PRIMARY CARE
CONNECT

Strategic Plan 2024-28

Acknowledgement of Country

In keeping with the spirit of reconciliation, we acknowledge the Traditional Owners of the lands where we now stand – and acknowledge that these have always been places of teaching and learning. We wish to pay our respects to their Elders – past, present and emerging – and acknowledge the important role Aboriginal and Torres Strait Islander people continue to play within the community.

Child Safe Standards

Primary Care Connect (PCC) is committed to ensuring the safety, wellbeing and participation of all children, young people and their families; we want children and young people to be safe, happy and empowered. PCC is committed to preventing child abuse and identifying early risks and take the relevant actions in removing and reducing these risks. PCC has a zero tolerance to child abuse and neglect, and all allegations and safety concerns will be treated very seriously and consistently with our robust policies and procedures. We have legal and moral obligations to contact authorities when we are worried (concerned) about a child or young person's safety, which we follow rigorously. PCC is a culturally safe and inclusive organisation and ensures that all children and young people will receive care that responds to their individual needs. We support and respect the wellbeing of all children and young people, as well as our staff and volunteers. We are committed to the cultural safety of Aboriginal children and young people, the cultural safety of children from culturally and/or linguistically diverse backgrounds, and to providing a safe environment for children with a disability, or who identify as LGBTIQA+. PCC employs robust human resource systems of recruitment, retention and accountability that prioritises the safety of children; and provides training to all board members, staff and volunteers on child abuse risks and obligations. PCC have specific policies and procedures in place to achieve these commitments.

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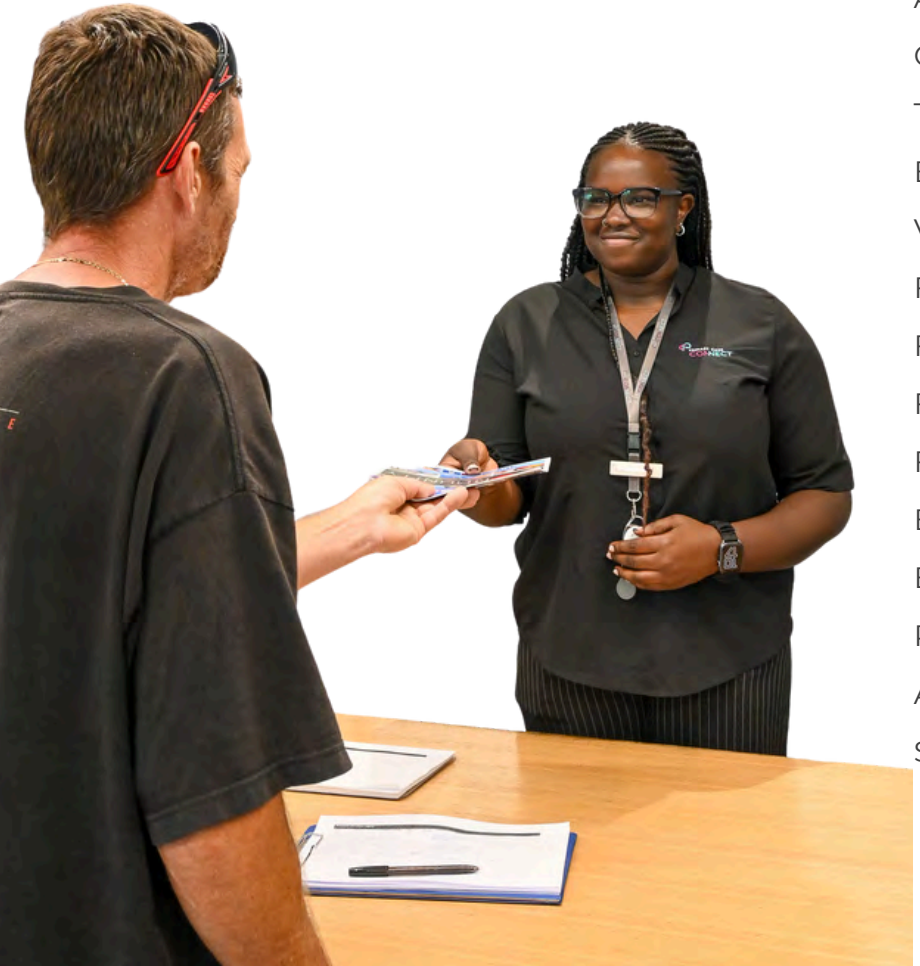


Executive Foreword

Pictured left to right; PCC CEO, ***Trish Quibell*** *and PCC Board Chair,* ***Wendy Ross***

The Primary Care Connect Strategic Plan 2024-28 has been designed to build on PCC's existing strengths, including our well-established values. The PCC Strategic Plan reaffirms and demonstrates the important role that PCC plays in the local systems and the unique value proposition of community health.

