General Practice Queensland
Strategic Plan

11 December 2010
and
19 & 20 February 2011
## Contents

- Attendees ................................................................................................................................. 3
- Coach ........................................................................................................................................... 3
- Our Objectives ........................................................................................................................... 5
- Potted History ............................................................................................................................ 7
- Pressures and Proximity .............................................................................................................. 9
- Reckoning and Impact ............................................................................................................... 11
- RadarLock™ .............................................................................................................................. 35
- Mapping ...................................................................................................................................... 43
- Wonder How they Feel About... ............................................................................................... 44
- Forum De-brief ............................................................................................................................ 45
- Strategic Milestones .................................................................................................................. 46
  - Governance and Corporate Structure ...................................................................................... 47
  - Strategy and Organisational Structure .................................................................................... 47
  - Board and Leadership .............................................................................................................. 48
  - Our People and Culture .......................................................................................................... 49
  - Programs and Services ........................................................................................................... 50
  - Funding and Finance ............................................................................................................... 51
  - Government ............................................................................................................................. 52
  - Data, Knowledge and Quality ................................................................................................. 53
  - Medicare Locals ....................................................................................................................... 54
  - Industry Partners ..................................................................................................................... 54
  - Members and Primary Care Network ....................................................................................... 55
  - Primary Healthcare Providers ................................................................................................. 56
  - Hospitals and Local Health Networks ..................................................................................... 57
  - Consumers and Community .................................................................................................... 57
  - Suppliers and Infrastructure ..................................................................................................... 58
  - Technology ............................................................................................................................... 59
  - New Revenue Streams ............................................................................................................. 59
  - Marketing and Public Relations ............................................................................................... 60
  - Environmental Pressure ........................................................................................................... 60
- Strategic Workshop Activation .................................................................................................... 61
Attendees

Session One: Marriott, Gold Coast - 11 December 2010

Ms Ann Maree Liddy                Chief Executive Officer
Ms Karen Dennien                  General Manager
Ms Libby Dunstan                  Team Leader
Ms Jann Offer                     Team Leader
Ms Lindy Fentiman                 Team Leader
Ms Michelle Melnikoff             Team Leader
Dr Dilip Dhupelia                 GPQ Board Member
Dr Fiona McGrath                  GPQ Board Member
Dr Ann McBryde                    GPQ Board Member
Dr Graham Emblen                  GPQ Board Member
Associate Professor Michael Greco  GPQ Board Member
Dr John Kastrissios               GPQ Board Member
Mr Mark Tucker-Evans              GPQ Board Member
Dr Susan Dann                     GPQ Board Member

Session Two: Sofitel, Brisbane – 20 & 21 February 2011

Ms Ann Maree Liddy                Chief Executive Officer
Ms Karen Dennien                  General Manager
Mr David Phillips                 Business Manager
Ms Libby Dunstan                  Team Leader
Ms Jann Offer                     Team Leader
Ms Lindy Fentiman                 Team Leader
Ms Michelle Melnikoff             Team Leader
Ms Julia Leigh                    Team Leader
Dr Dilip Dhupelia                 GPQ Board Member
Dr Fiona McGrath                  GPQ Board Member
Dr Ann McBryde                    GPQ Board Member
Dr Graham Emblen                  GPQ Board Member
Associate Professor Michael Greco  GPQ Board Member
Dr John Kastrissios               GPQ Board Member
Mr Mark Tucker-Evans              GPQ Board Member
Dr Susan Dann                     GPQ Board Member

Coach

John Vamos
Our Objectives

*We shared our objectives*
Our Objectives

- All on the same page – a clear picture of where we are now
- Look at the organisation through different eyes – different perspective
- A realistic assessment of the future for General Practice Queensland as an organisation
- A preferred future that is conscious of the reform trends
- Where we fit into the bigger picture – a broader perspective
- Generate some concepts that can add additional value – make us compulsory
  - Ideas that can motivate our stakeholders
- Maximise the opportunities that are before us. Understand and address the challenges in reaching that
- Consider all the impacts on our future beyond the significant ones (i.e. Government)
- See where what we do now fits into the future. Do not lose what we do well
- An opportunity for the Leadership Team to harness their shared expertise and to have complete engagement in a shared plan
- Reality check in what we do now – conclusions about how to apply limited resources
- Some rigour in how we implement the strategy – take the dialogue forward
Potted History

We reflected on the events, accomplishments and challenges for which the last twelve months or so would be remembered
Potted History

Highlights

- Awarded funding for chronic disease
- Changed the relationship with Divisions - credibility
- Appointment of Directors – Non GP
- Re-definition of focus – broader stakeholders
- Constitution reforms
- Re-branding to General Practice Queensland
- Bulk billing clinics issues
- AMA and colleges take General Practice Queensland more seriously
- Formation of GPNLG and our role in it – National presence
- Leadership Connection for Chairs improves effectiveness
- Significant funding in indigenous health
- Targeted approach to Queensland Government engagement – commitment to partnership
- Engaged with other primary health care providers
- Successful delivery of MSOAP Program
- Formal Strategic Planning process – detailed road map
- Rapid growth in funding means many business development opportunities – broader funding base
- Quality culture – vigour and rigour
- Gained ISO certification
- Introduced Award and Recognition Program
- Introduction of General Manager and Team Leaders – structure to support strategy
- Take on more space for Training and Development
- Joined the National Organisation
- Non GPs elected, not appointed
Pressures and Proximity

Our Proximities were determined according to the following definitions:

- **Urgent**: Of utmost importance
- **Soon**: Moderate importance
- **Eventually**: Will occur in time
# Pressures and Proximity

<table>
<thead>
<tr>
<th>Pressures</th>
<th>Proximity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government <em>(Federal)</em></td>
<td>U</td>
</tr>
<tr>
<td>Government <em>(State)</em></td>
<td>U</td>
</tr>
<tr>
<td>Government <em>(Local)</em></td>
<td>U</td>
</tr>
<tr>
<td>Members</td>
<td>U</td>
</tr>
<tr>
<td>Primary Health Care Providers</td>
<td>S</td>
</tr>
<tr>
<td>Consumers</td>
<td>S</td>
</tr>
<tr>
<td>General Practice Representative Bodies</td>
<td>S</td>
</tr>
<tr>
<td>AGPN and state based organisations</td>
<td>S</td>
</tr>
<tr>
<td>Community Health</td>
<td>E</td>
</tr>
<tr>
<td>Economy <em>(Local / Global)</em></td>
<td>E</td>
</tr>
<tr>
<td>Labour Market</td>
<td>E</td>
</tr>
<tr>
<td>Demographics</td>
<td>E</td>
</tr>
<tr>
<td>Technology</td>
<td>E</td>
</tr>
<tr>
<td>Climate Change</td>
<td>E</td>
</tr>
<tr>
<td>Political Climate</td>
<td>U</td>
</tr>
<tr>
<td>Health Care System</td>
<td>U</td>
</tr>
<tr>
<td>Governance and Compliance</td>
<td>U</td>
</tr>
<tr>
<td>Competitors</td>
<td>S</td>
</tr>
<tr>
<td>General Practitioners</td>
<td>S</td>
</tr>
<tr>
<td>Peak Bodies</td>
<td>E</td>
</tr>
<tr>
<td>Suppliers</td>
<td>S</td>
</tr>
<tr>
<td>Insurers</td>
<td>S</td>
</tr>
<tr>
<td>Hospitals <em>(Private and Public)</em></td>
<td>S</td>
</tr>
</tbody>
</table>
Reckoning

