ProCare

Statement of Service Performance 2024

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 values

Integrity guides us.

Pou whakamanawa

We walk alongside people.

Kia haerenga tahi

All people are taonga.

He taonga tātou

We courageously embrace meaningful change.

Kia whakamana te tangata

We collaborate for collective impact.

Kia whakakōtahi

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 Tāmaki Makaurau and strive to improve equity of access and outcomes for Māori, Pacific and at-risk communities.

Total enrolled population: 860,227* (2023: 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 Auckland.

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-Judgements

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.

* As at 30 June 2024

What we do

1 July 2023 – 30 June 2024

The health needs of **860,227 people** are supported by:
(2023: 848,951)

167
Practices
(2023: 172)

903
General Practitioners
(2023: 874)

729
Nurses
(2023: 731)

94
Healthcare Assistants
(2023: 88)

Collectively providing:

2,095,096
GP consultations
(2023: 2,074,558)

26,057
HPV vaccines
(2023: 25,010)

189,291
Flu vaccines
(2023: 185,556)

77,649
Cervical screens
(2023: 68,938)

28,775
Mental health referrals
(2023: 21,127)

9,529
2 year immunisations
(2023: 9,221)

Wrap up of 5 year plan

Our Population Health Strategy

A population approach to improving health.

Our Population Health Strategy was 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.

This strategy was a five-year programme of work and guided clinical care and practices, with the 2023/2024 Financial Year being the final year of this strategy. The strategy had a life course approach to prioritise population health efforts across five goals to help achieve our vision: An Aotearoa where all people, across all life stages, are enabled to meet their full potential.

Woven throughout this strategy was a commitment to Te Tiriti o Waitangi and a focus on reducing the equity gaps for those identified by ProCare's health needs assessment as having the most to gain. Our focus was to improve health outcomes, experience of care and address equity across the ProCare network, especially for Māori and Pacific people.

Each year's document builds upon the successes of the previous year, showing a progressive and adaptive approach to healthcare delivery and community support.

In 2020-21, we focused heavily on establishing foundational tools and response systems for the pandemic.

In 2021-22, we expanded these efforts and introduced more collaborative initiatives, particularly in mental health and diabetes management.

In 2022-23, we emphasised the continuation and refinement of previous initiatives, with added focus on maternal and newborn health, as well as detailed reporting and data improvements.

This year in 2023-24 we focused on giving practices a refined list of clinical targets to meet, given the complexities in the healthcare environment during this year.

General Practice teams are seeing increasingly complex patient needs, pent-up demand, and a cumulative backlog due to the legacy of Covid-19 deferred care. This is compounded by ongoing capacity pressures from a lack of workforce, and financial sustainability issues.

We have taken many learnings from the 5-year Population Health Strategy. Given the changing health landscape, going forward we will not extend or repeat the Population Health Strategy beyond this final Year 5 (2023-2024).

Success Across the Years

The following highlights key achievements and initiatives from the ProCare SSP reports (2021, 2022, 2023) with the planned objectives and some of the key achievements outlined in the Health Strategy Report (2019).

The focus is on how ProCare's activities have addressed the strategic goals of improving equity, health outcomes, and service delivery, particularly for Māori and Pacific populations.

For a full summary, please click here to read the SSP reports from 2020-21, 2021-22 and 2022-23.

Covid-19 Response:

- Consistent strong support for practices, patient-facing services, and vaccination efforts. This resulted in high vaccination rates across the ProCare and New Zealand population.

Quality Improvement Collaboratives

- Over the five years, despite the pandemic we managed to run New Zealand's largest series of virtual quality improvement collaboratives, named 'Better Together'. In all we have had 61 sessions covering the following topics: Early Pregnancy (Best Start Kowae assessment tool); Health Start to Life, Increasing Immunisation, Youth Friendly Practices, Smoking Cessation, Alcohol screening & intervention, Cervical Screening & HPV, Cardiovascular Disease, Diabetes, Gout, Falls and Polypharmacy in the elderly, and Shared Medical Appointments.

Healthy Start to Life

- Developed a pregnancy register and actively promoted uptake of pregnancy assesment tools to improve health outcomes
- Focused on reducing the equity gap through targeted initiatives, particularly for Māori and Pacific hāpū māmā
- Encouraged newborn enrolments by practices to improve childhood immunisations
- Promoted and monitored pregnancy immunisation rates
- Consistent support and focus on immunising Tamariki.