A wide range of stakeholders were consulted in the development of this plan including our community and clients at sessions held both onsite at PCC and at locations within the community. PCC staff were also consulted as well as many of our partner organisations and external stakeholders.

> ***"PCC has a vision that every person in our community is connected, supported, and empowered to lead safe, happy and healthy lives."***

Delivery of PCC's vision will be supported by the specific role and focus outlined in the Value Proposition:

- Providing health promotion, early intervention, chronic care management, safety support, and recovery-focused community health services to people living in our catchment.
- Supporting everyone in our community and particularly those who are disadvantaged or at-risk. We take the time to connect with people and listen to their health and wellbeing goals. We then empower people to achieve these goals.
- Building strong and trusted relationships with community groups, removing barriers to accessing care by providing outreach support, co-locating our services with other essential supports and ensuring care is easy to access regardless of where you live in the catchment.
- Working in multidisciplinary teams internally and with other service providers to deliver integrated and team-based care. Our clients experience holistic intake, clear and connected care pathways, and comprehensive follow-up to ensure they continue progressing and thriving.

Over the next 4 years PCC will deliver on several strategic priorities that have been grouped into focus areas:

- Building Trust Based Client Relationships
- Connecting Services and Integrating Care
- Strengthening Community Ties
- Improving Community and Service Knowledge

In addition to the four focus areas, two further 'enabling' focus areas were identified, which focus on the areas of significant internal focus and performance change required to drive delivery of the strategic priorities:

- A diverse, highly skilled and supported workforce
- Intuitive infrastructure that drives connection, understanding and evidence

This document provides detailed information of the initiatives and key performance metrics that articulates how PCC will achieve the successful delivery of the Strategic Plan.

Vision and Values

OUR VISION

Everyone in our community is connected, supported and empowered to lead safe, healthy and happy lives.

OUR VALUES

INDIVIDUALITY
We recognise everyone is unique and we strive to understand and build on their strengths.

GROWTH
There are many different paths to a solution, and we support people on their journey.

MEANINGFUL CONNECTIONS
We bring our focus and skill to build meaningful connections.

COMMUNITY
Through equity and quality, we strive to improve the health and wellbeing of our community.


PRIMARY CARE
CONNECT
ARRCH
Alliance of Rural & Regional
Community Health
PROGRAM GUIDE
2024
COMMUNITY
nexus
Primary Health
SCHS

BUILDING TRUST-BASED CLIENT RELATIONSHIPS

STRATEGIC FOCUS AREA 1

Overview:
Trusted relationships are the foundation of strengths-based approaches and PCC's focus on empowering people and communities to achieve their health and wellbeing goals.
Over the next four years, PCC will focus on developing approaches that ensure strong, trust-based and enduring relationships centred around developing and sharing ownership of clients' health and wellbeing goals and routine follow-up with all our clients.

Priorities *What will we do?*	**Initiatives** *How will we get there?*	**Expected Commencement**	**Outcomes** *What will success look like?*
• Agile scheduling and care coordination • Strengths-based and holistic understanding of support needs • High-quality care delivered by multidisciplinary teams • Comprehensive goal-based follow-up	PCC model of care and care manual development	Commences Year 1	Our clients feeling heard, supported, and placing their trust in us to help them achieve their health and wellbeing goals regardless of what their goals are
	Master scheduling review and integration	Commences Year 1	
	Target service plan development	Commences Year 2	

CONNECTING SERVICES AND INTEGRATING CARE

STRATEGIC FOCUS AREA 2

Overview:
Connecting services means services are easier to access, and that communities and clients can get the right care at the right time. Connected services helps create genuinely client-centric services, helps people access care sooner and reduces the cost of the required care.
Over the next four years, PCC will invest to take our partnerships to the next level, using our networks to improve service access, establish clear pathways for the community, bring experts together to support client care and co-deliver services.