Through Reckoning, we brainstormed everything we saw, thought and felt that was relevant
Reckoning and Impact

RECKONING: Government – Federal

- They want wins, fast, obvious, before the next election (uncertainty)
- Want it branded as theirs (Medicare local)
- Have no idea how to deliver what they want
- Paradigm is National / Local – bypassing the States but changing
- Now accepting that States’ role will be meaningful
- Under State GST pressure
- Have not articulated their vision (even less than before)
- State Government’s win not translating into a win for us yet
- Federal Health Department do not understand (possibly resisting) Federal Government reform agenda
- Significant cost cutting underway
- Do value investing at the Local level but will not fund what makes it work
- Not seeing a whole of Government approach – lacks integration
- Distracted away from Health (e.g. NBN)
- Hung Parliament means Regional and Rural focus
- Health is symbolic to Labour

IMPACT: Government – Federal

- Need to provide an end-to-end solution
- Demonstrate they cannot do it without us
- Evidence our capability to deliver on the reform agenda
- Build our competency against any established gaps with the reform agenda in mind
- Have other organisations advocating on our behalf
- Target both sides of politics in our lobbying and both levels of representation
- Improve our visibility at a Local level – have Local deliverability understood
- Network with Divisions to get them to look forward and work collectively
- Improve our direct relationship with Federal Government and not rely on third parties
- Have the consumer organisations advocate for us
- Describe / define the efficiency of our systems – evidence the ROI
- Build, execute a clear Marketing Plan
- Respond to consultations – have a seat at the table
RECKONING: Government – State

- They want wins, obvious, public
- Want Media off their back / want to avoid industrial unrest
- Want to keep what they have / know they need to de-centralise some but how to retain control is their concern
- Came out stronger from the reform agenda
- Want a payroll system that works
- Well positioned in a reform agenda – done thinking and better set up to deliver
- See reform agenda as part of the solution to their problem
- Investing in population shift Health infrastructure and infrastructure broadly
- See a need to do it better (Hospital structures)
- Strong leadership drive from Premier and Treasurer – not carried through consistently
- Face predictable change-management challenge
- Seen as secondary, tertiary Health focused
- Prepared to work with Primary Health Care providers – but what to end?
- See e-Health as a means of achieving goals (including telehealth / NBN)
- Better engaged Regionally – tension and opportunity
- Invested in State-wide clinical networks to engage their clinicians
- Question longevity of change

IMPACT: Government – State

- Demonstrate our relationship with the Federal Government will assist the State Government to continue to influence the reform agenda
- Position ourselves as a partner of choice in the reform process and offer to work with them during the transition process
- Focus our energy and resources on programs / services that build on our strengths and deliver visible and measurable results for Government
- Provide some targeted Regional solutions
- Use the advocacy and key partner relationship / status to deliver the Peak Primary Care bodies into a relationship with the State Government
- Demonstrate we have a comprehensive understanding of the needs specific to Queensland and the people of Queensland
- Merchandise our understanding of this ‘uniqueness’ beyond State Health Department to other State Government Departments
- Clearly articulate the values and goals of working with Primary Health Care
- Hold Government accountable to their commitment to Partnership Agreement
- Demonstrate that they have in us a credible organisation with State based governance worthy of their confidence to invest in Primary Care through us
RECKONING: Government – Local

- Growing importance
- Degree of ignorance around reform
- Variation in willingness to be involved and their understanding
- Being forced to be involved / engagement is patchy
- Engaging in Queensland Health dialogue
- Some will become members
- A lot to learn from amalgamation and change management Local Government went through
- A growing need for stronger discussion at Local and State level
- Growing move to Regionalism
- Being asked to be involved in improving the health of their community
- Forced to be involved with Primary Care (Queensland lacks the historical relationships between Local Government Health organisations, both private and public)
- State will have more influence on their role than Federal
- Will be greater opportunity for shared approach to planning (Health planning and zoning as an example)
- Becoming more militant
- Health not high on their agenda

IMPACT: Government – Local

- Understand each other’s business and develop a partnership
- Find which Local Governments have a social planning capability and get some wins that could then be promoted – engage with Community Health Action Plans
- Encourage and support our members to engage with Local Government
- Map out Local Government landscape and be careful in the resources we allocate to the challenge of partnership
- Become a preferred source of information, unique knowledge base for Local Government with regards to Primary Care
- Demonstrate some wins that they can share some benefit from
- Build on the wins from Medicare local division planning and take message to Government
RECKONING: Members

- More confused, more self-interested / paranoia
- Status is being threatened – facing change
- Understand the ‘system’ better than ever before
- Being ‘de-funded’ / growing uncertainty about the relevance of State based organisations
- Competition has become a major factor (internal especially)
- New funding and other opportunities for members when they can seize them
- Some uncertainty about what the future will look like
- CEOs wielding a lot of power
- At risk of spending energy fighting the small issue and not the big picture
- In discussions with other Primary Provider groups – more meaningful – but not all
- Struggling with how they sell the reform as positive – how to keep General Practice engaged in the new system
- Variations in Board knowledge of the landscape and the trends
- Some accept that the organisations want to be dominated by GPs
- Dealing with hostility / tension / and lack of knowledge from other providers at a local level
- Question their understanding of the capacity building they will need to do to meet funding expectations
- Looking to work with each other – shared resources – not certain it will happen
- Natural inclination to ‘reset’ representation post-reform and improve their position
IMPACT: Members

- Facilitate the change-management process
- Continue to lead and challenge the transition group and push the message into the Boards and their organisations in turn
- Continue to foster and develop a collegiate approach to the network; e.g. the Chairs’ leadership connection
- Build on the strengths within the members
- Continue to provide liaisons and communication with full Boards
- Define who our future members should / could be and determine a purpose beyond a member based organisation. Be open about strengths / weaknesses of the network
- Work with Divisions to build their capacity to become PHCOs and work with them to move their vision to be inter-sectorial versus vertical in their approach
- Migrate membership to become customers to ensure our relevance as a non-member based model
- Involve members in what they want for their Medicare local future and involve them in the planning
- Assist members to sell the reform – promote the truth of the subject
- Being a source of mediation / negotiation
- Take a position and stick to it
RECKONING: AGPN and State Based Organisations

- Future funding uncertain
- Structure and function is uncertain
- Differing views across AGPN and State based organisations as to their purpose and function
- Pressure not to be funded by the Government
- Using their power to influence the decisions of the Minister – dependent on some (few) key relationships
- New funding to implement transition to the PHCOs that they control
- Not taking the views of their members forward – more a leadership agenda
- SBO framework is getting weaker
- Changes to AGPN Board will mean less appreciation of Queensland issues
- Some significant changeover of leadership staff imminent
- Increasing competitive tension between AGPN and State based organisations and General Practice Queensland
- Increasing influence over Minister

IMPACT: AGPN and State Based Organisations

- Redefine the role of General Practice Queensland and claim the space with the support of our Business Partners (Could we tender for commission of the National Office?)
- Keep collaborating with what is left of the structure
- Maintain our integrity in a challenge that may cause others to take shortcuts
- Build a relationship with new COO of AGPN
- Support capacity building across the SBO network
- Strengthen the relationship with AGPN Board of Directors
- Consider our place in the network and role of a State Office of AGPN
- Consider additional or alternative partners in our strategic framework
RECKONING: Political Climate

