goal to improve youth health benchmarking and youth health reporting across the network.

All people in a whānau are engaged and enabled to improve wellbeing

Our 5 year targets

- Increase in equitable access to effective behaviour change services
- Improvement in patient experience
- Reduced suicide rates and inequities by population group.

Milestones achieved

- Expanded the Te Tumu Waiora service to a total of 47 practices with high numbers of Māori and Pacific patients
- Delivered a Focused Acceptance and Commitment Therapy (FACT) training session for the network
- Implemented systems to encourage an increase in referrals to smoking cessation services for practices with the most Māori and Pacific whānau who are coded as current smokers
- Supported Alcohol ABC and Having Conversations About Alcohol training for Health Improvement Practitioners and Health Coaches to ensure patients' records were updated with their alcohol status
- Improved network performance of alcohol screening and intervention recording of eligible population (15 years and over)
- Recruited one new practice and continued to support the existing nine practices to increase the number of whānau they assess for alcohol intake and offer advice and support to those who are drinking above the low-risk drinking guidelines
- Worked with practices promoting prioritised NHI lists of wāhine who are overdue or have had a high-grade cervical smear result
- Organised and ran a three-month cervical screening awareness campaign to support practices to reach and motivate patients to have a cervical screen (included promotional material and provision of incentives for patients)
- Worked in partnership with the #SmearYourMea Trust to provide cervical screening and education at events leading up to Te Matatini and throughout the four-day competition
- Fostered practice appreciation for their practice's cervical smear takers through a nomination competition with the winner receiving tickets to the Women's Rugby World Cup final
- Developed a data sharing and patient recall partnership with Well Women and Family Trust which provides additional support for practices to reach their high-grade overdue wāhine for cervical screening
- Developed and delivered an oral submission to the Health Select Committee on the Smokefree Environments and Regulated Products (Smoked Tabacco) Amendment Bill and the Smoked Tabacco Regulatory Regime
- Made a submission to the Justice Select Committee supporting the Sale and Supply of Alcohol (Community Participation) Amendment Bill.

Ongoing activities [1]

Dependent on practice interest, run a Better Together Collaborative, focused on alcohol assessment and brief advice rates

Practices are being surveyed to determine which top three collaborative topics are preferred by them for Year 5.

Create benchmarking reports to identify practices with the lowest alcohol screening rates and largest equity gaps in order to target practices that need the most support

Limited activity reports for internal use now available with further work to be undertaken in year 5 dependent on data team capacity to provide these for the network.

Continue to roll out Te Tumu Waiora (TTW) health and wellbeing model to practices with high numbers of Māori, Pacific, and youth

We acknowledge that we are slightly behind schedule in the roll out of the integrated primary mental health model to practices due to the ongoing impacts of covid and practice capacity to host the Health Improvement Practitioners. However, we have acceptance from practices for the full cohort workforce funded in the next tranche of the roll-out.

We will be providing training to Health Coaches to improve smoking cessation referral pathways for whānau. Training was planned, however, Ready, Steady, Quit staffing capacity meant this was unable to be completed, but will be reprioritised for Year 5.

Improved quality of life for people living with long term conditions

Our 5 year targets

- Reduction in ASH (Ambulatory Sensitive (avoidable) Hospitalisation) rates attributable to Cardiovascular Disease (CVD), heart failure and diabetes and ASH inequities
- Improvement of care processes for primary and secondary prevention of CVD, diabetes, heart failure, COPD, gout and reduction in inequities.

Milestones achieved

- Developed Better Together Collaboratives focused on the new cohort eligible for healthy heart checks and diabetes management
- Shared resources and learnings from the Health Navigator gout collaborative
- Continued to promote the diabetes report
- Monitored the uptake of new diabetes medicines (SGLT2/GLP1)
- Developed and implemented strategies and campaigns to provide healthy heart checks for the old cohort and newly eligible cohort
- Produced resources to support improved health literacy that align culturally with Māori and Pacific
- Developed reporting to promote improved gout management
- Identified key issues affecting the wellbeing of our population and provided advocacy as needed
- Developed and implemented strategies to improve management of microalbuminuria
- Developed and implemented strategies and campaigns to improve CVD triple therapy management
- Supported the regional Stroke Prevention Group to implement new initiatives relating to the management of atrial fibrillation
- Supported a Chronic Kidney Disease study day for our Northland practices in September 2022
- Delivered CVDRA checks at Pasifika, HVAZ Church events, Ngāti Whātua Ōrākei Health Expo, and the Ngāti Whātua Ōrākei Whānau Day
- Worked in partnership with Ngāti Whātua Ōrākei health to deliver a Men's Health session and delivered onsite CVDRA checks.