Priorities *What will we do?*	**Initiatives** *How will we get there?*	**Expected Commencement**	**Outcomes** *What will success look like?*
• Integrated service delivery with partner organisations • Connected pathways for chronic care management • Seamless cross-referrals • Collaborative community health needs and service planning	Service pathways analysis and partnership strategy development	Commences Year 1	Our clients being able to access high-quality care where and when they need it, and without having to retell their story over and over again
	Partnership trust framework development	Commences Year 2	

STRENGTHENING COMMUNITY TIES

STRATEGIC FOCUS AREA 3

Overview:
Communities are at the heart of community healthcare. Strong relationships with our communities across the catchment give communities a voice in their care and help to reengage, support and empower community members to achieve their health and wellbeing goals.
Over the next four years, PCC will focus on broadening its front door and getting back into communities particularly those communities outside of the Greater Shepparton LGA. It will do this by engaging and strengthening relationships with community groups and increasing health promotion. PCC will also develop new partnerships aimed at supporting the disadvantaged and at-risk in our communities to ensure they have the support they need.

Priorities *What will we do?*	**Initiatives** *How will we get there?*	**Expected Commencement**	**Outcomes** *What will success look like?*
• More services delivered in the community • New partnerships that support disengaged, at-risk communities • Strong connections with community groups across the catchment	Marketing and Communications Plan implementation - public awareness raising	Commences Year 1	Our community knows who we are and what we do, and that we are there for them in their time of need. We are our community's community health provider of choice
	PCC mobile service van business case	Commences Year 2	
	Mobile work enablement	Commences Year 3	

IMPROVING COMMUNITY AND SERVICE KNOWLEDGE

STRATEGIC FOCUS AREA 4

Overview:
Strong community and service intelligence means that PCC has the knowledge, understanding and evidence to provide our communities with the best community health care.
Over the next four years, PCC will focus on increasing its analytical translation and evaluation capability and data quality. It will use this to improve its understanding of client needs and preferences and build an evidence base for its services. PCC will also increase opportunities for community participation and involvement in new service development.

Priorities *What will we do?*	**Initiatives** *How will we get there?*	**Expected Commencement**	**Outcomes** *What will success look like?*
• Increased community participation in service development • Comprehensive understanding of client needs, care and service preferences • Deep understanding and insights on the services and care that deliver outcomes for our community	Feedback framework	Commences Year 1	Having the evidence to know what impacts the health and wellbeing outcomes of our community the most and using this to design the highest quality of care possible
	Customer Relationship Management system review and enhancement	Commences Year 2	
	Community participation plan development	Commences Year 2	

A diverse, highly skilled and supported workforce

STRATEGIC ENABLER 1

Overview:
To deliver on the Vision and strategic priorities of this plan, PCC will continue to build the skills and diversity of its workforce, and work to ensure all staff feel safe, support and valued. This includes a strong focus on increased staff's comfort and knowledge about working in a multidisciplinary team environment.
The enablers identified here will be incorporated into the PCC Workforce Strategy to ensure that it aligns with and supports the achievement of the forthcoming Strategic Plan.

Priorities *What will we do?*	**Initiatives** *How will we get there?*	**Outcomes** *What will success look like?*
• A workforce as diverse as our community • Multidisciplinary training and professional development • Strengthen digital literacy, analytical and evaluation capabilities • Strengths-based and trauma-informed organisation	Develop and implement a PCC workforce plan	Our workforce mirrors our community and feel safe, supported and successful
	Regular reporting to Executive and Board on workforce plan progress	

