

# CAPITAL & COAST DISTRICT HEALTH BOARD

## DISTRICT STRATEGIC PLAN

2002/07



## FOREWORD

Planning for good health is vital, so the Capital and Coast District Health Board's (C&CDHB) District Strategic Plan is an important step towards improving people's health and ensuring communities share good services.

It is important to identify local needs, so we reviewed people's health in Kapiti, Porirua and Wellington<sup>1</sup>. At the same time, local solutions are needed for these local problems so the views of our diverse ethnic groups need to be heard. We have consulted closely with Ngā Iwi Tangata Whenua, our Treaty partners, who have already provided valuable advice to ensure Maori participation.

C&CDHB acknowledge that DHBs have to manage financial resources prudently to achieve health gain for the population. This responsibility has two elements:

- The ability to meet our financial commitments in the immediate financial year; and
- Investing responsibly to ensure our financial responsibilities can be met in the long term.

The Board of C&CDHB is committed to continuously identify and realise efficiencies.

I would like to thank the many people who have participated in this important process; particularly former Board members, Capital and Coast District Health Board, community representatives and Ngā Iwi Tangata Whenua who have all given their time to guide us.

**Bob Henare**  
Chairman, Capital and Coast District Health Board

Approved by:

**Annette King**  
Minister of Health

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<sup>1</sup> The Health Needs Analysis report is available from Capital and Coast District Health Board on (04) 803 1100 or [www.ccdhb.govt.nz](http://www.ccdhb.govt.nz)

November 2002

**Ngā Mihi...**

**Maori health is a well-known concern - youth suicide, heart disease and diabetes are increasing - so urgent action is needed. Last September we signed a Maori Partnership agreement with Ngā Iwi Tangata Whenua (comprising Ngāti Toa, Te Atiawa and Ngā Rauru Tētere, the Wellington Taurahere group) so Maori now have a voice, giving them the chance to join in the development of health services in this region. This Partnership agreement is an important step.**

**The agreed priorities for Maori health are clear. Ngā Iwi Tangata Whenua will work towards:**

- **Providing coordinated leadership and advice on Maori health issues;**
- **Providing better health services and matching these community needs; and**
- **Ensuring services are adequately funded.**

**This District Strategic Plan sets out Capital and Coast District Health Board's priorities for the next five years. Ngā Iwi Tangata Whenua supports this document as it identifies Maori health as a key priority and highlights the main requirements.**

**Na reira ...**

**Bill Katene  
Chairman  
Ngā Iwi Tangata Whenua**

## **Statement from Chief Executive Officer**

**This is our first District Strategic Plan, and outlines our path for improving health status and disability support services for our communities. Our vision is, “Together Improve the Health of the District”.**

**Many people have contributed to this plan, some by way of their work in the past to identify priorities of our people and others by making submissions during the consultation period. We are grateful to people who have contributed to development of this plan.**

**These directions are developed using our health needs assessment of the community and your feedback. We will continue talking to our communities so as to move forward on these directions and together, we will improve the health of the District.**

**The District Strategic Plan provides a sense of direction in which C&CDHB wants to move forward. These directions will be operationalised in our future District Annual Plans. The future District Annual Plans will identify and quantify opportunities for efficiencies and cost reductions.**

**Margot Mains  
Chief Executive Officer  
Capital & Coast District Health Board**

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## PART 1:

### 1. CONTEXT

#### 1.1 District Health Boards

District Health Boards (DHBs) were established on 1 January 2001, under the Public Health and Disability Act (2000). The 21 DHBs were charged with improving the health of their populations through implementing government strategies. Their prime responsibility is to:

*“Improve, promote and protect  
the health and independence of their populations.”*

This shifts the focus from individuals to communities. For our purposes, we have defined communities as ‘enduring networks of people with some common identity, interests and experiences’.

Boundary of Capital & Coast District Health Board



DHBs are responsible for planning and funding services that will meet the needs of their populations. These services will eventually include:

- All hospital-based services;
- All primary and community-based services, including Maori provider services and Pacific provider services;
- All mental health services;
- All disability support (including the elderly, possibly from June 2003) services; and
- Some public health services.

Until the DHBs were established, these were the responsibility of the Ministry of Health and, formerly, the Health Funding Authority.

## 2. ABOUT OUR STRATEGIC PLAN

### 2.1 *Where the plan fits into the planning process*

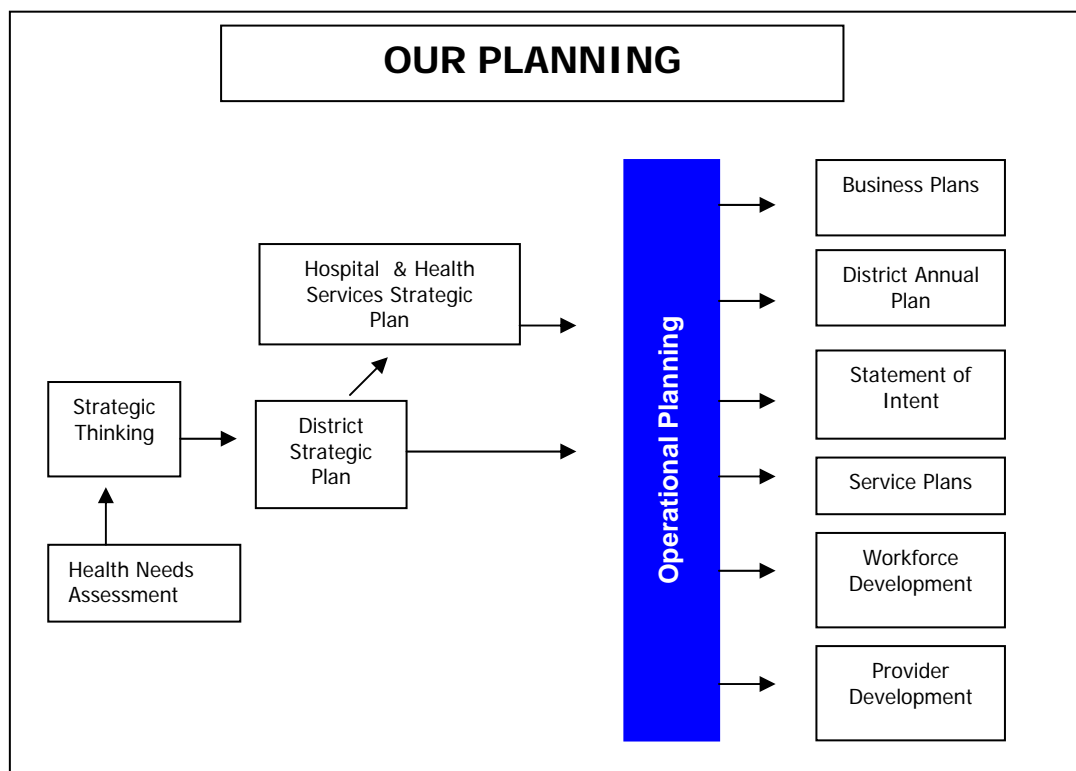
This Plan presents the C&CDHB's vision for the next five to ten years, and describes the necessary action. It is a snapshot of the Board's current thinking, so will evolve.