Ongoing activities [1]

Suspended - Promote shared medical appointments

It was not initially possible to roll-out shared medical appointments due to covid and people social distancing. The timing is still not right for this as our practices continue to struggle to return to business as usual post-covid as well as battling increasing workforce shortages. There are no current plans to implement this initiative.

Older people to have improved quality of life

Our 5 year targets

- Reduction in ASH rates for older population and ASH inequalities
- 80% of target population received holistic assessment
- Equitable optimisation of medical management
- Improvement in patient experience
- Improved communications and co-ordination of care via shared care plans and care coordinators.

Milestones achieved

- Implemented different approaches to increase influenza (flu) vaccination; outreach, helping practices update Patient Management System (PMS) for flu vaccination received elsewhere, promotion of flu vaccination events, providing practices with 'to-do' lists for flu and updated our flu data source for more accurate reporting
- Reached 70% target for Māori and total population flu vaccination coverage
- Encouraged practices to proactively offer Shingrix vaccine to patients as they turned 65 as it is only funded for this specific age cohort
- Provided practices with a list of patients eligible for Shingrix via the Population Health Report on the Members' Website
- Advocated for wider funding of Shingrix to Pharmac
- Screened patients for falls risk and referred them to strength and balance programmes on behalf of Counties Manukau practices
- Worked collaboratively with Age Concern and Harbour Sports to promote falls prevention
- Made reports/list of patients eligible for falls screening support available for practices on the Members' Website
- Promoted ACP (Advance Care Planning) to the network; funding, resources, and training for clinicians
- Reminded practices about the available funding for palliative care services and Hospice support
- Presented care plan tool to different teams internal and external to ProCare. Northland practices have now started using this tool
- Continued to improve flu vaccination for older people by maintaining relationships with outreach providers, providing accurate flu lists to practices and support as we transition from NIR to AIR (Aotearoa Immunisation Register)
- Achieved 70% coverage for Māori aged 65+ and 69% flu vaccination rate for Pacific aged 65+ years.

Ongoing activities [1]

Identify key issues affecting the health of kaumātua and kuia. Then to advocate for addressing these issues.

This is ongoing activity to ensure an equitable approach to aged care for Māori. It was suspended during covid but will now continue/resume.

Suspended - Education on rongoā/ traditional medicine and how it can be used in combination with clinical practice in a safe way

Activity discontinued. This activity relied on substantial resource and expertise which was unavailable to the PHS team. It is understood that this will be a focus within Te Aka Whai Ora to ensure national consistency of advice and implementation.

Suspended - Explore acceptability of cognitive impairment pathway (CIP) tool

This activity has been discontinued. The CIP tool (Cognitive Impairment Pathway) was explored in Year 4. The tool is currently undergoing refinement and it is not known whether this work will be completed in Year 5 along with securing the Te Whatu Ora funding required for general practice implementation.

[1] includes activities not fully achieved in year 4, carried forward to year 5, or suspended

Core Population Health Goals

- Improved quality, safety, equity & experience of care
- Improved sustainability of the health system
- Improved clinical outcomes and reduced acute demand
- Engaged, happier providers.