Intuitive infrastructure that drives connection, understanding and evidence

STRATEGIC ENABLER 2

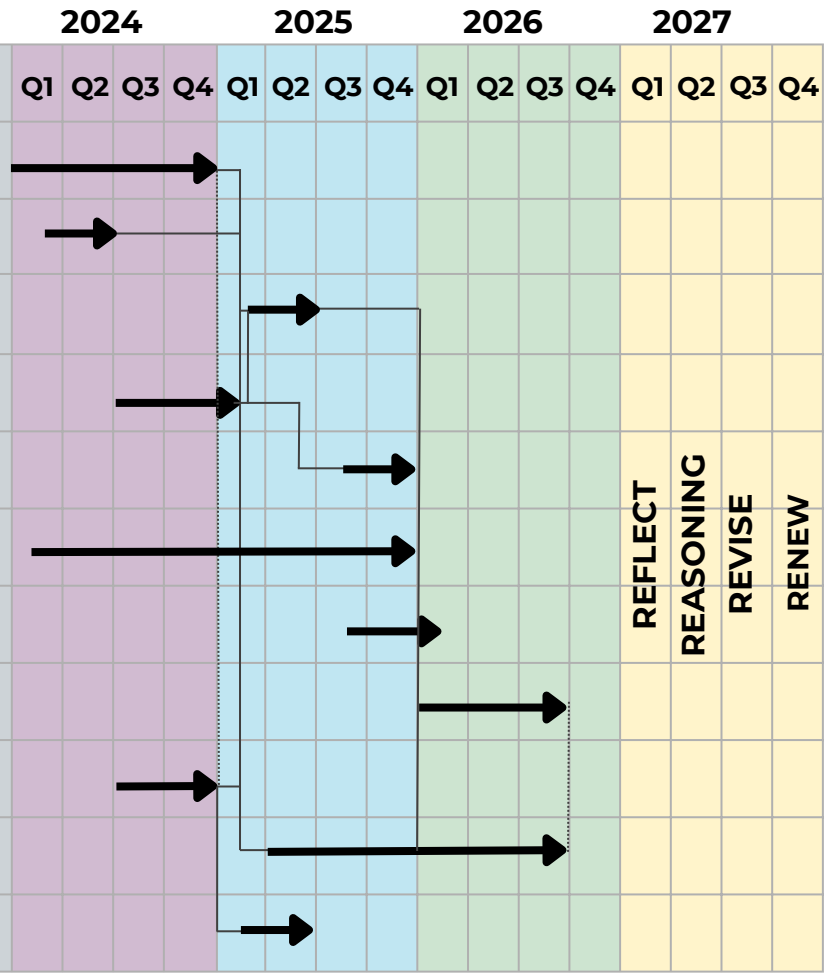
Overview:
To deliver on the vision and strategic priorities of this plan, PCC needs to review and upgrade its infrastructure, ensuring that it capable of driving connection of staff, services and clients; enabling workflows; providing intelligence on client and communities; and capturing evidence of service efficacy and impact.
The enablers identified here will be reflected in strategies for PCC's infrastructure and systems investment, ensuring that investment in assets is well aligned with the forthcoming strategic plan.

Priorities *What will we do?*	**Initiatives** *How will we get there?*	**Outcomes** *What will success look like?*
• Digitally enabled operational workflows • Advanced CRM driving client and service connections • Strong business intelligence interfaces • Mobile workforce capabilities	Promote ICT governance and policy development to enhance operations	Staff have the systems, tools and physical environment to deliver high quality care
	Review of current CRM for gaps and inefficiencies and compare with other market options to promote sustainable business development	
	Develop and implement forward integrating systems (including CRM program)	
	Utilise ICT programs and devices to work with clients, interact and engagement anywhere, anytime	

ROADMAP TO SUCCESS

Our **Roadmap to Success** provides a snapshot of how each of our Strategic Initiatives is interlinked. Once an Initiative reaches maturity it doesn't cease to exist - it is either linked to another Initiative, or continues to grow at the maturity level to achieve the metrics set out until the end of this strategic period. Our **Roadmap to Success** visually demonstrates the collaboration and interconnection required between teams and Initiatives to achieve the Outcomes desired.
The final year of our strategic journey will see us **Reflect, Reason, Revise and Renew** the Strategic Plan for 2028 and beyond.

	Initiatives	***Interdependencies***
1	PCC model of care and care manual development	9 (finalise together)
2	Master scheduling review and integration	
3	Target service plan development	1, 4, 9
4	Service pathways analysis and partnership strategy development	
5	Partnership trust framework	4
6	Marketing and communications - implementation - public awareness raising	
7	PCC mobile service van business case	2, 3
8	Mobile work enablement	10 (finalise together)
9	Feedback framework developed	
10	CRM system review and enhancement	1, 2, 3, 9
11	Community participation plan development	9