- Shift to conservative leadership at State level
- Signatures to COAG change means weakening of the Health Reform Agreement
- Suggestion that COAG might not exist in current form
- Composition of Federal Government requires detailed discussion / negotiation equalling tentative decision making
- Vacillation around what are the priorities; fundamental health reform or issue by issue focus for perceived wins for electorate
- Health policy for Coalition is different – consider Federal Government stability
- Likely change of government at next State election
- Growth in Ministerial expertise
- Impact of Greens in the Senate is uncertain
- Need for wider consultation because of fragmentation of responsibility
- Local issues can win or lose a seat

IMPACT: Political Climate

- Develop an image of political neutrality committed to delivering programs that improve health outcomes – not an extension of specific political agenda
- Have our agenda plan and described it in a way that is congruent with both policies
- Help to address the issues that cause political leaders to ‘scrum’ – Pressures
- A plan if the Health Reform does stall at each point
- Improve our liaison and linkages with key advisers and opposition MPs
RECKONING: Governance and Compliance

- Want cross governance between State based authorities and companies limited by guarantee
- Future status as charitable organisation is uncertain – potential tax implications
- Want more diverse Boards
- Changes in membership requirements
- More community engagement in governance equals constitutional review
- Potential to be responsible for Health outcomes over which we have little control
- Greater need for different sorts / types of contractual agreements
- Uncertainty about where the funding will flow; ex Federal and State Government
- Increased clinical governance requirements impacts across the membership

IMPACT: Governance and Compliance

- Review our engagement with the Government structures and what level of formality is required. A marketing process of structure to relationship
- Understand any new compliance requirements for the Medicare Locals
- Understand the business of the five national organisations
RECKONING: Competitors / Peak Bodies

- The door has been opened – at all levels
- AGPN as a competitor
- Members more competitive with each other
- Increased diversity of views and fragmentation of effort and effectiveness
- More ‘back door’ positioning of people
- Move to be the leader in the change program – all trying to influence the agenda
- The non-political bodies are having to ‘join the game’ and lobby
- Recognition of the wasted energy in lobbying
- Growing understanding that collaborators are competitors
- Opportunity for collaboration is increasing
- Looking more to us to engage and collaborate (Federal Government)
- Potential pool of collaborators much broader than Health
- Many have different agenda to State organisation

IMPACT: Competitors / Peak Bodies

- Develop a principles and intent public statement outlining our collaboration with other organisations
- Get a better understanding of who really are our competitors
- Stay vigilant and gauge the mood of collaborators to identify shift – actively evaluate the risks and benefits and prioritise our focus and our relationships
- Be clear on who might see us as a competitor and what the consequences might be
- Consolidate the work we are doing with Queensland P.H.C.N. and where this engagement could deliver us
RECKONING: Primary Healthcare Providers

- Changing role – broader role and integration
- Slow increase in electronic connectivity between all Primary Healthcare Providers
- Uncertainty and confusion about what Health reform may mean to them
- Do not have support mechanisms like Divisions
- Increasing desire to be recognised as an important part of the Healthcare Team
- Increasing desire to become members of Divisions / Medicare Locals
- Differing understanding of Primary Healthcare equals challenging understanding?
- Being seen as the solution to what is going wrong
- Huge variation and fragmentation; constitution, strength, scope, priorities and stakeholders

IMPACT: Primary Healthcare Providers

- Formally explore how we might become a Peak Body for Primary Healthcare Providers
- Map the mechanisms for Medicare Locals’ engagement with their providers and use it to inform our communication strategy with WIIFM case studies for providers
- Promote Medicare Locals as a support organisation for Primary Health Carers
RECKONING: GP Representative Bodies

- More unity than in the past
- AMA ambivalent about reform and the roles of all in the agenda
- Wondering what is in it for them (Reform Agenda)
- See themselves as changing their role – more member engagement
  - Fill the gap when the divisions ‘go’
- AMA more engaged in understanding issues in Primary Care
- AMA pushing to be GP leaders at a national level (GPs in leadership role)
- Not dividing the agenda and taking responsibility – no shared vision – less strategic
- Threatened by Health workforce changes
- AMA losing ‘only voice’ position
- Shifting their willingness to cooperate and grow joint leadership approach (at State level)

IMPACT: GP Representative Bodies

- Become thought leaders in the GP to PHC Provider service integration and implementers
- Explore with them about what the reforms mean for them
- Strengthen GP alliance at State level and lobby AGPN and strengthen UGPA
- Build solid relationships with the key people of influence
RECKONING: General Practitioners

- Losing Divisions is unsettling – change weary – untrusting Government
- Unconvinced about the outcome of reform
- Move to larger multi-disciplined clinics
- Move to nine-to-five GP
- Significant investment by Federal Government into infrastructure to support
- Growth in training and GP nursing
- Increasing Nurse Practitioners – concern over their influence
- Changing demographics of GP workforce
- More technology aware and application
- Shifting role of G.P. from individual patient care to being a team
- Corporate ownership of practices – Non G.P. ownership
- Perceived GP is getting harder and harder yet opportunities still in demand
- Greater push for demonstration of quality and accountability
- Increasing financial failure (less ROI) – rationalisation

IMPACT: General Practitioners

- Encourage more Doctors to choose General Practice as a career through the GP Alliance
- Maintain General Practice input through various mechanisms
- Leadership role in building clinician engagement and clinical leadership and what it means for Primary Healthcare
- A communications strategy that is inclusive and helps them understand what is in it for them and for their patients
- Be aware of our program impact on General Practice ref; workload, working smarter and quality of outcomes for patients
- Make sure programs do not adversely impact financially on GPs
- Look at ‘hijacking’ the Nurse Practitioners to reduce the conflict and influence their engagement – broaden to the new Health workforce
RECKONING: Insurers (Private)

- Increasingly involved in direct Primary Care support to members
- Opening clinics in their own name
- Building meaningful databases
- Increasing role in preventative healthcare and hospital avoidance
- Do not play well with others
- Bottom-line pressures
- Increasing technology costs
- Increased competition within their own sector
- Competitors for Divisions’ activities

IMPACT: Insurers (Private)

- Gain increased understanding of Queensland Insurers’ profile: market offer, demographic, their vision / mission strategy
- Become a service provider for some of the hospital avoidance / chronic disease programs – co-ordinate through the Medicare Locals
- Show them there is value in a partnership approach with us
- Demonstrate what GPQ has which is beneficial to them
- Play one against the other – competitive tension
- Learn from their lobbying agenda
- Ascertain mutual areas of influence – co-brand / co-market and raise our profile
- Show funders we are better placed to bring State / Nationwide reform / change
- Accept that we will both compete and collaborate (e.g. joint tendering)
RECKONING: Hospitals

- Increased public scrutiny – accountability; ‘My Hospital’
- Increased financial pressures
- Different funding mechanism – activity based / efficient price
- Increasingly made to cut budgets – Government taking action against overspend
- Clustering into local hospital networks with charge in governance frameworks
- Focus beyond acute care to maintain funding
- Broadening their funding base
- Push for 4 hour maximum wait time
- Recognising the need for benchmarking and looking outside traditional boundaries for solutions
- Growing IT / IT reform base
- Rolling out new clinical information systems
- Trying to manage patients better – quality of care initiatives
- Integrated care – within and without