Milestones achieved

- Launched Te Pūheke — ProCare's cultural competency training course (endorsed by RNZGCP) — to our provider network to further educate themselves in Tikanga Māori and understanding how to operate in a work environment from a Māori worldview (including building on the ihi app to assist with te reo Māori, tikanga and kawa for Māori)
- Launched Tala-Moana, our Pacific language app to assist with Pacific cultural competence and resources
- Cultural support and training provided to practices to increase te ao Māori and Pacific knowledge
- Promoted use of the national Patient Experience Survey (NZ Health Quality & Safety Commission) and loaded practice results on the Members' Website as a snapshot report
- Continued to encourage practices to use the 'Ask, Build, Check' approach to documents and communication to assist with health literacy of the system and provision of care
- Completed a quality improvement collaborative on 'Welcoming Practice' to encourage a focus on cultural safety, client satisfaction and whānau voice
- Managed funding increases to pass through to practices including the Equity Adjuster, uplift and pay parity adjustments
- Accepted the lead contract for facilitating roll out of the Comprehensive Primary & Community Teams from Te Whatu Ora for Metropolitan Auckland (Wellsford to Tuakau)
- Discussions with Te Whatu Ora about developing a workforce hub to assist with training and placement of graduate doctors, nurses, and other healthcare workers.

Performance metrics

Health goal	Indicator	Performance 2022-23	Performance 2021-22	Performance 2020-21	Performance 2019-20
Children to have a healthy start to life (0-4 years)	8-month immunisation rates	87%	87%	92%	93%
	2-year immunisation rates	85%	80%	88%	91%
Engaged and enabled to improve wellbeing	Smoking brief advice	77%	74%	79%	88%
	Cervical screening	72%	72%	76%	74%
Improved quality of life for people living with long term conditions	Cardiovascular Disease (CVD) — Risk Assessment Old Cohort	81%	85%	88%	89%
	Cardiovascular Disease (CVD) — Risk Assessment New Cohort	63%	49%	37%	N/A
	CVD — Secondary prevention	67%	67%	67%	66%
	CVD — Primary prevention	54%	54%	52%	49%
	Diabetes care — blood pressure control	63%	58%	60%	63%
	Diabetes care — management of microalbuminuria (protein in urine)	77%	77%	78%	78%
	Diabetes — Glycaemic control (HbA1c)	64%	60%	60%	60%
Older people to have improved quality of life	Flu vaccine rates for >65's (June results)	61%	66%	63% *	75%

These targets are complex and require partnership between the patient and general practice, and some are impacted by patient choice or by an inability for a patient to take a specific medication. However, ProCare strives hard to meet and exceed these targets.

Throughout Year 4 of the Population Health Strategy (PHS) delivery, it was clear that the post-covid impact of the pandemic and its long tail, were still prevalent through the primary healthcare landscape. This had a roll-on effect on many of the areas that PHS focuses on, particularly when it came to preventative care and working with those with long-term conditions as the focus for many remained elsewhere.