PCC
PCC is the gym for

APPENDIX

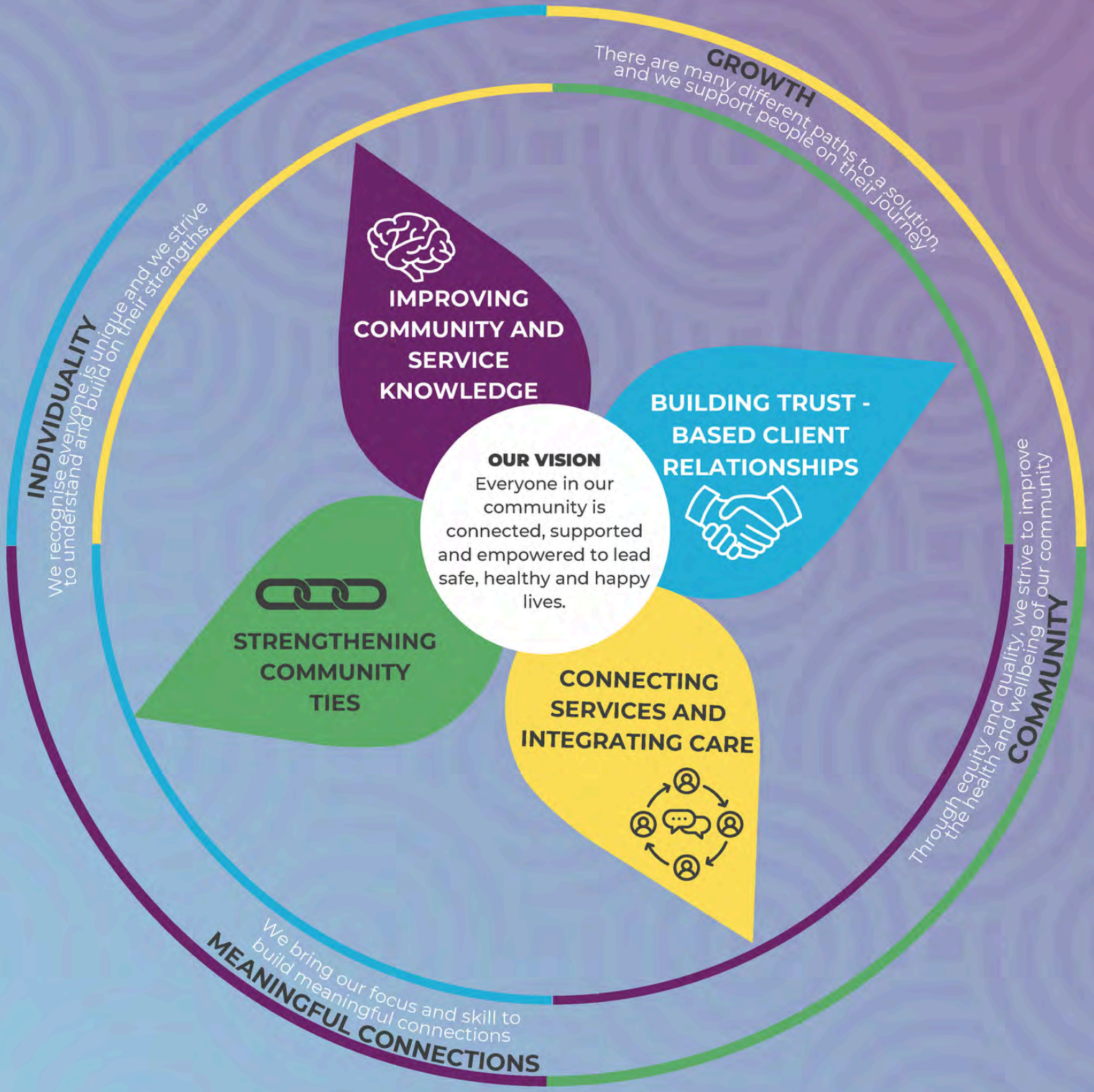
Initiative description:

1	**PCC model of care and care manual development** **(i)** Development of an overarching Model of Care aligned to PCC's agreed value proposition and including expectations on holistic intake, care planning, multidisciplinary care and follow-up. **(ii)** Translate this into a detailed Care Manual for client-facing staff that supports high-quality, consistent and integrated care.
2	**Master scheduling review and integration** Review PCC's service schedule in order to drive integration and alignment of services at a whole-of-organisation level, increasing the convenience of scheduling for clients and the capacity for integrated and multidisciplinary care.
3	**Target service plan development** Review of PCC's service and program mix, with the identification of future target service mix, as well as service investment and divestment opportunities aligned with PCC's mission, value proposition and model of care.
4	**Service pathways analysis and partnership strategy development** **(i)** Undertake mapping to understand where current and future potential clients received their health information from to ensure we are collaborating and promoting our services well. **(ii)**Develop a Partnership Strategy that identifies the types and service areas for Partnerships (public, private NFP, philanthropic), and establishes a consistent performance driven approach to partners (including consideration of governance, performance management and collective decision making)
5	**Partnership trust framework development** Develop a method for measuring and monitoring the level of trust that partner organisations have in PCC, aligned with the Partnership strategy and agreed partnership performance management and governance approaches.
6	**Marketing and communications – implementation – public awareness raising** Implement the projects and initiatives detailed in the approved PCC Marketing and Communications Plan with the objective of increasing the public awareness and perception of Primary Care Connect.