Youth Engagement

- Established the Youth Advisory Group to provide guidance to ProCare based on lived experiences, to help us improve health outcomes for children and young people
- Ongoing initiatives to improve youth health outcomes, including audits, educational resources, and funding support
- Implemented the YouthChat tool and focused on substance abuse, contraception, STDs, and mental health issues
- Hosted te Pou Tautoko Rangatahi - Youth health Forum where 81 youth from across Tāmaki Makaurau attended. This forum focused on two key issues affecting rangatahi, mental health and vaping, alcohol and other drugs.

Wellbeing

- Utilising collaboratives to share learnings across practices
- Promoted the Te Tumu Waiora (mental health access and choice) service and expanding this across more practices each year
- Promoted smoking cessation services and alcohol screening to address alcohol-related harm
- 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.

Long-Term Conditions

- Developed and implemented care strategies for chronic diseases, promoting vaccinations, and conducting health checks
- Quality improvement collaboratives held on microalbuminuria, Shared Medical Appointments, cardiovascular disease and diabetes medication management
- Reviewed care models for acute, chronic disease, mental health, and care planning
- Enhanced flu vaccination coverage for those with long-term conditions
- Delivered health checks at community events and partnered with regional health organisations.

Older People's Health

- Persistent efforts in improving flu vaccination rates, falls prevention, and care planning for the elderly
- Implemented polypharmacy and medication review programmes
- Improved flu and herpes zoster vaccination rates among Māori and Pacific.

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 co-ordination (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 friendly 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 5

Board endorsed KPIs for 2023 - 2024

For the final year of the current strategy, the ProCare Health (PHO) Board agreed to focus efforts on the areas in the table below.

The focus for Year Five took into consideration the continuing post-covid healthcare complexities (large volume of unmet and deferred patient needs), general practice workforce issues and financial constraints, alongside the health reform disruptions to Aotearoa's health system.

The Board endorsed the following six indicators with an overall KPI for the Executive Leadership Team and the practices it supports to achieve 4 of the 6 in the 2023-24 Financial Year.

General Practice teams are seeing increasingly complex patient needs, pent-up demand, and a cumulative backlog due to the legacy of Covid-19 deferred care. This is compounded by ongoing capacity pressures from a lack of workforce, and financial sustainability issues.

The ProCare Health Board was also keen to simplify our KPI framework and have fewer indicators, due to a concern that we were spreading our focus too thinly. With this in mind, it was decided to reduce the number of KPI indicators for the 2023/24 year to provide a focus on indicators aligned with Te Whatu Ora's (TWO) likely national priorities.

In September 2023, the rollout of HPV self-screening and subsequent updates to the Cervical Screening pathway, changed the way we received the National Screening Unit data. The indicator in the format agreed to prior to these changes, was not able to be tracked post the changes as this data was no longer supplied by the government.

KPI Description	Achieved	KPI Target	Result
Achieve >82% for management of Microalbuminuria with ACEi or ARBs for people with diabetes (2023: 77%)	Yes	82%	83%
Reduce the overall percentage of women who have had a prior history of high-grade abnormality and are overdue for their smear (prioritising Māori/Pacific) to 33% (approx. 636 additional women) (N/A in 2023 as it was a different percentage, and is now not tracked)	**Not tracked post-rollout of HPV screening changes**		
Increase 8-month immunisation completion rates for Māori and Pacific children (2023: 85%)	No	90%	80%*
Increase 2-year immunisations for Total Population* (2023: 90%)	No	90%	87%*
To provide assistance to current smokers to stop smoking — SBA offered to 90% of smokers in the last 15 months (N/A in 2023)	No	90%	82%
Achieve 62% for dual therapy for enrolled Māori & Pacific people with a 5-year CVD risk >15% (>20% old cohort) (N/A in 2023)	Yes	62%	66%

*We have excluded decliners and babies overseas (8-month and 2-year immunisations), and patients who have been reviewed (dual therapy and microalbuminuria coded exempt, respectively) from the eligible (denominator) population.

Our approach for Year 5 cont.

It is acknowledged that although good progress was made against the Smoking Brief Advice indicator (up from 77% last year) the final result of 82% fell short of the 90% target. This indicator was hampered by out-of-date patient contact information, and strategies to address this will be implemented during the 2024-25 year.

Messaging errors and data delays due to the change over from the National Immunisation Register (NIR) to the new Aotearoa Immunisation Register (AIR) in November 2023, impacted the two immunisation indicators. In addition, there is continuing vaccine hesitancy, particularly for our Māori and Pacific populations. The two-year immunisation result was very close at 87% (against the target of 90%) but is still a significant achievement, as nationally the immunisation rate for 2 year olds was 77.8% (as at 31 March 2024). The focus on childhood immunisation will continue in the 2024-25 financial year. 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 in the full year programme, 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.