The Plan is deliberately pitched at a high level - focusing on goals and priorities, not detailed methods.

Designing safe and effective health services is complex. This means two things:

- Wide consultation is required to ensure the best decisions; and
- Planning and time is required to marshal resources.

Operational plans and strategies will then flow from this Plan.



- The District Strategic Plan provides a view of the next 5-10 years.
- It provides direction and purpose.
- It is an evolving document and will be reviewed.
- Strategies will be implemented over time.
- Communities, consumers and providers are essential to the process.

## ***2.2 Using the Strategic Plan***

The Strategic Plan will be used:

- To give C&CDHB direction and purpose;
- To provide the basis for an integrated health care network across the District;
- As the basis for service development decision-making and resource allocation;
- To develop the hospital and health services strategic plan;
- In the planning of the Regional Hospital and Newtown;
- As the basis for discussions with communities; and
- As the springboard for further strategic thinking.

## ***2.3 Moving forward***

Change takes time. This Strategic Plan shows where we would like to be in 5 to 10 years and outlines our high level priorities. Many future decisions will need the input of health professionals, communities and individuals. We already have for example:

- Service Advisory Groups (involving health professionals and communities) to help plan services in primary care, maternity care and for people experiencing disabilities;
- The Service Advisory Group working on developing the Accident and Medical Emergency Centre at Kenepuru; and
- 70 working groups (involving hospital staff, communities and health professionals) to review the delivery of hospital services, to see how things can be done better under the new regional hospital developments.

Not everyone can contribute to formal working groups, so we will provide different methods for comment. These might include using community radio, church and community meetings or encouraging people to attend our meetings.

Working with the community to gather the best ideas in our District on improving things is a key step in achieving our priorities.

## ***2.4 Being accountable***

Performance measures will be included to ensure public accountability. This follows the discussions on Kenepuru Hospital's future, when it was realised that performance measures will help gauge whether community and primary care services were functioning well enough to permit a reassessment of bed numbers.

### 3. VISION

The directions of the New Zealand Health Strategy, New Zealand Disability Strategy, Maori Health Strategy, and objectives of the DHB (as set out in the Public Health and Disability Act 2000) were considered in developing our vision. Local priorities, identified in the Health Needs Assessment, were also included (refer to Section 10).

#### 3.1 *Our suggested vision*

***Together, Improve the Health of the District***

**By**

- **Acknowledging and reducing disparities**
- **Supporting people to fulfil their potential**
  - **People with disabilities feel included, participate and are independent**
  - **Mental health services continue to improve**
- **Developing partnership with Maori**
- **Investing in Communities**
- **Being innovative**
- **Working with others**
- **Developing and maintaining the quality of existing services**
- **Identifying and realising efficiencies**

## 4. OUR PRIORITIES

We will never have enough money to do all we want. We have to make choices (see 6.5). The Government's three year funding package provides for some growth and investment in primary care (see section 5.7.2). Increasing the challenges we face is the need to provide for an ageing population, increases in our high need population, industrial relation tensions and new technology.

To achieve the result outlined in this strategy we will have to:

- **Manage our present funding well;**
- **Make savings; and**
- **Make choices between services.**

Our Funding is Limited. This means making choices.

Two themes underpin our strategic objectives and priorities. These are:

### *4.1 Reducing disparities*

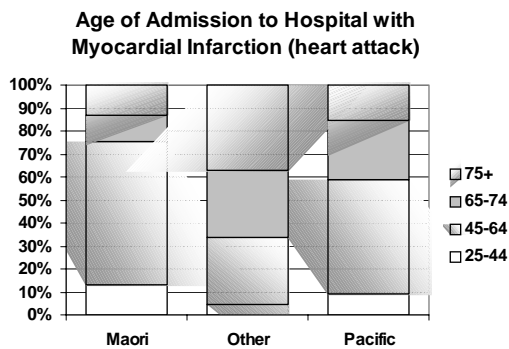
The Government has committed to reducing disparities across a wide range of areas, including health. Our analysis of local health need reinforces this commitment. The health of people in the Capital and Coast District is, on average, better than the rest of New Zealand, but this average hides pockets of severe deprivation and associated high health needs (about 10% of our people). Our Health Needs Assessment (see section 10) reconfirmed the strong links between deprivation and health, and ethnicity and health. Maori people and Pacific people carry higher burden of disease<sup>2</sup> than other ethnic groups.

The following examples underline the case for reducing disparities as a priority for this District:

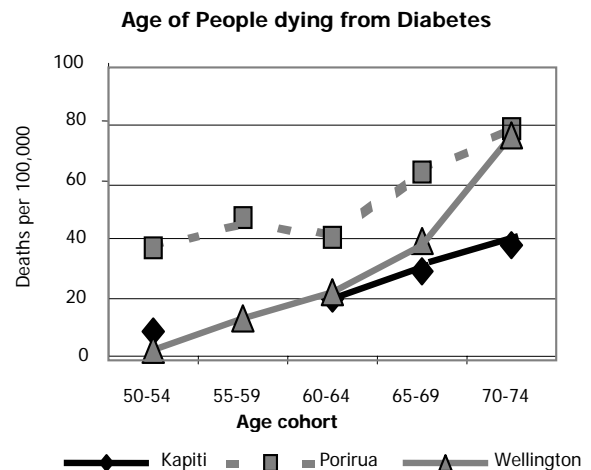
- **The Maori burden of heart disease is 2.5 times the non-Maori burden**
- Maori people and Pacific people die younger than others;**
- **Heart disease and diabetes are the main causes of early death;**
- **Maori people and Pacific people with these illnesses die, on average, 20 years younger than comparable groups;**
- **Maori children and Pacific children have higher rates of severe asthma and chest infections, with poorer oral health; and**
- **Maori adolescents have a higher suicide rate than other groups.**

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<sup>2</sup> The burden of disease is measured in disability adjusted years of life (DALYS) which combines measures of loss of years of life with reduced quality of life.



Maori and Pacific people are admitted to hospital for heart attacks at a much younger age than others



The graph shows that people in Porirua with diabetes die earlier than people with diabetes in other areas.

People with very poor health tend to be concentrated in parts of Porirua and in Wellington East and South and a small area of Kapiti. They are mostly (but not exclusively) of Maori or Pacific origin. Our Health Needs Assessment showed that low-income people in Porirua, who are not Maori or Pacific, share similar health problems as that of Maori and Pacific.

## 4.2 Population-based approaches

Why are some people healthy and others not? Despite efforts to provide universal coverage for core health services, some population groups emerge as having particularly poor health.