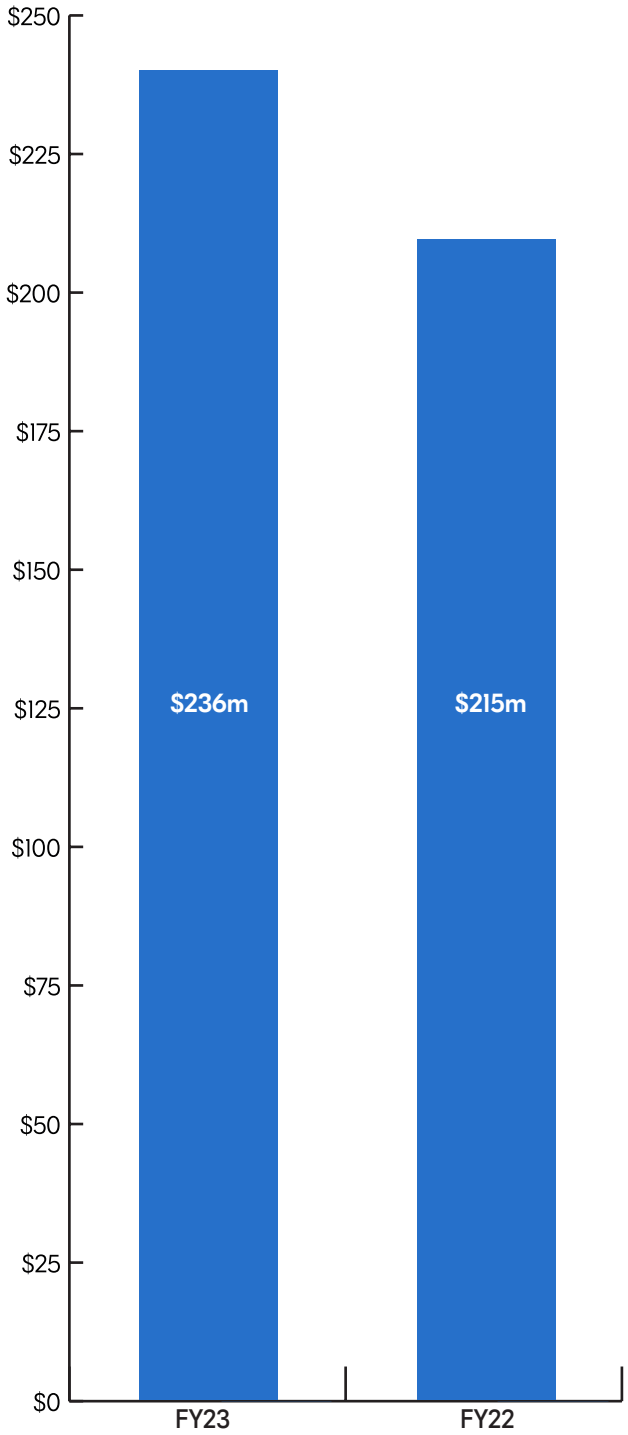
In conjunction with this, the ongoing workforce shortages in primary care meant that practices focused their limited resources on presenting issues and did not have expendable capacity to make up, in full, the preventative care missed during the covid outbreaks and sustained efforts across the multiple indicators within the planned strategy.

Further, the uncertainty of the primary healthcare landscape moving forward, with the health reforms and their development, has left an inability to plan out the future of the Population Health Strategy beyond Year 5 (2023-24).

*Due to additional data sources

Funding revenue recognised

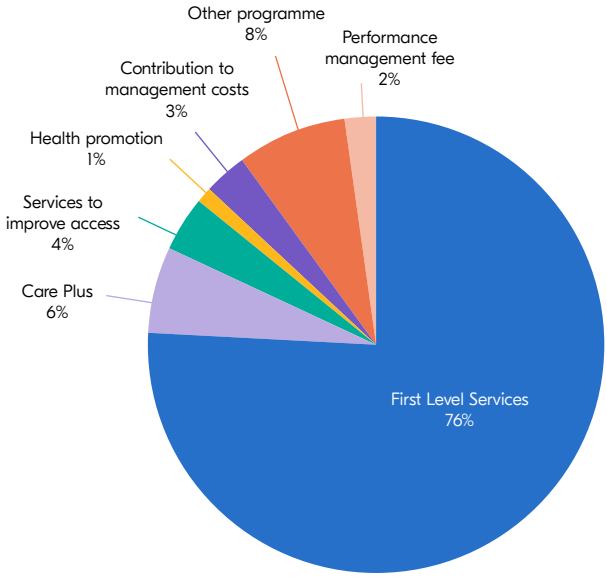
Total funding ($m)