An agile approach to population health

As the world of healthcare changes around us, so must we evolve. Being able to respond to the needs of our practices is the driving force behind our growth, innovation, and success. In response to feedback from practices and the changing healthcare landscape, this financial year we restructured our practice enablement teams into agile teams, colloquially known as squads. This was to make sure we remain relevant, forward-thinking, and proactive in this ever-shifting landscape.

We have segmented practices into three allocated groups:

- Practices with high needs populations
- Small/medium practices
- Large practices.

Each group is supported by a Practice Enablement Team made up of subject matter experts who support practices across all facets of their practice — be it business and clinical improvements, clinical education, practice quality or population health goal delivery.

We have adopted agile methodology so we can be more nimble, flexible and outcome focused.

This approach means our practices get support from ProCare in a more targeted way. It also means that we are more focused as a Network on meeting the Pae Ora Act to achieve equitable, accessible, and cohesive people-centred care.

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

- Led incentive campaigns with whānau and practices with the most overdue high needs childhood immunisations. This campaign utilised the national prioritisation matrix
- Launched video resources for practices with key health experts to share with patients the importance of immunisation and some top tips that can be implemented by practices
- Provided digital support for practices to ensure immunisation data is correct in the Patient Management System (PMS), particularly after the change from the National Immunisation Register (NIR) to the Aotearoa Immunisation Register (AIR) in November 2023
- Worked with all practices to recall patients who were overdue for immunisations
- Undertook regular data deep-dives, comparing NHI lists with the AIR to ensure our immunisation data is as accurate as possible. This uncovered several errors in the AIR data which were escalated to the national AIR team
- Created flowcharts outlining best practice for newborn enrolments within general practice, including detailed instructions and 'top tips' for practice staff
- Actively promoted the Best Start Kowae Tool (this encouraged practices to recall for Boostrix during pregnancy with associated education)
- Created reports for practice showing their list of children who are overdue for their scheduled immunisations before the milestones.) This has allowed practices to be proactive in following up children and help to hit the milestone targets at 8 months and 2 years
- Collaborated with National Hauora Coalition, Māori providers, and marae to reach tamariki and their parents through Hauora Days
- Further developed Ara Hauora to support and supplement Outreach Immunisation Services in the community, aiming to support the most vulnerable whānau
- Collaborated with the Immunisation Advisory Centre (IMAC) on a Vaccine Barriers Assessment Tool (VBAT) survey, researching what barriers are in place for Māori in Counties Manukau in regard to vaccination. It is hoped that the outcomes from this research can be used to reduce barriers in the future
- Advocated on behalf of general practices regarding the importance of childhood vaccinations remaining in general practice to Pharmac and Te Whatu Ora.

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

- Developed a White Paper outlining insights into the challenges faced by rangatahi in relation to mental health, and the use of vaping, alcohol, and other drugs. The paper also highlighted a number of potential solutions to these challenges
- Developed stronger connections between ProCare, Fresh Minds and Te Tumu Waiora to support greater access to Mental Health and Sexual Health services for young people
- Responded to the growing concern regarding the issue of school age children and their vaping through promotion of a webinar in the Members' Bulletin
- Provided regular updates to the network on advances in Gender Affirming care
- Worked alongside practices who requested support to complete the Youth Friendly Audit Tool
- Free membership to Society of Youth Health Professionals Aotearoa New Zealand (SYHPANZ) promoted in Members' Bulletin
- Encouraged practices to participate in Aotearoa Youth Week events
- Worked with the Te Whatu Ora Waitematā Clinical Nurse Specialist, Child and Youth Services Team to provide refresher training on supporting mental health needs of Asian youth
- Provided practices with youth-friendly flyers and resources to encourage referrals to Health Improvement Practitioners who could provide young people with appropriate tips and resources.

Ongoing activities

Reporting
The Data Analytics team will continue to look into improving and benchmarking youth health reporting across the network in the coming year.

Re-enrolment
Processes will be developed in the coming year to ensure practices contact youth turning 16 years of age, to re-enrol using text suggestions co-designed with the Youth Advisory Group.