IMPACT: Hospitals

- Be a leading light on consumer engagement – build on our track record
- Be involved in clinical governance, clinical networks and leading clinician groups
- Maintain our links with clinical leaders to facilitate GP input and advice – expand this to primary healthcare advice
- Support Medicare Locals in their efforts to engage with hospitals – refer clinical governance
- Position ourselves to ‘pick up the pieces’ when accountability leads to reduced outcomes
- Improve our understanding of how hospitals work – influence re-direction of service
- Consider ‘MY PHCO’ and promote an alternative approach to merchandising and measuring our performance – link to our collaboration and the benefits derived
- Be involved in e-Health opportunities – stay ahead of the game
- Re-focus our consideration in light of their diminished accountability – impacts for us
- Understand varying categories and focus of hospitals
- Specific consideration for private hospitals
RECKONING: Community’s Health

- Recognition of importance of managing chronic diseases
- Greater focus on prevention and self-management
- Away from reliance on traditional sources of information
- Encouragement to self-manage – organised promotion
- Utilisation of allied health providers increasing
- Recognition of the importance of social determinants
- Greater investment in Indigenous Health
- Greater investment in other marginalised groups
- Disparity in health literacy
- Increasing expectations for remedy – unrealistic but helps ‘lift the bar’
- Focus on health of populations in addition to individuals
- Healthy population as a productivity issue with other paybacks
- Recognition of need for better data about health of a community
- Mobile population increases expectation – puts pressure or resources in growing markets
- Growing awareness healthcare system is fragmented in information flow in personal health records and service access
- Paradigm shifts in our approach to health management (e.g. once-off flu vaccine etc.)

IMPACT: Community’s Health

- Need to build on / enhance work on community profiles – improve the data / build data systems
- Clearly understand the issues and needs of the Queensland population
- Education strategy – community to understand what we do / deliver / value-add
- Work with peak bodies on program to improve health literacy
- Maybe start a dialogue with organisations interested in ‘good health’; e.g. Worker’s Compensation / Productivity Council / Education Queensland
- Take a ‘lateral approach’ (e.g. Beyond Blue) beyond traditional partners
- Become central service; information, training, co-ordination. Be clear on our role; prevention, promotion and early intervention
- See floods as an opportunity – partnership – unique produce development
- Promote the unique products / services we promote
- Consider the implications of step down facilities
RECKONING: Health Care System

- Changing financing arrangements
- Fragmented health care service planning – within and across sectors
- Increasing awareness of role of system boundary problems and how to fix them
- Recognition and identification of population groups that fall outside the system
- Globalisation of view and approach
- PC shifting thinking to population health – starting dialogue
- Increased recognition and funding to Primary Healthcare rather than Hospitals?
- Starting to integrate the providers
- Inappropriate funding mechanisms for the changing work priorities in the sector
- Anti-bureaucracy sentiment across the sector
- Changing of innovative solutions
- Increased expectation of evidenced outcomes / research partnering and engagement in the system
- New national organisations / national targets
- More focus on local outcomes
- More focus on paid for performance
- Embracing contemporary management models
- Growing focus on networked services and service networks

IMPACT: Health Care System

- Must not duplicate something that exists – must value-add
- Have to address linkages between primary healthcare and community – social services sector
- Be aware of the different models in each State
- Should our planning be more about our ability to react / respond rather than build and solve?
- Identify the key drivers that need to be in place so community gets the best care
RECKONING: Consumers

- Growing consumer movement / power / influence / expectations
- Increasing but patchy health literacy
- Prepared to challenge the status quo – from passive to active engagement
- Growing focus on satisfaction
- Transfer of accountability
- People with co-morbidity wanting comprehensive health care needs met
- Consumer driven solutions – to consumers rather than providers
- Recognition of carer needs – especially for the vulnerable
- Recognition of consumer engagement frameworks and approaches
- Aware of cultural sensitivities
- Consumer as an integral part of clinical networks
- Want access when they want it
- Influencing the quality agenda and fit for practice expectation
- Growing body of research to support consumer engagement
- Increased professionalisation of consumers
- Changes in complaints mechanisms

IMPACT: Consumers

- Be cautious of populist policy and advocate evidence-based policy
RECKONING: Labour Market

- Union angst about industrial arrangements changing
- Patch protection e.g. General Practitioners versus Nurse Practitioners
- Tripling of workforce in training
- Increasing unsettled staff in Divisions / State-based Organisations – reform equals change
- Recognition we will be short of Health Service Planners
- Increasing costs of workforce to attract and retain
- Increased competition to access the same workforce
- Greater demand for Practice Nurses will not be met by supply
- Need to populate the Indigenous Health Care initiatives
- Development of completely new rules

IMPACT: Labour Market

- Maintain our staff ‘IP’ and quality workforce – make sure they are confident in our role and engaged with our strategy
- Recognise labour market (workforce) and IT as genuine game breakers
- Should we re-visit relationship with Health workforce Queensland?
- Opportunities; training, service workforce development, service model – be innovators
- Look at it in the context of the bigger economic picture – trends in overseas Health and their lessons
RECKONING: Technology

- Personalised i-Phone applications for managing your health
- Shift to on-line health management – many applications (one-on-one / one-on-many)
- E-health records (PCEHR)
- Genomics influence on diagnosis and treatment
- Miniaturisation of diagnostics and treatments
- Virtual meeting and conferencing
- Home monitoring and telemetry
- Increased spend of GDP on health and technology
- Widening technology gap
- Health care providers will need to build their skills / understanding
- Whole of life supply – transport, housing

IMPACT: Technology

- Build this into our workforce solutions modelling
- Understand the impacts on service model and process design
- Training and support for the uptake on IT development
- Bid for roll-out of tele-Health initiatives
- Do not get ahead of the funding model or influence it to support IT
- Merchandise our PL as being e-Health ready
- Investment scrutiny in any IT spend – rigorous due diligence and quality control
RECKONING: Suppliers

- Increased pool of potential suppliers equals diversity
- New purchasing options
- High surveillance on issues like IP, copyright, privacy protection
- Commercial leasing opportunities – volatility
- Brokerage in Financial Markets (Finance and Insurance)

IMPACT: Suppliers

- Greater scrutiny and useful SLAs – due diligence in selection and quality control – contracting complexity
- We have a leadership role to play in quality management
RECKONING: Demographics

- Ageing population
- People working longer
- Staying home longer
- Migration to South-east Queensland continues
- Regional towns growing, rural towns dying
- Communities connections growing (mobile population, small families)
- Greater cultural diversity
- Growing obesity
- Increased education

IMPACT: Demographics

- Refer prior impacts
RECKONING: Economy

- Global Financial Crisis impact not yet fully felt
- Pressure on funding of services as disposable income reduces
- Casualised workforce uncertain about income
- International financial de-regulation
- Strong currency impacts imports and exports
- Farming and tourism dependency leads to volatility
- European markets not a source of funds for Australian Banks
- Community more in touch with the mood of the economy – economic literacy
- Increased Australian Government intervention – trend away from de-regulation
- Increased wages push

IMPACT: Economy

- Must diversify our revenue sources
- Maintain value for money as an underlying philosophy
- Demonstrate the effectiveness of our organisation
RECKONING: Climate Change

- Categorisation of illnesses
- Perceived as requiring action
- Increase incidence of extreme weather events
- Growing economic costs
- Investment in community resilience and disaster planning
- Expectation of businesses to be green and demonstrate awareness
- Expectation that we should warn of health consequences

IMPACT: Climate Change

- Be involved in the State’s disaster planning
- Watch the shifts in where research and related funding shifts to
- Promote ways to build community resistance
- Work closer with Public Health Unites
- Be a ‘green’ organisation
RadarLock™

Using our situation analysis from the Download, we developed in partnership a Future of Choice. An aspirational description of how we would like to see things in five years’ time.
RadarLock™

It is February 2016 and we are celebrating the most successful year in the history of our business. Success by any measure.