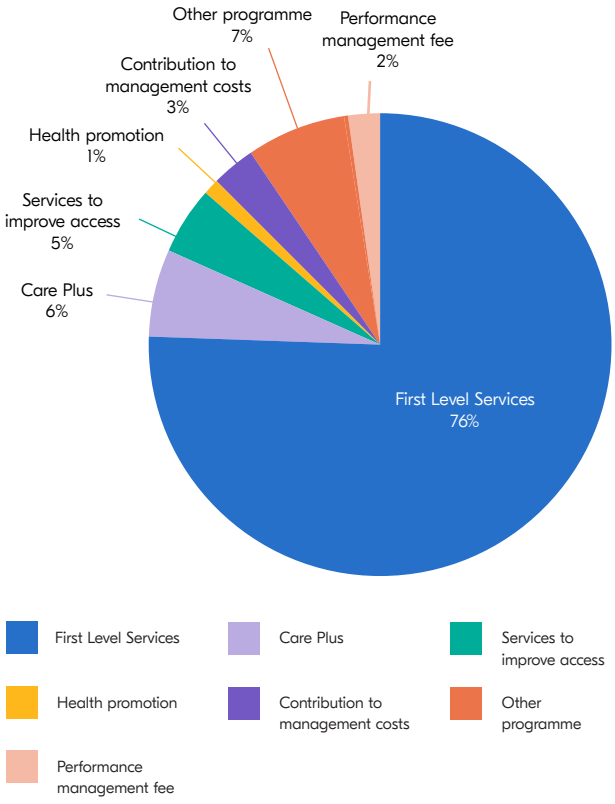
99.9% of funding is received from Te Whatu Ora Te Toka Tumai, Te Whatu Ora Counties Manukau, and Te Whatu Ora Waitematā (FY22: 99.9%)

$530k of funding was utilised on Population Health Strategy initiatives ($653k in FY22)