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

- Developed campaigns on the importance of Smoking Brief Advice and Smoking Cessation for practices
- Worked with Living Smokefree - Counties Manukau to contact patients, through campaigns, on behalf of numerous practices to provide Smoking Brief Advice
- Investigated automation of providing Smoking Brief Advice, including a direct referral system to Ready Steady Quit and Living Smokefree, and having the activity write back to practices' PMS.
- Funded a Smoking Brief Advice text initiative to more than 7,000 patients on behalf of practices
- Provided funded support to deliver Smoking Brief Advice to patients on behalf of our general practices, via our Smokefree Contractor. This support helped 44 practices and achieved 2,227 records of Smoking Brief Advice over 237 hours
- Developed and distributed monthly Population Health 'Bingo' sheets to practices. These were linked to the Population Health campaigns that were being promoted to encourage using the campaign's 'words of the day'
- Partnered with Living Smokefree Counties Manukau to provide Smokefree Best Practice training to 33 Health Coaches and five Team Leaders during February and May 2024
- Developed 'How-to guides" for Health Coaches around entering Smoking Brief Advice data into a PMS as a way of working more collaboratively across our teams and ensuring referral instructions for Ready Steady Quit and Living Smokefree were included
- Developed 'Arrival Cards' as a way of working 'smarter' to collect personal information and aiming to achieve higher numbers of smoking brief advice being given
- Used Smokefree May as a rationale to conduct proactive and organised activity for Health Coaches
- Commissioned Ready Steady Quit videos with clients that could be shared on Health TV as testimonials to encourage whānau to consider giving up smoking
- Wrote to Minister Costello highlighting how disappointed we were by the potential ramifications of the decision to repeal the amendments to the Smokefree Environments and Regulated Products Act 1990
- Ensuring that 61 practices with high numbers of Māori, Pacific and youth use the Te Tumu Waiora (TTW) model, having at least one Health Improvement Practitioner or Health Coach
- Held best practice sessions on cervical screening and the HPV self-testing rollout over the course of four sessions and focused on quality improvement with attendees from numerous practices
- Created a campaign on the importance of cervical screening and equity, which helped improve smear rates
- Created new reporting for HPV/Cervical Screening for practices to track progress, and to work through lists of those needing to be screened
- Ensured Health New Zealand/Te Whatu Ora messaging was shared with practices
- Actively supported the rollout of HPV self-testing across the Network, while also maintaining key information about the need for smears

- Encourage data sharing partnerships between practices and Well Women and Family Trust, targeting overdue women specifically Ara Hauora and ProCare partnered with Smear Your Mea and Well Women and Family Trust for Te Matatini May 2024 to increase awareness of and participation in cervical smears
- Wrote to Te Whatu Ora advocating for increased access to HPV screening for our wāhine by allowing Registered Nurses who haven't completed the cervical sample taker training to be able to undertake HPV Primary Screening
- Worked alongside services such as Ara Hauora, to promote active calling of wāhine who fall into the high-grade overdue cohort. Considered use of Māori providers or referral to marae
- Encouraged alcohol screening and Alcohol Brief Advice across the Network, actively promoting 'Dry July' to Members
- Wrote letter to Hon Ginny Andersen advocating on passing the Sale and Supply of Alcohol (Community Participation) Amendment Bill to help substantially reduce barriers to participation and subsequent alcohol-related harm
- Advocated to fund aripiprazole depot injection as an alternative antipsychotic treatment option.

Ongoing activities

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

There was insufficient interest expressed from the Network to run this Collaborative.

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

Reports have been made available, and the Data Analytics team will continue to look into improving and benchmarking reporting across the Network in the coming year.

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

- Ran cardiovascular disease and dual therapy campaigns during February and April 2024 providing practice and patient resources, patient lists and information on understanding exemption codes
- Created patient-facing videos about cardiovascular disease which were made available to practices and displayed on Health TV during the months of February - April 2024
- Developed a Cardiovascular Disease Risk Assessment (CVDRA) 'Readiness' Report for practices, to identify patients who are eligible for a CVDRA and what information is required to complete these
- Through promotion of the CVDRA Readiness Report, continued to support practice completion of CVDRAs for the eligible cohorts, especially targeting the newly eligible cohorts, Māori and Pacific populations
- Developed practice facing videos where Dr Allan Moffitt outlined the importance of dual therapy, encouraged practices to review patients on dual therapy list, and to complete CVDRA re-screening i based on the new algorithm
- Ran best practice sessions ('Better Together Collaboratives') on Cardiovascular Disease Risk Assessments and Management focusing on quality improvement with practices
- Held Continuing Medical Education (CMEs) sessions for GPs and Nurses on the topic of Cardiovascular Disease
- Deployed a CVDRA 'Robot pilot ' in five ProCare and two Pinnacle practices, completing
- Cardiovascular Risk Assessments using the CVDRA Readiness Report and writing the results back into the Practice Management System thereby reducing the administrative burden on those practices and their GPs
- Developed and implemented new strategies to improve the management of microalbuinuria, including encouraging practices to enter additional alerts for people with diabetes with microalbuminuria
- Ran Microalbuminuria campaigns during December and March which included providing practice and patient resources, and developed two videos by Dr Allan Moffit — one for practices and one for patients
- Created patient-facing videos about diabetes which was made available to practices and displayed on Health TV during the months of February — June 2024
- Ran best practice sessions ('Better Together Collaboratives) on diabetes medication management focusing on quality improvement for participants and practices
- Wrote submission to Pharmac advocating for funding for continuous glucose monitors, insulin pumps, and insulin pump consumables as we believe this would improve health outcomes and life expectancy for people with diabetes, offer people with diabetes a less painful and less disruptive way of monitoring their blood glucose levels, make it easier for New Zealanders living with diabetes to self-monitor their glucose levels and better self-manage their condition, and go a long way to achieving equitable care for people with diabetes
- Provided gout awareness, screening and proactive health promotion at Pasifika, along with Arthritis NZ, as a way of providing patient education
- Ran best practice sessions (Better Together Collaboratives) on gout management focusing on quality improvement for participants and practices
- Advocated for Special Authority for GPs to diagnose and prescribe ADHD medication as way of meeting the Pae Ora Act in terms of mauri ora (healthy individuals), whānau ora (healthy families), and as a way of meeting the Te Tiriti o Waitangi principles of Kaitiakitanga (active protection) and Ōritetanga (equity).