Currently, our services are well designed to serve individuals, but there are circumstances where balance is needed between an individual versus a population approach. In these circumstances, focusing services at whole population groups (or sub groups) can be more effective, particularly where we want to:

- Emphasise preventative and health promotion or education;
- Target unmet needs; and
- Impact on the underlying environmental causes of ill health, such as poor housing.

Equity in health outcomes for all groups is desirable. Different approaches are required in designing and delivering services that are both relevant and acceptable to different population groups, particularly those with poor health and poor access to services. We strongly support the Government's approach of a population-based approach to health. This will be particularly effective in our District because the population groups are relatively well defined by age, ethnicity, income and region.

**The two main themes that underpin our strategic priorities are:**

- **Reducing health disparity within communities:** The majority of people in the district have very good health but there are pockets of our population that have poor health.
- **Population based approaches to health:** We acknowledge the different population groups, and the challenge to tailor services to meet this difference. We want to expand from services focussed on individuals to services focussed on the population as a whole. This will mean an emphasis on unmet need and access.

### 4.3 Bringing it together

Our strategic priorities are based upon:

- Government expectations of our focus;
- Local health requirements (as identified by our Health Needs Assessment); and
- Our knowledge of making services effective.

The following table lists:

- Our strategic objectives over the next 5 to 10 years;
- The priority areas; and
- Examples of activities, or approaches, that will make this happen.

Aims	Focus	Method (not exhaustive)
<p><b>Acknowledge &amp; reduce disparities</b></p>	<p>High need people Identifying disparity by ensuring accurate information at the provider/ funder level Developing services for*:  <ul style="list-style-type: none"> <li>- diabetes,</li> <li>- cardiovascular disease,</li> <li>- child health,</li> <li>- smoking cessation,</li> <li>- suicide, oral health and</li> <li>- mental health</li> </ul>   <p>*(not necessarily in this order of priority)</p> </p>	<p>Develop and implement Maori health strategy for this district            Develop and implement Pacific health strategy for this district            Develop disease management programmes for integrated services, focused on managing disease across community and hospital-based services            Develop programmes to improve nutrition, especially in children and people with diabetes and cardiovascular disease            Invest in primary and community-developed health care to improve access to primary care services            Use population-based health approaches            Do things differently – being innovative and encourage diversity in programmes to suit the different ways in which people (Maori, Pacific, refugee/recent migrant communities, youth) use services            Improve ethnicity data collection to help analysis of health status, access patterns and degrees of disparity            Develop and support Maori providers and Pacific providers who specialise in Maori paradigms and Pacific paradigms to deliver</p>

		<p>health and disability services Develop Pacific Unit in the Hospital</p>
<p><b>Support people to fulfil their potential</b></p>	<p>Promoting inclusion, independence and participation in society by people with disabilities Developing and improve mental health services</p>	<p>Implement the NZ Disability Strategy. (See Appendix 1) Review and improve delivery of disability services by our provider (hospital and health services) arm Improve community support, disability support, mental health and home care support services. Review all contracts for compliance with NZ Disability Strategy Prepare for devolution of disability services for older people to DHBs Develop an integrated service for older people. Implement the Blueprint for mental health services, Develop our role as a provider of regional and tertiary mental health services, Contribute to regional and national mental health service planning, Develop primary and community mental health services. Work with NGOs to strengthen links to ensure continuing care for those with severe mental illness</p>
<p><b>Invest In Communities</b></p>	<p>Building effective and equitable relationships between DHBs, providers and communities Learning about community processes and values that will inform our decision-making, planning and monitoring activities Sharing information on the health status of our region, the effectiveness of services and ideas on how we can do better Be accountable to our communities and to Government Participate in community-led projects to support and promote the improvement of health</p>	<p>Develop a suitable infrastructure and processes for formal engagement (see section5.3) Build relationships so our informal networks with communities ensure ongoing information on community developments Consult continuously Develop communication strategies and tools to ensure meaningful discussions with our District's diverse ethnic groups Develop suitable outcome and process indicators so people can assess our progress</p>

	<b>Work with others to develop Communities to support building the capacity of primary care providers</b>	
<b>Develop relationship with Maori</b>	<b>Develop Maori governance and organisational competence</b>	<b>Acknowledge and live our obligations to Maori under the Act Support Maori Governance Develop appropriate HR policies to strengthen our Maori resource Build provider, Iwi and community relationships</b>
<b>Be innovative</b>	<b>Develop processes and an environment for encouraging innovation Encourage collaboration as a means to inspire and foster innovation.</b>	<b>Listen to communities and providers and their experience &amp; ideas for improvements Focus on goals and results to ensure innovations are relevant Environmental scanning to gather the best knowledge available on doing things better Development of a new model of service delivery at all sites focused on ambulatory care services, improved community and primary care integration Development of an integrated local service delivery model focused on community and primary care for Kapiti community</b>
<b>Work with others</b>	<b>Develop networks and partnerships</b>	<b>Establish forums so health professionals can see how services are developed Establish forums so communities can contribute to decisions that will affect them Work with other DHBs to ensure co-ordination, particularly where other DHB decisions impact upon our district Contribute to developing regional and national strategies and service planning and delivery where appropriate Work with people and organisations whose work complements the funding and delivery of our services (eg. Housing NZ, CYPS, DWI, ACC)</b>
<b>Identify and realise efficiencies</b>	<b>Demand-driven community services (pharmaceuticals and laboratories) Hospital services Infrastructure efficiency</b>	<b>Review of purchasing and delivery arrangements for pharmaceuticals and laboratory tests Continue drive for efficiencies in delivery of hospital and health services Ensure efficient processes in the new regional hospital</b>

<p><b>Develop &amp; maintain quality of existing services</b></p>	<p><b>Quality improvement activities</b></p> <p><b>Develop plans to monitor and audit services</b></p> <p><b>Evaluate efficiency and effectiveness of current services</b></p> <p><b>Build and develop new regional and district facilities at Newtown, Kenepuru and Paraparaumu,</b></p> <p><b>Ensure the New Regional Hospital is able to contribute to the health of the region and contribute to national tertiary service provision.</b></p> <p><b>Improve strategic planning and forecasting.</b></p> <p><b>Improve disability support services<sup>3</sup></b></p> <p><b>Improve community support services</b></p>	<p><b>Implement programme to monitor and audit services regularly</b></p> <p><b>Evaluate new services and pilot programmes to ensure effectiveness</b></p> <p><b>Ensure there is a skilled workforce</b></p> <p><b>Succeed with the Regional Hospital Business case</b></p> <p><b>Redevelop Wellington Hospital as the new regional hospital</b></p> <p><b>At Kenepuru retain current in-patient beds for next 5 years and after that period, retain a similar number of in-patient beds to support the concept of the Communities Hospital</b></p> <p><b>Work with GP's and Community to develop Accident and Medical Emergency services at Kenepuru</b></p> <p><b>Major facility redevelopment of the Kenepuru campus</b></p> <p><b>Work with other providers to improve co-ordination of emergency transport services in Kapiti community</b></p> <p><b>Construct a new integrated health facility, Kapiti Health Centre</b></p> <p><b>Maintain or set up Service Advisory Groups to further strategy and service development in maternity, health of the older people, Primary Health Organisation development, disease state management in diabetes and heart disease, accident and medical emergency services at Kenepuru and other areas as required</b></p> <p><b>Improve community support, disability support, mental health and home care support services.</b></p>
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<sup>3</sup> Our ability to influence Disability Support Services is limited as the Ministry of Health funds these services.