FY23 revenue streams

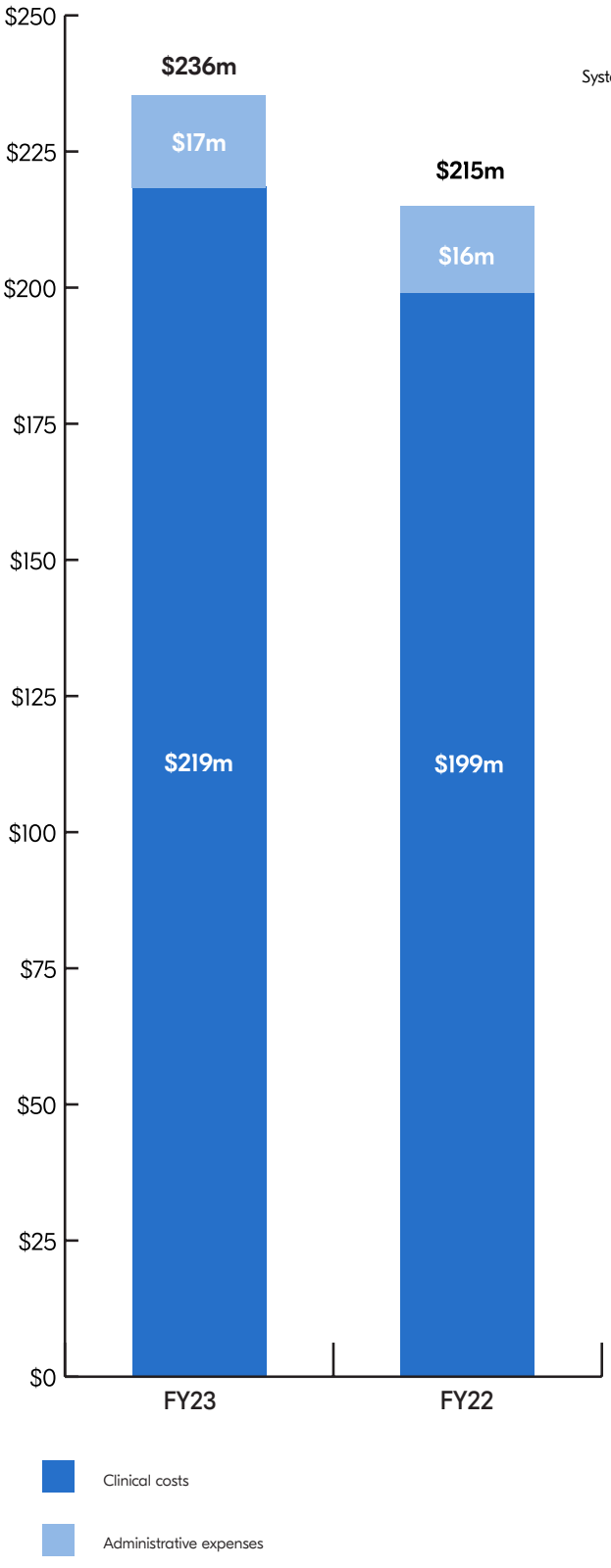


FY22 revenue streams

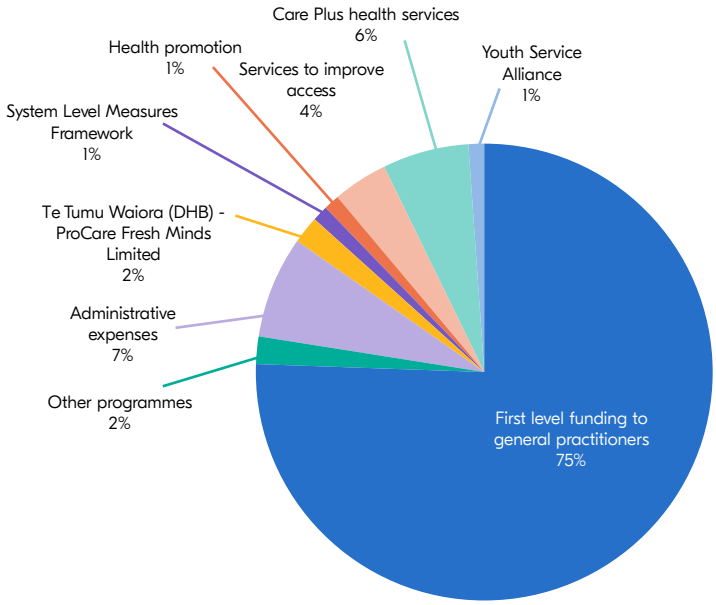


Clinical and Administrative Expenditure Incurred

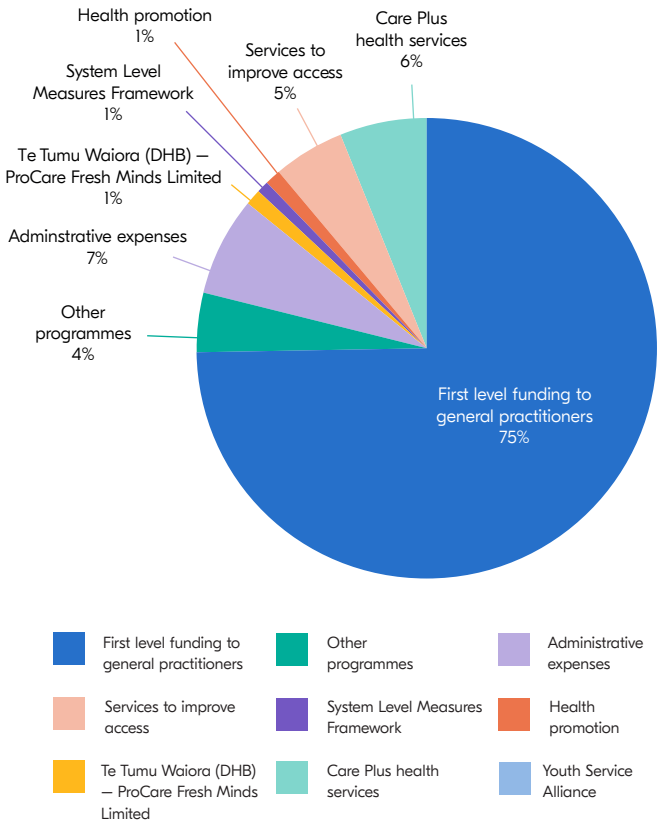
Total expenses ($m)



FY23 spend



FY22 spend



Whakapuaki tānga

Our Declaration of Intent

We're born full of potential, of spirit, of hope, of readiness

Ready to experience all that life brings to us

Ready with laughter

Ready with tears, sometimes of joy, sometimes of pain

Ready to feel

It makes us want to support

To uplift

To be present

To be there

It makes us want to care

For people, for whānau

Delivering progressive, pro-active and equitable services

Walking alongside people, a precious taonga

With empathy, with kindness, with humility

Presenting pathways to enable potential to thrive

It's the best of what makes us human and all of what makes us ProCare

Healthcare reimagined

ProCare