Ongoing activities

Review Patient Dashboard prompt/alert with Procon for Primary Prevention of Cardiovascular Disease (CVD)

Deferred to FY25

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

- Developed campaigns on the importance of influenza vaccinations to practices and reminders of the reports available for practices
- Promoted Advanced Care Plans to practices
- Provided practices with access to discounted influenza vaccinations
- Continued to promote Falls prevention programmes across the network
- Continued screening for The Fono Manurewa and sent referrals via Care Connect
- Participated in the Counties Manukau District's (CMD) Falls and Fracture Prevention Steering Group and networking events
- Worked with CMD to recognise and share issuesand challenges identified with the referrals
- Worked with Papakura Marae outreach team to promote falls prevention and provide home safety checklist for older adults.

Ongoing activities

Investigate activities to support poly-pharmacy
Medication review tool has been included in the ProFusion form for Pharmacists as part of the CPCT roll out. Further activities to support poly-pharmacy will be investigated in the coming year.

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

During the coming year, we will continue to identify the key issues and work to address these for our kaumātua and kuia.

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

- Organised marae visits for practices to build relationship with the local marae and learn more about Te Ao Māori customs and traditions
- 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. The SLM objective was to increase response rates of 5% or more for participants. ProCare achieved a 1.0% statistically significant uplift over 5% for Māori/Pacific patients and a smaller uplift for non-Māori/ Pacific patients, whose response rates remained the same
- Continued to encourage practices to use the ABC ('Ask, Build, Check') approach to documents and communication to assist with health literacy of the system and provision of care
- Managed funding increases to pass through to practices including the Equity Adjuster, uplift and pay parity adjustments
- As holders of the lead contract for facilitating the roll out of the Comprehensive Primary and Community Teams (CPCT) from Te Whatu Ora for Metropolitan Auckland (Wellsford to Tuakau), 27 roles were deployed across 22 practices with a strong focus on practices with the highest needs populations. The roles are clinical pharmacists, extended care paramedics and care coordinators. practices with the highest needs populations since March 2024. The roles are clinical pharmacists, extended care paramedics, physiotherapists and care coordinator
- Started developing a customised Pacific cultural competency training for our clinical staff in partnership with Le Va. This is to help enhance the capability of the non-Pacific workforce to ensure access to best possible services for Pacific people and their families
- Given the tough environmental factors our practices have faced this year, we focused on providing additional support to our practices and advocating on the issues that matter to them. Our latest Pulse Survey result show that this has improved significantly with 92% of practices believing ProCare is relevant for their practice, and 82% strongly agree/agree that ProCare advocates on the things that matter to them
- Developed the Community Care Challenge to help encourage practices to meet their population health clinical indicators by the end of June 2024 and recognise them for their achievements.

Total population performance

		Post-Covid		Covid		Pre-Covid
Health goal	**Indicator**	**Performance 2023-24**	**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	88%**	87%	87%	92%	93%
	2-year immunisation rates	87%**	85%	80%	88%	91%
Engaged and enabled to improve wellbeing	Smoking brief advice	82%	77%	74%	79%	88%
	Cervical screening	64%	72%	72%	76%	74%
Improved quality of life for people living with long term conditions	Cardiovascular Disease (CVD) — Risk Assessment New Cohort	66%	63%	49%	37%	N/A
	Cardiovascular Disease (CVD) — Risk Assessment Old Cohort	83%	81%	85%	88%	89%
	CVD — Primary prevention	67%**	54%	54%	52%	49%
	CVD — Secondary prevention	68%	67%	67%	67%	66%
	Diabetes care — blood pressure control	66%	63%	58%	60%	63%
	Diabetes care — management of microalbuminuria (protein in urine)	83%**	77%	77%	78%	78%
	Diabetes — Glycaemic control (HbA1c)	63%	64%	60%	60%	60%
Older people to have improved quality of life	Flu vaccine rates for >65's (June results)	58%	61%	66%	63% *	75%