## 5. MAKING IT HAPPEN

These improvements will be achieved by:

- Strengthening our Iwi relationships;
- Adopting an integrated model of service provision putting the community at the centre, as developed during the Regional Hospital consultation (Section 9.3);
- Ensuring the way we work reinforces our objectives - supporting diversity in delivery, supporting approaches enabling individuals and their families to take responsibility for their own health, and working towards a seamless integration of care (Section 5.7);
- Developing specific strategies for Maori people and Pacific people (Section 5.4 and 5.5);
- Developing an effective infrastructure and processes;
- Over time changing the balance in funding between primary and community care and hospital care (Section 5.7.4); and
- Successfully managing the change processes that will result from these strategies.

### 5.1 *Strengthening our Iwi relationships*

The Treaty of Waitangi established the special relationship between Maori and the Crown. We acknowledge that the C&CDHB has a responsibility to assist the Crown in fulfilling its Treaty obligations. The C&CDHB considers the Treaty of Waitangi principles important - partnership, proactive protection of Maori health and the participation of Maori - and they underpin our approaches to, and practice of, health planning and funding in this District.

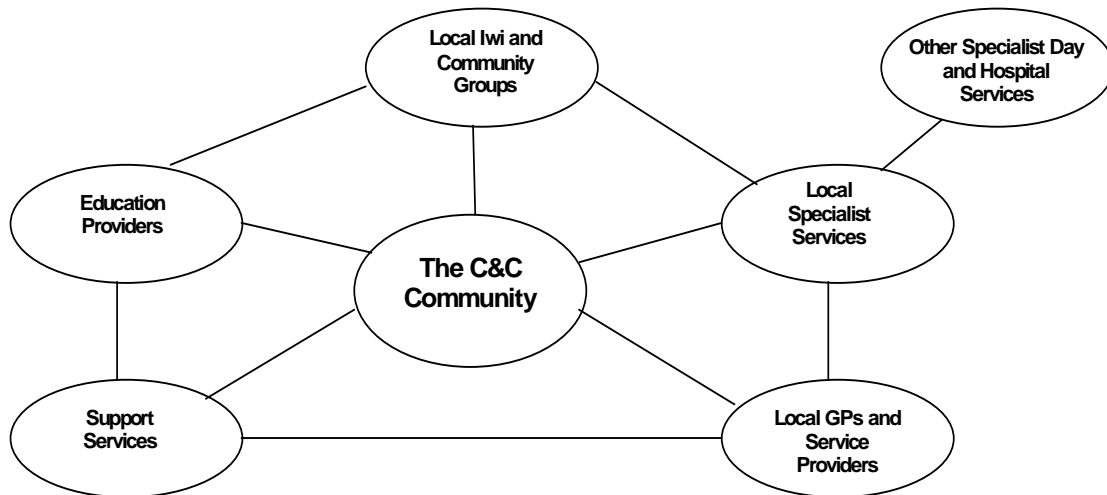
Maori health is also an important strategic priority for C&CDHB because of the poor health status currently experienced by Maori populations. The C&CDHB will strengthen and build on our existing relationships with Maori - Iwi and Taurahere - to ensure the principles and objectives of He Korowai Oranga (the Maori Health Strategy) are achieved and Maori health in our District is improved.

C&CDHB has an extra ordinary commitment to its Iwi partner, and includes:

- Consultation with and participation of Maori in planning and policy making;
- Improving access to health services;
- Having better information to understand the health needs of Maori; and
- Improving the health outcomes for Maori over time.

## 5.2 Putting communities at the centre

As a result of community discussion during the Regional Hospital consultation, we changed our service model from the traditional 'hub and spoke' (with the Regional Hospital as the hub) to a Community-centred model,



as shown in the figure below.

- We will work to deliver services as close as possible to where people live and work within the constraints of safety and cost.
- We will work with the communities, regional councils and other bodies including volunteer drivers to improve access and reduce the cost of access to service as much as possible. We will explore the feasibility of improving mobile services including specialist services.

## 5.3 Working with you, our communities

The issues determining health outcomes for C&CDHB are complex as decisions occur at many different layers. It is vital stakeholders share their experience and knowledge in influencing strategy, policy and decisions.

We will be seeking solutions to some enduring health issues so are particularly interested in talking with people who understand the four groups who are this strategy's main focus: Maori, Pacific peoples, people who are disabled and those with low incomes or relatively few material resources.

Communities are enduring networks of people with some common identity, interests and experiences.

We acknowledge that, in the past, community involvement in planning has been - at times - frustrating and - at times - disappointing. In future C&CDHB wants to ensure communities are productively involved in planning, design and delivery. This requires mutual trust, leading to enduring relationships, and this must be earned through effort, consistency and openness. We have started this approach with various projects and will build on these beginnings.

This does not mean, however, we will agree on everything! The factors that inform decision-making processes in health are complex and often require difficult balancing tensions. The ultimate responsibility for financial and service performance rests with the staff, management and Board of C&CDHB.

As a new organisation, we are working to establish a network of community involvement at all levels from working with the Board (high level strategic decisions) to working with staff (implementation details). Beside this will sit the formal decision-making process of C&CDHB.

#### Structure for Community Involvement<sup>4</sup>

##### Board

The Board consists of seven elected by community and up to four members appointed by the Minister of Health. The chairman is a ministerial appointment.

##### Board Committees

The Act requires three permanent committees to advise the Board: the Community and Public Health, Disability Services and Hospital Advisory committees, whose members are drawn from the Board and nominated community representatives.

##### Reference Groups

The Board has relationships with existing external community groups, often geographically based; for example, Porirua Healthlinks.

##### Service Advisory Groups

Service Advisory Groups have been formed (comprising community representatives, providers, and DHB staff) to focus on specific service areas, such as maternity services, Accident & Medical Emergency Services - Kenepuru.

Other working groups and mechanisms will be formed as required to assist discussion on service development and changes; for example, the Diabetes Podiatry Working group.

#### Examples of working with communities – Kapiti and Porirua Healthlinks

The Ministry of Health has established Healthlinks projects in Porirua and Kapiti. They have Ministry funding and are developing projects to improve access to primary care; for example, Porirua Healthlinks is committed to building an information centre, developing a community health workers' service, and improving access to primary care.