Success was built on our ability to understand and respond to the enduring demands of Government. We endured the life under a hung Parliament and we operated in a period of uncertainty by informing the decision makers about the value we could add. We employed a lobbyist to target our message and to help refine it. We targeted decision makers and Government departments to expand our communication. We took the step of inviting senior Government officials and Health bureaucrats to meet with the Board and hear our vision. The clarity of our vision that evidenced our understanding of this agenda was compelling and they listened. They recognised the value of our State-based focus and our local knowledge in their dealings with State Health departments. We brokered that relationship and became the go-between for Federal and State. Our funding reflected our success and our membership expanded to include the Medicare locals in Queensland and beyond and peak bodies for healthcare in the State. This lead to national and international contracts for primary healthcare co-ordination and change management.

The real power came when we reduced our reliance on Federal Government funding by the introduction of alternative revenue streams which meant the Government needed us more than we needed them and we became a sustainable voice in the market. We decided to hive-off some of the Business Units and stopped badging ourselves as an SBO, instead presenting ourselves as being able to add value independent of the historical networks. Alternative funding initiatives included NGOs; e.g. Heart Foundation, who are engaged with some relevant State-wide health initiatives, private health insurers who fund programs that align to their charter, not to mention some more lateral partnerships including the National Farmers’ Federation Living Health program, the Queensland Mining Council and Queensland Retailers’ Association. These partners were not just impressed with the quality of our programs but our very deep insight into the understanding of membership service-based organisations. The starting point was our stakeholder engagement program, targeted beyond health and aimed at all who have a direct stake in community health. We are no longer seen as locked into the healthcare sector. This was done in a staged approach and built on a validated ‘stocktake of our proven and notional competencies which identified immediate opportunities for which we built our reputation and track record.
It wasn’t just our insight into *members* that helped; it was the trusted partnerships with our members and other stakeholders that facilitated the rolling out of our services and initiatives in an efficient way. We seized the health agenda based on the needs of patients. Today the agenda is driven by validated needs of the *community* built on an evidenced-based platform rather than measured on its response to Government policy. Our credibility was positively underpinned by a clear and robust data gathering and interpretative system that builds our evidence base and our quality improvement approach. Also contributing was our new and innovative partnership with universities to enable us to present to our partners validated evidence-based business cases to win their support and their sponsorship.

Our *partners* work with us in cash and in kind. We are smarter about how we manage cost and maximise investment. Our Board is seen as valuable and our endorsement has commercial value. We allow other learning organisations to co-brand and they are happy to pay for the privilege. We have become an RTO and a profitable one. We select our curriculum carefully and we don’t build product where we don’t have rights to the IP that we can use to build our top line.

We have a targeted *Federal Government* relationship management plan that does not depend on *AGPN* – we are a first point of contact for Federal Government decision makers and they value our input on matters both directly and indirectly linked to our field of influence.

Our *data systems* are so good they drive our branded “Healthy Nations Report” which provides commentary and guidance on the investment in productivity, community building that primary healthcare can drive and support. We have won national and international awards for work on issues like ‘Closing the Gap’, making Queenslanders Australia’s healthiest people. It’s this look that attracted our World Health Organisation commission, the first of many.

Our *lobbying* is balanced and we have been able to build quality links with both sides of Government because of our diverse funding and sustainable programs. We insulated ourselves from changes in power at both a Federal and State Government level. By late 2012 the Federal Government funding only accounted for 20% of our income though in real terms it had increased.

*At a State Government level*, we partnered with the Minister to drive primary healthcare and reduced admissions significantly.
This model formed part of our IP and we have commercialised the know-how which we exported. We hot-housed with all our partners the development of that model, including the consumers and the community. We had many discussions that were aimed at resolving the tensions and prioritisation between our role as a direct deliverer that could place us in competition with our members and partners versus a design and developmental approach that built on those relationships and the successes of members and partners.

Ultimately it was our data and research that helped determine when we operate under each model. Engagement with partners and the evidenced skills of our workforce meant that on each occasion we drew the right delivery versus promote conclusion. It remains a consideration with each new initiative we develop today. Once the 11 Medicare Locals had formed, we consolidated our position as a partner of choice for State Government and we negotiated a process with them around transfer of some key patient healthcare services over to the Medicare Locals. We also had targeted efforts with a number of key State Government departments, further enhancing the role of the Medicare Locals. Events like the 2011 floods and our validated response presented an opportunity to manage the continuation of Medicare Locals, State Government and ourselves to promote a better outcome and have the right entities doing the right things with the right references and mandate.

We have demonstrated our ability to represent the needs of Queensland and it is recognised by all political parties.

At a Local Government level, our health planning activity was enhanced through collaboration with LGAQ to utilise their extensive planning capability and data. This extended beyond State and down to a Local level, impacting positively on the Medicare Locals. Because we worked collaboratively, it opened up new opportunities and areas of involvement around initiatives like Healthy Community. The highlight was when we were able to co-ordinate the planning of primary healthcare activities through Local, State and Federal jurisdictions, which came about by our brokerage between State and Federal, made possible by our universally accepted neutrality (political) and our track record of success.

Our Corporate structure has evolved with a broad membership of our parent company and our Constitution amended to allow us to have broad groups and categories amongst membership. The membership structure gives voice to many, represented by few and allows us to freely engage in commercial ventures through subsidiary enterprises which have brands that resonate with their purpose and their market example membership.
categories including primary healthcare providers with sub-categories like NGOs and private healthcare providers.

*Peak Bodies* now choose to become members including RDAQ, AMAQ and the relevant ‘category’ Associations.

We have strong relationships with the *State-based organisations* and managed our engagement with *AGPN* to ensure that we controlled the agenda without creating unnecessary political or industrial aggravation. As our mandate evolved and the national organisation was more clearly defined, we were able to secure our strategic objectives and defended and grew our offer without interference from our State and National peers.

The strength of our reputation and performance enhanced the reputation and performance of the national organisation. This was helped by clarity of our objective to help build the capability and efficiency of *Medicare Locals*, a deliverable that eluded the National Body in the first instance. We invested our energy into the GP Alliance rather than GPNCG because the GP Alliance was more aligned to the health of Queenslanders. They are today an important participant in the relevant sub-category of membership. Now we are clear on who our partners of choice are, why we work with them and the outcomes of the partnership. These alliances are formal, documented and focussed on outcomes.

Some of these partnerships are not just related to funded delivery but to both the business services and political influence objectives of our strategic direction. We carefully managed all partnerships through transitions to this level of accountability.