Throughout Year 5 of the Population Health Strategy (PHS) delivery, it was clear that the post-covid impact of the pandemic and its long tail, financial and workforce constraints and the ongoing health reforms were still prevalent through the primary healthcare landscape. Adding to this, the change in Government meant that many of the areas that PHS focuses on, particularly when it came to preventative care and working with those with long-term conditions, were not met as the focus for many remained elsewhere.

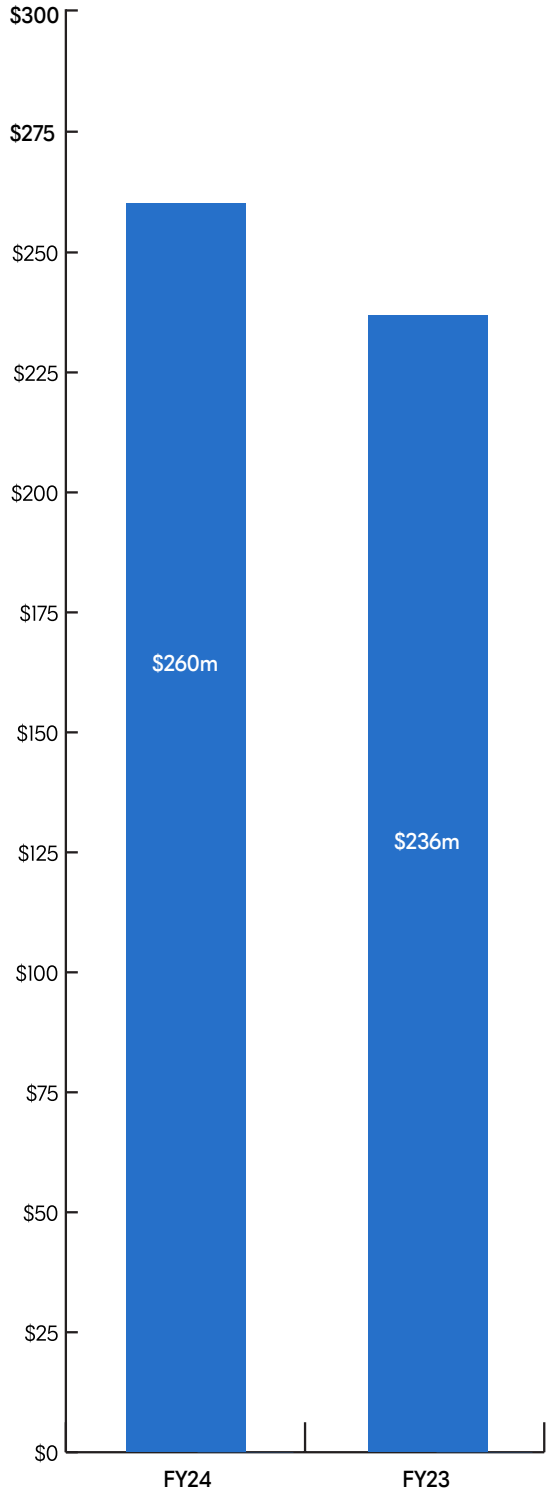
We have not included the intial targets developed in 2019 in the table above as the impacts of covid have meant we are operating in an entirely different landscape.

*Due to additional data sources

**We have excluded decliners and babies overseas (8-month and 2-year immunisations), and patients who have been reviewed (dual therapy and microalbuminuria coded exempt, respectively) from the eligible (denominator) population.

Funding revenue recognised

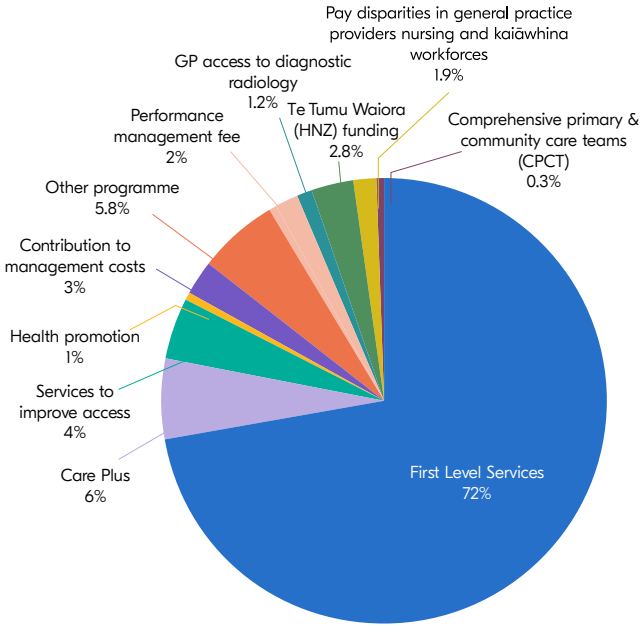
Total funding ($m)