#### **5.4 A strategy for Maori health**

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<sup>4</sup> Refer to the Board Structure in Appendix 3

C&CDHB findings support the Ministry of Health's vision for Maori – Whanau Ora<sup>5</sup> and the three endorsements - rangatiratanga, Maori population health objectives and building on gains. We aim to reduce health disparities between Maori and non-Maori through:

- Improved access to services (primary/ secondary/ tertiary);
- Increased utilisation of services and ensuring Maori affordability;
- Reducing poor health amongst Maori (diabetes, heart disease, cancer and respiratory illnesses);
- Integrated case management for high risk Maori whanau;
- Strong links between service providers and their community; and
- Cultural responsiveness of primary and secondary care sectors.

Key priorities for Maori are:

- Youth health and suicide prevention;
- Primary health care and preventative services;
- Provider and workforce development; and
- Improved ethnicity information to help research and information dissemination.

### ***5.5 A strategy for Pacific people***

C&CDHB support the Ministry of Health's vision: *'Healthy Pacific peoples achieving their full potential throughout their lives'*.

The following priorities have been identified to improve Pacific health:

- Strengthen Pacific provider capacity by developing leadership, management and governance;
- Build our capacity to analyse Pacific use of services from both Pacific and mainstream providers;
- Build effective dialogues with Pacific communities;
- Build the knowledge base of effective interventions to inform future funding and service to contribute to Pacific health gains; and
- Improve ethnicity data.

Pacific peoples' health improvements will be targeted through:

- Child and youth health;
- Promoting healthy lifestyles and well-being;
- Primary health care and preventative services;
- Provider and workforce development;
- Promoting participation by Pacific peoples with disabilities; and
- Health & disability information and research.

### ***5.6 Developing different models of care for our diverse communities***

Fewer people are being admitted to hospital for respiratory illnesses such as asthma, and smoking cessation programmes have been effective in some

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<sup>5</sup> He Korowai Oranga – Maori Health Strategy Discussion Document, Ministry of Health, April 2001.

areas. These successes are worth celebrating. Unfortunately, the improvements are less marked in some groups, in particular Maori and Pacific. Differences in health outcomes and service access between various ethnic groups must not be tolerated.

It is inevitable different people will access and receive services in different ways. Diversity in delivery must be encouraged to ensure everyone receives effective health services.

**C&CDHB will:**

- Move from a '*one size fits all*' approach to allow for a range of delivery models and practices – which may mean different funding levels to achieve standard effectiveness across the District;
- Move from institutional / organisational to community approaches;
- Emphasise multi-ethnic approaches;
- Redirect resources (including funding) as necessary to achieve equity of outcomes between various ethnic groups;
- Work with Maori, Pacific, other communities' organisations to discover culturally based and effective ways communities have, to lifestyle changes that will assist address key priority areas; and
- Work in collaboration with agencies involved with refugee sector to obtain better information and to support the development of services for refugees as survivors.

### ***5.7 Organising and integrating care***

We will develop an integrated service across the District with communities at the centre. The emphasis will be shifted from institutions and sector segments vying for resources to an integrated network with communities as powerful guides in negotiating and arbitrating services development, according to the District Strategic Plan. The emphasis will be on getting results for the District as a whole.

**For this we require:**

- Close involvement with communities, users, providers and staff;
- Good information infrastructure (see Section 6.2);
- Good facilities, appropriately sited (see Section 6.4);
- Well trained and highly motivated providers and staff; and
- Well-developed values and principles.

The key to a successful integrated service will be clear definition of roles, with strong links. For example, Newtown Regional Hospital will be tightly focused on its role in the national and regional network of highly specialised services and provider of more complex hospital services for the District. Services requiring lower levels of support will be delivered nearer to users - either from facilities such as the Kenepuru Community Hospital or as part of community and primary care networks. Links will be provided by efficient information / communication networks and sharing of protocols, clinical pathways and guidelines. The focus will be on benefits to users.

**The important Infrastructure of the future will be our Information Management and Knowledge Systems**

### ***5.7.1 Population-based approaches***

Population-based approaches means services are designed and delivered according to the needs of a particular population (eg: Maori) or sub-population group (eg: low income Maori). This approach takes account of the many other factors impacting on health (eg: income, cultural differences in perspectives of health). We can also focus on keeping healthy people healthy, while targeting others who are not as fortunate. This approach also helps us to target our focus on unmet need.

We believe this is the right approach for our District because we have relatively well-defined groups with poor health, who are not likely to use health services:

- Low socio-economic areas in Porirua East, Strathmore/Miramar, Newtown/Berhampore;
- Ethnic groups with significantly poorer health overall - Maori and Pacific; and
- Age - where the health of children and elderly people is a concern; or
- Some combination of these factors.

C&CDHB also has significant populations who are very healthy and able to look after themselves, providing effective health services are maintained.

Population-based approaches mean we can bring together many services (with families and communities at the centre) such as:

- The interface between public health promotion and personal or individual health services;
- Coordination of primary and community-based care with secondary specialist expertise;
- An integrated approach to developing services around diseases and conditions that are prevalent among some groups (eg: diabetes, cardiovascular disease); and
- Developing culturally specific health promotion models.

**We will improve core health outcomes by:**

- A network of services that integrate and co-ordinate care;
- Strong focus on primary care;
- Encouraging different approaches to achieving equity in outcomes;
- Encouraging different service arrangements that will best meet the needs of target populations;
- Working with other agencies to improve the environment;
- Providing individuals, families and their communities with the tools to take responsibility for their own health; and
- Community involvement in designing, planning and delivery of services.

### ***5.7.2 Stronger Primary Care***

Strong primary care is an important part of our strategic priorities – it will be strengthened through integration and innovation, recognising:

- Its effectiveness is affected by ‘pre-primary’ or how individuals cope with, and understand, illness before seeking medical advice;
- Access to medical advice can be limited by funding, geographical and cultural barriers; and
- Access can be limited at the other end, depending on how successfully primary care connects with specialist expertise (possibly hospital-based) to manage illness or a chronic condition in the community.

We will:

- Actively develop primary care services, including prevention and health promotion activities;
- Target services at Maori, Pacific peoples and other low income populations;
- Work with others to change those environmental factors leading to poor health;
- Be innovative in how services are developed, configured and funded;
- Seek efficiencies so resources are released for new initiatives;
- Encourage a multi-disciplinary team approach and develop the roles of nurses and other health workers;
- Monitor services to ensure they are meeting the expected needs; and
- Complete the Newtown regional hospital and services development to improve connections between tertiary, secondary and primary services.

### ***5.7.3 Primary Health Organisations - a mechanism***

Primary Health Organisations (PHOs) aim to:

- Achieve better health;
- Reduce inequalities;
- Improve service access through a population focus; and
- Involve communities in their governing processes.