We have a role in *developing and delivering training* in the engagement of care providers, particularly clinical leadership and clinical governance streams for Medicare Locals and other primary care employers. This provides support which was missing from the Industry and was preventing their full participation in the formation and governance of the Medicare Locals. The early partnership we formed with Health Consumers Queensland and related community organisations has helped produce a more health aware and literate community. This came about through our stakeholder partnerships with organisations like Improvement Foundation (IF) to bring together providers and consumers under a quality improvement setting. This is an extension of our engagement in APCC as early as 2011. We are seen today as a trusted representative body at State level for these previously disorganised categories of primary healthcare practices.
With **GP representative bodies** we have clear memorandums of understanding in place that guided their entry into a membership role in our organisation. As they became aware of our success they now better understand the value of primary healthcare in the system.

For **General Practitioners** we have pioneered the role and integration of Nurse Practitioners and other health professionals into a re-invigorated General Practice and a more widely focussed primary healthcare approach.

About General Practitioners; we have fostered the development of clinical leadership skills amongst GPs in particular and other providers using primary healthcare focussed clinical networks. This helped GPs be involved in the planning, management and measurement of primary care performance and enhanced quality in policy and practice. Our work with Medicare Locals further fosters the engagement of General Practice which then allows a smoother more consistent roll-out of programs. This happens because we reality test and evaluate all of the initiatives that we consider. We never lost sight of the importance of the provider consumer relationship / partnership.

We brokered an arrangement with **Queensland Health** which saw them build a stronger partnership between **LHNs** and **primary care providers**. A component of this was a facilitated leadership program for cultural change in taking these organisations from vertically integrated entities to ones that seek opportunity through 'lateral', community integrated primary healthcare models, an important contributor being the **private hospitals**. We worked with the relevant clinical bodies and colleges to up-skill the existing primary care workforce to undertake many of the services that once were the domain of hospitals and are now in the community. The balance of our relationship with hospitals was recalibrated due to the importance of the National Quality and Safety Agenda which required a shift from both sectors towards greater accountability.

Our **data systems** (with National Broadband Network infrastructure) were so robust that the hospitals came to us requesting from us detail on electronic personal health records and how they could leverage both our data and our skills to apply this asset in their favour. We have overseen an IT roll-out across the State between hospitals (private and public) and primary care providers which saves dollars (through reduction in duplication) and lives (through better health management). We agreed on an overarching integration framework between the **hospitals and the primary healthcare sectors**, identifying enablers and targets which lead to regional forums and change-management initiatives to help realise the targets. We now have a GP liaison team linking hospitals and **Medicare Locals**. We now understand the business of private hospitals, where their aspirations and focus link with public and where they differ, so we target our approach to private hospitals...
to help make their operations increase safety, quality and efficiency on metrics that are relevant to them. Every private hospital, public hospital and aged-care facility pays for the use of our Healthcare plus directory.

One of our most prominent successes was securing attention for an investment in prevention, promotion and early intervention messages and activities. Our logo was highly visible across the merchandising and delivery of these initiatives.

One of the first steps we took was to bring our key partners and members together to articulate our collective vision for an improved health care system in Queensland. That vision included recognition of the importance of a partnership approach across a broad range of Government and Non-Government authorities. It has provided us with the foundation for our collective activity over the past five years. Because of our successful methods and evidenced results we have been asked to share the message with other States and peer organisations. One of the reasons we could undertake this adaptation and take a primary position within the healthcare system was because of the capacity of the Board and the CEO to create a flexible, responsive and to an extent opportunistic organisation that could roll with the consistent evolution of the political and regulatory environment.

We partnered with Healthcare Queensland and the Consumer Advisory Committee (CAC) of HQCC around the quality and safety agenda to address the core complaint area, thus improving health services to consumers. HQCC reached out to us for assistance to directly help Medicare Locals in delivery of effective complaint follow-up.

As our organisation grew, we recognised in our own labour force the need to work smarter and manage our choices and correctly value our services and staff. This means a strong top and bottom line. We are an employer of choice and our organisational structure is now clearly aligned to our strategy. We have found a home in a good location and we have the capital resource to provide our talented team with the tools to do their job. We constantly review our talent mix, skills matrix and succession plan to ensure that we continue to attract and retain the talent needed to realise the potential of our organisation.

We have grown and strengthened our lead role as a change manager for the uptake of new technology; particularly applications and hardware that help the Healthcare Industry. Our leadership role in this field is due to our own commitment to embrace new technology in our own organisation. We walk the talk. As part of the technology improvements we were also able to value-add to our business services portfolio and expand into new
markets; e.g. i-Healthcare plus finance and i-Healthcare plus directory. We crafted a business unit that developed a partnership with QHCHI, CSIRO and private sectors in which we were the lead primary healthcare technology assessment and implementation arm.

In our *Community Health Agenda* we successfully targeted programs to improve the health of disadvantaged communities within Queensland. We advanced these programs in partnership with the Health, Community and Social Services sectors. Through our work in this area we have been able to demonstrate the importance of quality healthcare - both access and delivery. We pioneered chip implants for the homeless that allows them to have the benefit of their health records.

We have established such a significant profile in the Queensland and National Health markets that *suppliers* were coming to us, even without an RFT, to offer their assistance and all our forums are well supported through their sponsorship.

All these efforts have ensured that today, stakeholders regard us as an indispensable part of the health community and the pre-eminent change agent providing healthcare.
Mapping

We agreed this future of choice would only be possible if we delivered on the following core competencies
Mapping

- Hospitals & LHNs
- Consumers & Community
- Environmental Pressure
- Industry Partners
- Technology
- Primary Healthcare Providers
- Government
- Data, Quality & Revenue Management
- New Revenue Streams
- Marketing & PR
- Governance & Corporate Structure
- Suppliers & Infrastructure
- Programs & Services
- Members & Primary Care Network
- Funding & Finance
- Our People & Culture
- Strategy & Organisational Structure
- Board & Leadership
- Medicare Locals

From where you are .... to where you want to be IN BUSINESS™
Method and Layout Copyright © 2011 Business Coaching Systems™
www.bcscoach.com.au
General Practice QLD Strategic Plan Feb 2011 SW 000
Wonder How they Feel About…

1. Introductions
2. Context for forum
3. Key themes of GPQ Future of Choice

Topics for discussion

- What is shaping our industry?
- What should we be thinking about in forming our strategy?
- GPQ fails if they don’t…
- Is there a space for a primary healthcare peak body / could it be us?
4. Would GPQ present as a national partner for you?
- How wide should a primary healthcare partnership be framed?
- Where do Medicare Locals fit in this picture?
- Role of GPQ in the quality improvement agenda and beyond
- How do they see GPQ adding value?
- Independent State-based versus Branch Office for National organisation
Forum De-brief

- GP central to change – will GPQ empower them?
- Isolation of Medicare Locals is real and present risk
- Collaboration is key – forcefully position GPQ in primary healthcare alliance
- Share the industry advocacy – set the example
- Each stakeholder has limited industry and geographic influence
- Help share and benchmark know-how in our industry – promote flow of IP
- Build and act on evidence of quality outcomes – aggressively promote
- Confront what we have not achieved and reflect in strategic choices
- GPs as epicentre of primary healthcare? Understand the contrary argument
- Consider a consumer centric organisation – GPQ as voice of consumer – who else?
- Understand the gap between Medicare Locals mandate and capacity to deliver
- Must appeal to what the Commonwealth wants
- Leave behind membership framework
- More national partnerships – influence and leverage IP
- Promote better integration between primary healthcare and acute care
- Centralisation puts historical gains at risk – must defend
- Quality improvement fails without GP engagement
- Must continue the evaluation program / evidence base / data
- Data is king – Savings is queen
- Better communicate your value to GPs – ref AMA ‘centralist’
- Be a standard setter – define the priorities for the sector
- Policy, planning, delivery must be GPQ point of difference
- Do not just look at the gaps – take some risks
- Confront the social justice issues in community health
- Be; true to vision, influence or gracefully exit, true to funders, migrate from member focus to customer / partner focus
We determined the objectives required for the next twelve months. Objectives that, if accomplished, would take us purposefully towards our five-year goals. We call these objectives our Strategic Milestones.