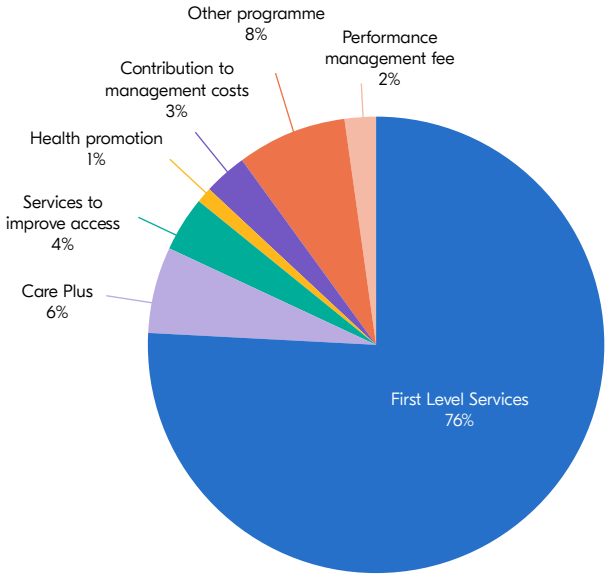
99.9% of funding is received from Te Whatu Ora Te Toka Tumai, Te Whatu Ora Counties Manukau, and Te Whatu Ora Waitematā (FY23: 99.9%)

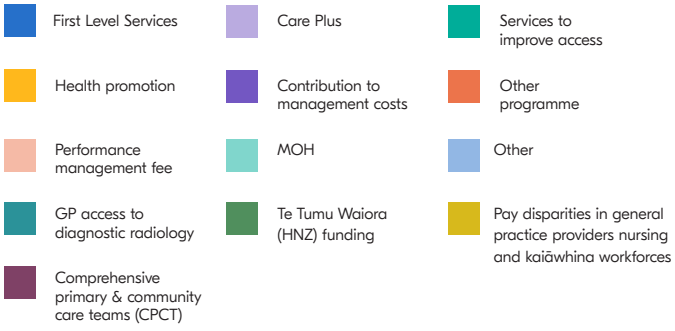
$448k of funding was utilised on Population Health Strategy initiatives ($530k in FY23)