The Health Needs Assessment provided strong guidelines for PHO development, including a focus on:

- Parts of Porirua and South/East Wellington;
- Maori people’s health and Pacific people’s health;
- Innovation;
- Building on recent gains; eg: asthma and respiratory disease; and
- Proactively attacking diseases, in particular, cardiovascular disease and diabetes.

We are working with communities (through Service Advisory Groups) to determine the most effective shape of PHOs for our District.

### ***5.7.4 Balancing funding between hospital and primary care.***

Over five years we will change the balance in funding between hospital and primary care so as to increase resources for primary and community care. We will ensure this happens by:

- Supporting the community model developed in the Regional Hospital Business case;
- Being ready to obtain and use any additional Government funding available for primary care and Maori development and Pacific development;
- Working with the hospital to integrate services with primary care and provide a continuum of care which leads to better use of hospital resources (eg. the community radiology service);
- Working with the hospital, primary care providers and the community to reduce the load on the hospital. In particular to reduce acute admissions from asthma and other respiratory conditions, cardiovascular disease, diabetes and infections in children. In addition ensure that community services are available to allow safe early discharge of patients. We will work to improve the quality and effectiveness of primary care and community care so as to enable these outcomes;
- Move services where appropriate from the hospital into the community;
- Support the hospital and health services provider arm in gaining efficiencies so as to be able to shift funds to primary care;
- Identify and withdraw funding from hospital services that are not contributing significantly to the DHB's strategic direction;
- Reviewing the provision of tertiary services and assisting the hospital and health services provider arm in ensuring it is adequately compensated for provision of regional and national services; and
- Ensuring that any new services provided by the hospital are cost effective and consistent with the DHB strategy.

This project will identify areas of potential health gain in primary care (eg. improved treatment of asthma) by development of primary care services or improved integration and the consequent impact on secondary services. This will allow us to plan funding flows.

**C&CDHB is committed to:**

- Changing the balance of funding between primary care and the hospital;
- Implementing the Primary Care Strategy and developing Primary Health Organisations; and
- Building a New Regional Hospital in Newtown and redeveloping hospital/ services in Porirua and Kapiti.

## ***5.8 The Hospital development as a catalyst for change***

### ***5.8.1 Improving facilities and new models of care***

Existing hospital facilities at Newtown, Kenepuru and Paraparaumu are inadequate for providing quality and efficient healthcare in the 21<sup>st</sup> century. The proposal to build a New Regional Hospital in Wellington and redevelop the facilities at Porirua and Kapiti should ensure C&CDHB has the infrastructure to

provide high quality care. As part of this we are developing new ways of delivering care.

The new methods of service delivery supported by the new facilities and models of care will:

- Address the urgent need to upgrade facilities, enabling the delivery of contemporary health care over the next 20 years;
- Meet patient safety and earthquake needs;
- Ensure the hospitals operate efficiently;
- Move to community care being delivered;
- Ensure services and facilities match the needs of Maori and other groups;
- Integrate with primary care; and
- Integrate and support relationships with education providers.

We also need, with providers, to address the standard of facilities used to deliver primary and community care and ensure that they are of a standard that will attract people and provide for safe care.

### ***5.8.2 The Regional Hospital as part of the Regional and National network***

As the owner of the largest and most developed hospital in the Central region and its geographical position, C&CDHB will play a major role in the development of the network of Regional and National services. These services will clearly be services requiring high levels of specialist staff, equipment and technology. We expect to continue development of these services in the interest of our population and the region. Consistent with our proposed strategy and ways of working we look forward to assisting these services to:

- Work towards equitable access and outcomes for these populations experiencing greatest disparities;
- Engage with their wider communities and other DHBs in planning, designing and monitoring the quality of their services; and
- Contribute their expertise to the design of integrated services that will improve the health of the population.

### ***5.8.3 Community Hospitals***

A community hospital at Kenepuru and the redevelopment at Paraparaumu will play an important role in developing and integrating care in the respective communities. We welcome the opportunity to use these developments to be innovative and develop new models of care which better service local needs.

## ***5.9 Mental health services***

The mental health of our community impacts in many ways upon its general health. The scope of mental health problems is very broad. The number of people, at any point in time, coping with some degree of distress due to mental health issues is approximately 20 percent. It is predicted that by 2020 depression will be the most prevalent disease on a worldwide basis. Depression and anxiety disorders are already among the most frequent diagnoses in General Practice. The incidence of youth suicide while having reduced nationwide is still increasing in the C&CDHB area. The numbers of people with psychotic disorders and alcohol and drug disorders continue to provide challenges for our services. Of the total population with mental health problems our greatest concern is for the 3 percent suffering severe mental illness.

The National Mental Health Strategy has the following main goals:

- To decrease the prevalence of mental illness and mental health problems within the community; and
- To improve the health status of, and reduce the impact of mental disorders on consumers, their families, caregivers, and the general community.

Expansion within the Mental Health sector has been significant over the past 5 years with growth of approximately 25 percent in funding and services. Capital Coast Health provides a range of specialist services including General Adult, Child and Adolescent, Forensic and In-patient Rehabilitation and Transcultural (Maori and Pacific Island) Services. In addition the non-government sector provides services for people with conditions ranging from psychotic to alcohol and drug disorders.

Further work is needed to establish specific local needs for mental health care. To date, the focus has been on the 3 percent of people with severe mental illness and services are designed to ensure this group can access treatment and rehabilitation. We need to understand, however, the mental health needs of other people so that an increasing focus can be given to providing mental health services in the primary healthcare sector. In the future particular emphasis will be given to early detection and intervention and public health approaches, which focus on mental health promotion and the prevention of serious mental disorders.

Overall Mental Health Services have already moved in the direction of our model of an integrated network of services. This involves high quality hospital care where necessary but with emphasis being given to community care and a wide choice of services delivered by different and diverse agencies. Emphasis is also being given to the participation of consumers, families / carers, community groups and Maori people and Pacific people in the planning and development of services. We endorse this progress.

In line with Government Policy C&CDHB has played its part with other DHBs, in setting up a Regional Mental Health and Addictions Network (CRMHAN) which will be based on the establishment of Local Advisory Groups in each district. CRMHAN priorities for the next year include quality improvement, work force development, Forensic Services, Maori Mental Health and the development of consumer participation in service planning and development.

### ***5.10 Disability services***

The New Zealand Disability Strategy envisages an inclusive, non-disabling society. C&CDHB will promote 'inclusion, independence and participation in society' by people who experience disability. The current focus provides support for people to live within the community, such as environmental support, carer support and home support services.

A regional group has been meeting, including community representatives, to develop a direction to meet our future needs. The group has suggested six vision components to support the overarching goal for disability including future activities. The detailed outcome of these meetings is attached as Appendix 1.

The ability to plan successfully is complicated by uncertainty over the devolution of disability funding, which is at present retained by the Ministry of Health. We look forward to greater clarity over our role.