APPENDIX

Initiative description:

7	**PCC mobile service van business case development** Develop a business case to determine the benefits of investing in a mobile service delivery van to support outreach activities. This investment should be considered in light of scheduling review and service plan development and delivery of performance targets of the strategic plan.
8	**Mobile work enablement** Enhance systems and digital infrastructure that supports a more mobile workforce and upholds the security of personal and organisational data (integrated with the enhanced CRM capacity).
9	**Feedback framework development** Develop comprehensive approach for the collection, collation and analysis of client and community feedback that ensures feedback is reported on, evaluated and actioned.
10	**CRM System review and enhancement** **(i)** Review TrakCare system including development of a business case to upgrade or replace TrakCare with a view to ensuring high-quality care, improved intelligence capabilities and enabling excellent reporting and governance processes. **(ii)** Implement system changes aligned with approve business case and supportive of digital specifications of agreed Model of Care, Master Scheduling requirements, Service Plan and Feedback Framework, and mobile work enablement.
11	**Community participation plan development** Develop an approach to community participation for PCC that amplifies a diverse set of voices and ensures future service design and organisational decision making is strongly informed by consumers, their carers and families perspectives.


GROWTH
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Through equity and quality, we strive to improve the health and wellbeing of our community
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IMPROVING COMMUNITY AND SERVICE KNOWLEDGE
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OUR VISION
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PRIMARY CARE CONNECT

STRATEGIC PLAN 2024 - 2028

VALUE PROPOSITION |

- Providing health promotion, early intervention, chronic care management, safety support, and recovery-focused community health services to people living in our catchment.
- Supporting everyone in our community and particularly those who are disadvantaged or at-risk. We take the time to connect with people and listen to their health and wellbeing goals. We then empower people to achieve these goals.
- Building strong and trusted relationships with community groups, removing barriers to access care by providing outreach support, co-locating our services with other essential supports and ensuring care is easy to access regardless of where you live in the catchment.
- Working in multidisciplinary teams internally and with other service providers to deliver integrated and team-based care. Our clients experience holistic intake, clear and connected care pathways, and comprehensive follow-up to ensure they continue progressing and thriving.

OUR KEY STRATEGIES

BUILDING TRUST-BASED CLIENT RELATIONSHIPS

HOW WILL WE GET THERE

- Agile scheduling and care coordination.
- Strengths-based and holistic understanding of support needs
- High quality care delivered by multidisciplinary teams.
- Comprehensive goal-based follow-up.

WHAT DOES SUCCESS LOOK LIKE

Our clients feeling heard, supported, and placing their trust in us to help them achieve their health and wellbeing goals regardless of what their goals are.

STRENGTHENING COMMUNITY TIES

HOW WILL WE GET THERE

- More services delivered in the community.
- New partnerships that support disengaged, at-risk communities.
- Strong connections with community groups across the catchment.

WHAT DOES SUCCESS LOOK LIKE

Our community knows who we are and what we do, and that we are there for them in their time of need. We are our community's community health provider of choice.

CONNECTING SERVICES AND INTEGRATING CARE

HOW WILL WE GET THERE

- Integrated service delivery with partner organisations.
- Connected pathways for chronic care management.
- Seamless cross-referrals.
- Collaborative community health needs and service planning.

WHAT DOES SUCCESS LOOK LIKE

Our clients being able to access high-quality care where and when they need it, and without having to retell their story over and over again.

IMPROVING COMMUNITY AND SERVICE KNOWLEDGE

HOW WILL WE GET THERE

- Increased community participation in service development.
- Comprehensive understanding of client needs, care and service preferences.
- Deep understanding and insights on the services and care that deliver outcomes for our community.

WHAT DOES SUCCESS LOOK LIKE

Having the evidence to know what has the biggest impacts on health and wellbeing outcomes for our community, and using this to design the highest quality of care possible.


#END
OVERDOSE