FY24 revenue streams



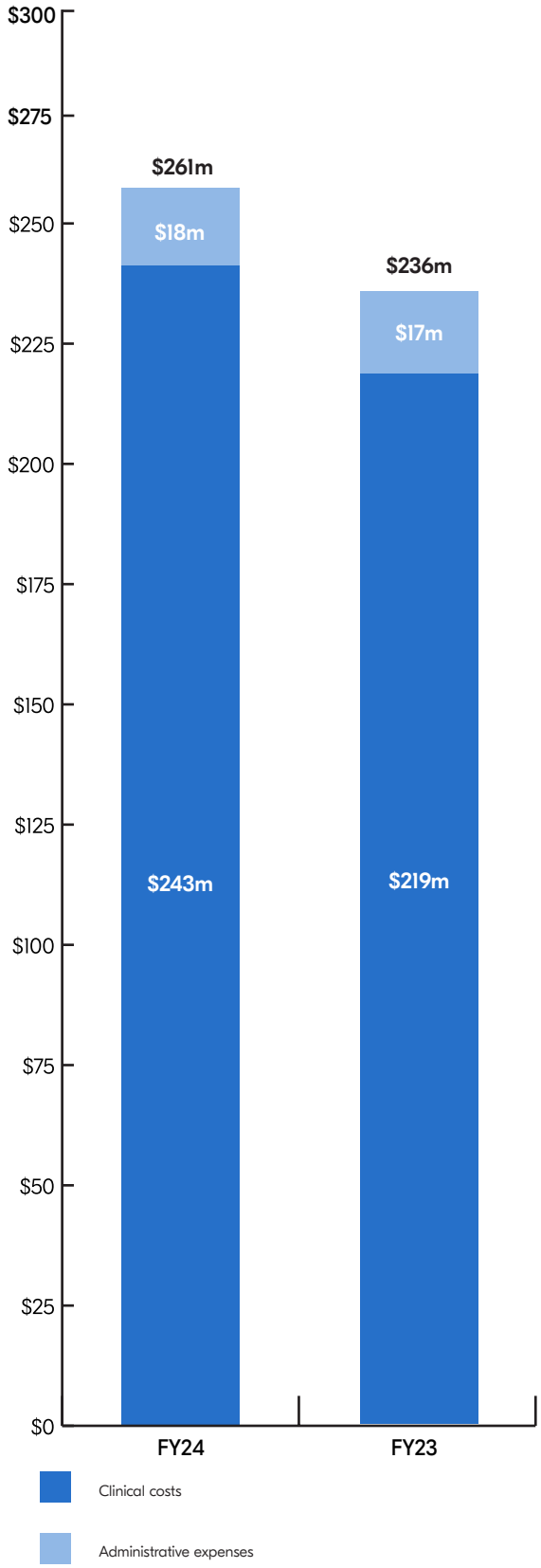
FY23 revenue streams



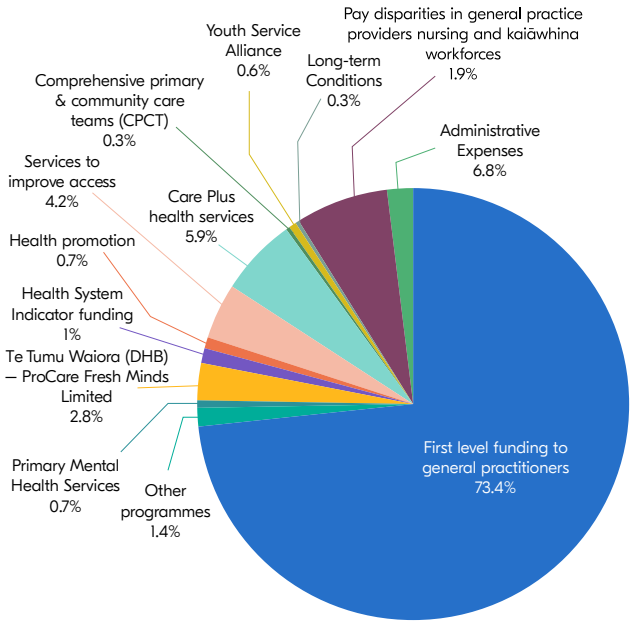


Clinical and Administrative Expenditure Incurred

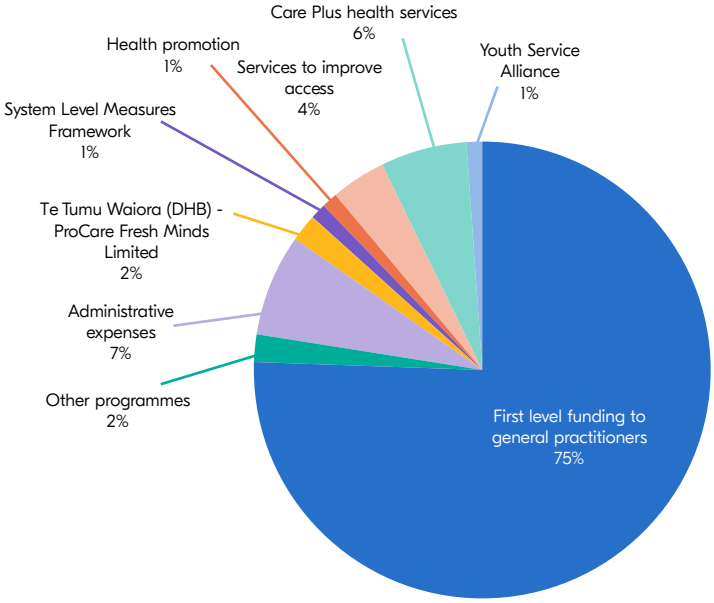
Total expenses ($m)

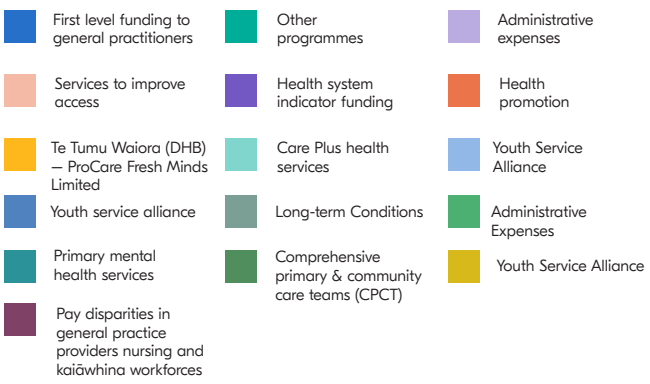


FY24 spend



FY23 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