### ***5.11 Public health***

**Public health services continue to be funded by the Ministry of Health. We look forward to the devolution of these services as we regard public health services as an integral part of overall service delivery, particularly with the advent of PHO's.**

**At present our public health services are delivered by Regional Public Health at Lower Hutt. We look forward to working more closely with them to tailor services to meet our community's needs and our strategic direction. We have established and are maintaining a strong relationship with Regional Public Health services to ensure that our strategic priorities are reflected in their service plans. We are also working with the Ministry of Health to ensure that the monitoring is able to provide useful information to support our planning and funding activities and to establish a strategic planning process that is driven from the public health needs of our District.**

**PHOs will deliver some population health services and that integration is required between these additional services and existing Public Health services.**

## 6. THE DHB'S ENGINE ROOM

The Board's role is important. It needs a strong organisation that performs well – now, and into the future. The Board needs to strengthen existing capacity to make gains for immediate needs, but also so it is able to perform well in the future.

To do this, the Board needs:

- *Workforce development* supporting health professionals to develop their expertise and attract others who are equally committed to best practice;
- Good *information* supporting decision-making at all levels of the organisation;
- Responsible *financial management* supporting resource allocation decisions, with the flexibility to shift resources to the Board's changing priorities over time;
- Responsible *asset management* ensuring expenditure on equipment and facilities are relevant to the Board's priorities; and
- Sound, transparent *decision-making processes* ensuring a community perspective and reflecting the Board's priorities.

### 6.1 *Workforce development*

An experienced and qualified workforce is needed to achieve our priorities and to continue to deliver core services.

There are a number of approaches to be taken:

- Work with the Clinical Training Agency to implement the national strategic objectives developing from the Workforce Development Review;
- Strengthen our relationships with education providers to maximise learning opportunities for health professionals and assist in recruitment and retention;
- Strengthen our relationships with education providers to ensure significant development of health professionals to build the capacity of primary and community-based provision of services; and
- Work with the Ministry of Health and providers to develop and strengthen Maori health professionals and Pacific health professionals within Maori and Pacific and mainstream organisations (including the hospital).

### 6.2 *Information management*

Modern health practices encourage community-based services, requiring a different approach to managing information, particularly to support PHOs, disease state management and integrated approaches to managing care.

**EHR**

An Electronic Health Record is one important business objective we will try to achieve.



This means:

- Putting patients, not providers or health professionals, at the centre of the information management processes;
- Changing the focus of technology systems from 'ownership' and 'management' to 'enabling', which supports sound decision-making and quality of care. It means health professionals - on agreeing to codes of practice to protect patient privacy - can access a patient's full history of care, regardless of geographical location (eg: a hospital or general practitioner's surgery);
- Improved public education on what information is collected about individuals, and how they may access their own information; and
- Better and efficient collection of information (such as ethnicity) to support decision-making and health needs assessments to help set priorities for the District.

Our information strategy has been helped by the 'information landscape' developed by the Ministry of Health's *WAVE* (*Working to Add Value through E-Information*) project<sup>6</sup>.

The main difference in the information management role between a health and hospital services and a DHB is the responsibility for managing patient-centric information across a range of organisations and systems. This needs a change in focus from ownership and management of technology systems to enablement of the process of *information collection, collation, and distribution* – enabling sharing of information between systems and processes that have a range of owners. This change in focus is enabled by thorough constructive and critical analysis of processes and information requirements.

The DHB has several functions that did not exist within a health and hospital service. The main implication for information management is the need to enable decision support functions for clinicians, service analysts and funders. A second implication is the potential need to support a range of payment and monitoring processes for non-hospital providers. Four key projects are under development and, these are:

1. Infrastructure;
2. First Presentation to Community Care;
3. Employee Recruitment to Termination; and
4. Requisition to Payment.

### **6.3 Financial management**

C&CDHB is responsible for management of our funding, as agreed with the Ministry of Health. Our current funding level is \$403million for the 2002/2003 financial year, with assets (non-current) valued at \$235million.

This responsibility has two elements:

- The ability to meet our financial commitments in the immediate financial year; and

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<sup>6</sup> <http://www.moh.govt.nz/moh.nsf/>

- Investing responsibly to ensure our financial responsibilities can be met in the long term.

There will be occasional Government funding for new initiatives related to particular initiatives (eg. establishment of Primary Health Organisations), but we will continue to work on:

- Making savings in our existing funding/purchasing services;
- Better management of demand-driven expenditure; and
- Ensuring decision-making is supported by sound financial analysis.

We have recently received an indicative three-year funding package. A statement of financial performance is attached (Appendix 4)

#### **6.4 Asset management**

A number of significant projects will dominate our asset management. We will ensure these projects remain priorities and remain consistent with clinical safety and innovation, and evidence of effectiveness.

These projects include:

- Development of the regional tertiary hospital in Newtown;
- Improvement of day-care and outpatient services at Newtown, Kenepuru, and Kapiti (including improved diagnostics at Kenepuru);
- Building the capacity for Kenepuru to provide for a 24 hour/7 day Accident and Medical service; and
- An integrated health centre at Kapiti.

Changes in legislation allow us to use the proceeds from asset disposal for health purposes. These proceeds will be applied against capital expenditure and debt repayment.

#### **6.5 Making decisions**

The factors behind our decision-making processes are complex and often require difficult balancing of many tensions.

C&CDHB is committed to decision-making processes that:

- Are transparent and able to meet judicial review tests for fairness and good process;
- Provide for community input; and
- Reflect sound decision-making in the allocation of public resources

#### **DIABETES**

This is a major issue for the District. Deaths are increasing at 12% annually. It is the 3rd most common cause of death in Porirua for people aged 45-65. Now baby boomers are middle-aged, diabetes will put an increasing strain on health services. Lifestyle factors such as reducing obesity and increasing exercise are known to delay the onset of diabetes and minimise the impact on an individual.

How should C&CDHB best use the available resources? Options include:

- Investing in population programmes to prevent obesity and increase physical activity;
- Targeted hospital services to older people who already have complications of diabetes to ensure they have the best quality of life; for example, managing high blood pressure, kidney complications, eyesight and vascular problems leading to ulcers in the feet; and
- Targeting services to young people with diabetes to prevent the onset of complications.

(Funding Management Committee process – refer appendix 5).

C&CDHB has established Ngā Iwi Tangata Whenua (chaired by Mr Bill Katene) to assist the Board is making decisions.

This table outlines the decision-making principles the C&CDHB will use in allocating resources:

Principles	Comment
Improving Maori health	Services targeting improvements in Maori health and/or are able to be delivered by Maori will be given priority.
Value for Money Cost effectiveness	C&CDHB will obtain the best value from services by considering information on both the effectiveness and the cost of services or interventions.
Equity	C&CDHB will fund improving health in Maori or Pacific or other groups with poor health before targeting the general population.
Acceptability	The expectations, ethics and values of local communities will be recognised.
Disability	Improving the independence and participation in society by people with disability is a factor in evaluating proposals.
Consistency	Decisions must fit within legal requirements and will be consistent with the NZ Health Strategy, the NZ Disability Strategy and other Government strategy documents.
Innovation	Innovation will be weighed in decision-making in the absence of evidence demonstrating effectiveness. Piloting new approaches will be part of meeting service requirements.
Commercial Interest	The commercial interest of providers may be considered if the viability of a provider sustaining service delivery in other priority areas is at risk.