Our Priorities were determined according to the following definitions:

Is this milestone Critical, Important or Preferred?

- **Critical**: Not negotiable, failure will not be contemplated – terminal for RadarLock™
- **Important**: Not terminal, but an accepted Key Performance Indicator or measure of our performance
- **Preferred**: Not critical or important before these definitions
# Governance and Corporate Structure

**MILESTONE:** Within 12 Months We Will Be Able To Say

<table>
<thead>
<tr>
<th>GCS1</th>
<th>We reviewed our Constitution in light of our strategy to establish any obstacles and identify a solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCS2</td>
<td>Our corporate structure has been revised to facilitate our strategy</td>
</tr>
<tr>
<td>GCS3</td>
<td>Our re-structure was supported by a compelling education and consultation program with members</td>
</tr>
</tbody>
</table>

# Strategy and Organisational Structure

**MILESTONE:** Within 12 Months We Will Be Able To Say

<table>
<thead>
<tr>
<th>STR1</th>
<th>We completed our 2011-2016 Strategic Plan and secured Board sign-off</th>
</tr>
</thead>
<tbody>
<tr>
<td>STR2</td>
<td>We published ‘Tailored’ versions of our Strategic Plan and communicated it to our stakeholder groups to secure their engagement</td>
</tr>
<tr>
<td>STR3</td>
<td>We designed an Implementation framework and tracking system to support it to deliver on our critical Milestones. The Board was informed</td>
</tr>
<tr>
<td>STR4</td>
<td>We audited our organisational structure against our Strategic Plan, identified gaps and acted on findings. Our structure matches our future of choice</td>
</tr>
<tr>
<td>STR5</td>
<td>We have published our 2012 Strategic Plan refresh and committed to our Milestones for year two of our five year plan</td>
</tr>
</tbody>
</table>
Board and Leadership

**MILESTONE: Within 12 Months We Will Be Able To Say**

**BLT1** Reporting has been reviewed and aligned to the Strategic Plan to secure the Board’s attention to the critical Milestones  

**BLT2** Our Leadership Team agenda has ensured that we dedicated sufficient time and focus to our Strategic Plan  

**BLT3** The role and function of the Leadership Team was reviewed to ensure they clearly align to the Strategic Plan. Reporting matches the KPIs and needs of the CEO and Board  

**BLT4** We put reporting and accessibility procedures in place to ensure that the business of today was not compromised by our preparation for tomorrow  

**BLT5** We refreshed the Board skills review and acted on the findings
Our People and Culture

MILESTONE: Within 12 Months We Will Be Able To Say

PC 1  All GPQ staff have had their Job Descriptions reviewed, amended and aligned to the needs of the Leadership Team and Strategic Plan

PC 2  Through effective communication and engagement we maintained the enthusiasm of our Team and retained the talent

PC 3  We have an up to date skills matrix, conducted an audit and implemented a plan to up-skill, cross-train and career path manage

PC 4  We reviewed our organisational culture and values to establish its fitness for our ‘new purpose’ and strategy. We determined the shift required and implemented a program of change

PC 5  Each Leadership Team Member has a relevant Professional Development Program to prepare them to lead the organisation of the future

PC 6  We have and apply a disciplined and well documented change management process and apply it to all relevant Milestones. It is inclusive of all stakeholders
Programs and Services

MILESTONE: Within 12 Months We Will Be Able To Say

PS 1  We have completed a Programs audit to determine the future of each in the new funding environment (Up, Out, BAH)

PS 2  We organised a ‘safe landing’ for all useful Programs that we elect not to continue under the new funding regime

PS 3  We have an approach to ensure that our Programs meet their objectives and that we understand the value and appropriateness of over-delivery

PS 4  The future of key Programs e.g. Outreach Services exemplifies our preparation for the future and the showcasing of our point-of-difference
Funding and Finance

MILESTONE: Within 12 Months We Will Be Able To Say

FF 1  We reviewed and undertook a stocktake of our Fund holding and financial relationships with members and stakeholders to determine and resolve what governance, contractual and legal changes we needed  C

FF 2  We understand the future terms, composition and sources of our Funding Base  C

FF 3  We have a Funding Model that established financial viability of all Programs with reference to all sources of funding (traditional, sponsorship or commercialisation)  C

FF 4  The Board has reviewed the Financial Strategy in light of the new Funding and Program priorities of the future  C
Government

**MILESTONE: Within 12 Months We Will Be Able To Say**

**GOV1** We have a documented engagement and advocacy strategy that identified who matters, what relationship we need, what messages they need to hear and how (KISS) (All Government/All Stakeholders) **C**

**GOV2** We have a documented partnership plan for all key stakeholder organisations. It is a relationship management program **C**

**GOV3** We have considered the effectiveness of a lobbyist in our advocacy and relationship development initiatives **I**

**GOV4** Our relationships with Federal Government are direct, not third party on matters that are best represented by GPQ and aimed at elevating awareness of our credentials **C**

**GOV5** We formally track and report on all relationship management initiatives, they are well documented, outcomes expressed and all contact is reported **I**

**GOV6** We have clearly expressed the potential for and value in developing quality links with Local Government and have commenced implementation of our relationship development plan (refer appointment of new Minister) **I**

**GOV7** We implemented a communication and engagement plan to be prepared for the election agenda - State and Federal **I**
Data, Knowledge and Quality

**MILESTONE:  Within 12 Months We Will Be Able To Say**

| DKQ1 | We designed and established a state-of-the-art data management system to improve our data capture and knowledge information management capability |
| DKQ2 | We developed and implemented a GPQ knowledge management plan inclusive of data sets, collection mechanisms, interrogation and reporting |
| DKQ3 | We have merchandised and marketed our knowledge management system to clearly evidence our understanding of the needs of the Queensland community |
| DKQ4 | For every program we know the ‘SMART’ data set required to prove its value to the community. These form part of our data management scope |
| DKQ5 | Data and evidence form a focal point for each case made for program continuation, increased investment and launch |
## Medicare Locals

**MILESTONE:** Within 12 Months We Will Be Able To Say

<table>
<thead>
<tr>
<th>MCL1</th>
<th>We have clearly identified the value we can bring to Medicare Locals and helped their people of influence understand our point of difference</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCL2</td>
<td>We have identified how GPQ can assist Medicare Locals to build their capability, capacity and ability to achieve their stated role and functions. We know what assistance they value, and value from us</td>
<td>C</td>
</tr>
<tr>
<td>MCL3</td>
<td>We have a partnership plan with key stakeholders to support our shared engagement with Medicare Locals. It considers all range of service provision</td>
<td>I</td>
</tr>
<tr>
<td>MCL4</td>
<td>We are in negotiation with Government to pursue the transfer of targeted primary healthcare services and funding to Medicare Locals</td>
<td>I</td>
</tr>
</tbody>
</table>

## Industry Partners

**MILESTONE:** Within 12 Months We Will Be Able To Say

<table>
<thead>
<tr>
<th>IP 1</th>
<th>We completed a scoping study to identify and prioritise Industry partners for engagement and establish our partnership objectives</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP 2</td>
<td>We have strengthened our engagement with and representation to the GP Alliance</td>
<td>I</td>
</tr>
<tr>
<td>IP 3</td>
<td>Our Industry partner relationship strategies clearly identify those that might or do compete, our engagement plan reflects this</td>
<td>I</td>
</tr>
</tbody>
</table>
Members and Primary Care Network

**MILESTONE:** Within 12 Months We Will Be Able To Say

- **MPC1** Our revised Constitution addresses membership categories with consideration of the scope and classification to align to strategy

- **MPC2** We have a change management program to support members in transition

- **MPC3** We have a clear definition of the roles and responsibilities for a State-based organisation (versus a branch of National). We have developed the argument for our preferred option
## Primary Healthcare Providers

**MILESTONE: Within 12 Months We Will Be Able To Say**

<table>
<thead>
<tr>
<th>PHC1</th>
<th>We took a position as a catalyst for co-ordinating the efforts and advocacy for primary healthcare organisations and have successfully implemented some initiatives visible to the Industry</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHC2</td>
<td>We reviewed and refreshed our stakeholder engagement strategy to ensure all key peak bodies / professional associations were targeted</td>
<td>I</td>
</tr>
<tr>
<td>PHC3</td>
<td>We developed and implemented a communication plan to increase awareness and promote; our new vision, who we are and how we can support them</td>
<td>I</td>
</tr>
<tr>
<td>PHC4</td>
<td>We developed and published a suite of organisational ‘position’ statements clearly articulating our key messages</td>
<td>C</td>
</tr>
<tr>
<td>PHC5</td>
<td>We built on and expanded the Queensland primary healthcare network</td>
<td>I</td>
</tr>
<tr>
<td>PHC6</td>
<td>We understand the environment, constraints and aspirations of primary healthcare providers</td>
<td>I</td>
</tr>
<tr>
<td>PHC7</td>
<td>We have delivered a first offer of practical services to primary healthcare providers (e.g. Bulletin)</td>
<td>I</td>
</tr>
<tr>
<td>PHC8</td>
<td>We developed strategies to foster GP and other primary providers’ engagement in clinical leadership e.g. clinical networks</td>
<td>I</td>
</tr>
</tbody>
</table>
## Hospitals and Local Health Networks

**MILESTONE: Within 12 Months We Will Be Able To Say**

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HLH1</td>
<td>We have established initial partnership arrangements with the private hospital sector built on our understanding of their priorities and our mutual interests</td>
</tr>
<tr>
<td>HLH2</td>
<td>We have identified strategies and models to enable Medicare Locals and Local Hospital Networks to partner to reduce admissions. The motivation, options and partnership models are defined</td>
</tr>
<tr>
<td>HLH3</td>
<td>We have identified strategies and models to improve the patient journey and the primary healthcare / acute care interface</td>
</tr>
<tr>
<td>HLH4</td>
<td>We have identified models for LHN/ MCL collaboration</td>
</tr>
</tbody>
</table>

## Consumers and Community

**MILESTONE: Within 12 Months We Will Be Able To Say**

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC1</td>
<td>Developed and co-ordinated a State-wide database to support and facilitate effective health service planning (including GPQ, MCLs, Outreach, etc.)</td>
</tr>
<tr>
<td>CC2</td>
<td>We identified and actioned opportunities for formal data sharing arrangements to expand the database; e.g. Health, MCLs and others</td>
</tr>
<tr>
<td>CC3</td>
<td>We reviewed and refreshed our consumer engagement strategy and framework working with key partners (eg. HCQ) to guide our consumer representation and engagement strategy</td>
</tr>
<tr>
<td>CC4</td>
<td>We can evidence the voice of consumers in program design and delivery</td>
</tr>
<tr>
<td>CC5</td>
<td>We have offered and delivered community engagement training to MCLs</td>
</tr>
<tr>
<td>CC6</td>
<td>We developed a consumer web page for the GPQ website</td>
</tr>
</tbody>
</table>
Suppliers and Infrastructure

**MILESTONE:** Within 12 Months We Will Be Able To Say

**SUP1** We succeeded in obtaining recognition as an employer of choice through development of an action plan for accreditation

**SUP2** Our successful marketing and PR is reflected in the commitment of suppliers to provide quality services and competitive terms under documented SLAs

**SUP3** The re-development of the website has supported the promotion and supply to all organisational initiatives. It drives enquiry rates, ‘hits’ on the site and improved conversion to sales

**SUP4** We conducted and infrastructure audit to ensure it aligned to strategy, gaps identified and plans in place to address the identified needs
Technology

MILESTONE: Within 12 Months We Will Be Able To Say

**TEC1** We strengthened our lead role as a change manager for the uptake of e-health and other technologies in primary healthcare

**TEC2** We developed training and support packages to assist the roll out of e-health

**TEC3** All new IT and technology initiatives are committed against a robust business case that considers ROI, testing and evidence

New Revenue Streams

MILESTONE: Within 12 Months We Will Be Able To Say

**NRS1** We continued the fee for service growth strategy including new markets for i-healthcare plus

**NRS2** We identified and assessed the business cases for new and diversified products and services that meet the market beyond 2012

**NRS3** We have identified and consolidated the business partners we want to work with in order to create the new market opportunities

**NRS4** We created and carried the value for money principle into the design and recognition of all product and service offerings
Marketing and Public Relations

MILESTONE: Within 12 Months We Will Be Able To Say

MPR1 We have established a suite of marketing materials which contribute to and complement our organisation’s capabilities (i.e. program delivery, advocacy, finance system and training)

MPR2 We have deployed all our marketing collateral through all channels showing the benefits and capabilities of GPQ in progressing quality outcomes

MPR3 We have a marketing and communications plan developed with key targets and action areas that look forward two years. Activity is tracked and outcomes reported

Environmental Pressure

MILESTONE: Within 12 Months We Will Be Able To Say

EP 1 We continue to be a major contributor to Queensland’s reconstruction and recovery strategy post-2011

EP 2 We created a strong theme of building community capacity and resilience into our new product offering and services

EP 3 We monitor economic trends and markets to ensure the sustainability and relevance of our products and services

EP 4 We monitor wage and salary changes and benchmarks in the labour force to ensure comparability and relevancy within our own workforce

EP 5 We exploit the privacy of our central health role to dispel competing and limiting environmental pressures
Strategic Workshop Activation

1. Name the initiative (Thunderbird)
2. Massage the Milestones
   Milestone Rationalisation –
   - Fifteen days solo
   - Thirty days Team
3. Owner signs on
4. Recognise achievements
5. Power of four chunking
6. Communicate promises (thirty)
7. Identify obstacles
8. Matters for resolution – Leadership Team
9. Strategy meetings are strategy alone
10. Honour the rhythm