## **6.6 Communication and Feedback to Communities**

We will inform communities regularly about emerging models of care, enhancement and changes in the health & disability services and reasons for the same. Communities will also be kept informed of progress in the redevelopments in Porirua & Kapiti and building of new regional hospital at Newtown. We will explore very forum, including regular newsletter, community newspaper, community radio, our formal & informal networks within

communities including reference & service advisory groups to keep communities fully informed.

### ***6.7 Influencing and Collaboration with other Agencies***

We will work collaboratively with agencies to perform our role for the community and Government. These include the other Government agencies such as Housing, Social Services, Education, ACC and Department of Work & Income.

#### ***Key Messages***

Change needs to be supported by a sound engine room - the District Health Board. The C&CDHB is committed to:

- **Building a strong, performing organisation, able to deliver on strategic priorities and attracting / retaining experienced health professionals;**
- **Involving communities in all planning and knowledge sharing activities so resource allocation decisions are guided by the views of local people; and**
- **A transparent, principled decision-making process.**

## 7. MEASURING PROGRESS

Performance measures will be developed, once we have consulted on our strategic direction, to monitor our success over the next five years. Complex performance measures are already operated between C&CDHB and the Ministry of Health, but we want to be accountable to the community and measure our own performance. We have agreed to develop result-oriented evaluation criteria and performance measures with Porirua and Kapiti communities and, in doing this, will develop a more general set for the Strategic Plan.

We will be successful when:

- Our ability to respond is greatly enhanced (capacity); and
- People are healthier (influence on health status).

Examples of improved responses include:

- Better information on people's access to services (eg: ethnicity recording is accurate, its use is easier to track);
- Interventions are better targeted;
- Resources can be shifted to respond to priorities at the time; for example, investing more in primary care;
- We know more about how our services are used;
- More services are designed and delivered by communities;
- Services will be more oriented towards prevention and health promotion;
- We will be working closely with groups and services (other than health) which impact upon health;
- Ethnic-specific services will be an established practice for services delivery within Maori communities and Pacific communities; and
- Feedback shows the design and delivery of services are timely, well coordinated, accessible and meaningful.

Examples of knowing people are healthier are:

- All children will be immunised (with parental consent) and the incidence of childhood respiratory and other conditions will have reduced;
- Disparities in Maori health will have reduced;
- Inequalities in health among populations (eg: low income and Pacific) will have reduced;
- There will be good evidence to demonstrate service effectiveness to Maori, Pacific and those on low incomes;
- The impact / incidence of preventable diabetes (ie: Type 2) and cardiovascular diseases will be reduced;
- Those with mental illness will receive timely and responsive support to help them to live with their condition; and
- People with disabilities will feel included in the planning and delivery of disability services, and will receive quality care.

**C&CDHB will:**

- **Develop a set of result-oriented evaluation criteria and performance measures and markers as part of our accountability to communities; and**
- **Involve communities in the design and implementation of performance measures and markers.**

## **8. CHALLENGES WE WILL FACE**

The strategies we have suggested are ambitious and will require commitment and resolve from ourselves, providers and our communities. Success will be compromised if we don't engage successfully with communities and providers. Managing the change in emphasis from a hospital and institutional focus to a community led one will be a major challenge involving a significant change in thinking for the organisation.

A further challenge is the risk of continuing operational deficits by the hospital and health services provider arm. This would prevent our planned investment in primary and community care.

To successfully manage through a period of substantial change Capital and Coast DHB will need to ensure:

- We develop the human resources and organisational processes to manage the changes needed to fulfil the vision;
- The New Regional Hospital development does not absorb all our energies and detract from the wider strategic vision;
- We avoid being distracted from the Board's vision by crises and day to day pressures; and
- That we carefully prioritise our efforts and investments.

Risk management and mitigation strategies are detailed in Appendix 6.

## PART 2:

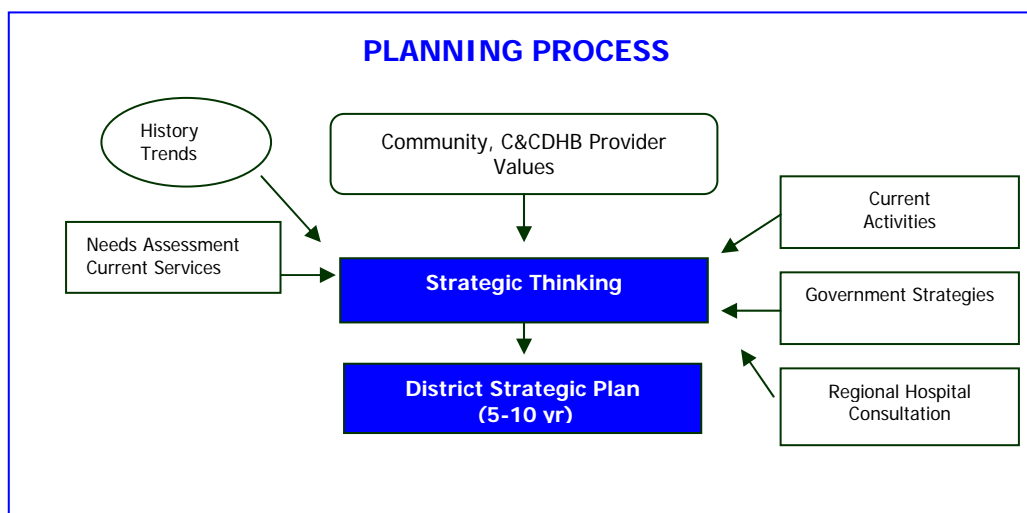
### 9. THE STRATEGIC DRIVERS

#### 9.1 *Factors influencing planning*

Ideally we would start from scratch, designing services perfectly matched to our District's needs. Some services would look the same; some might look a little different. That's unrealistic but there are some influential directions and factors strongly behind our Strategic Plan.

These include:

- Responsibility to implement Government policy, in particular key strategies such as the NZ Health Strategy, NZ Disability Strategy, Primary Healthcare Strategy, Maori Strategy and many others;
- Issues raised during last year's public consultation during the development of the Regional Hospital Business Case;
- The diversity in characteristics, population and history of service development of our communities in Wellington, Porirua and Kapiti;
- Community organisations' health reports (eg. Porirua city health report) which will guide future services; and
- Trends and technology developments in health care services and delivery.



#### 9.2 *Government expectations*

The Government's intentions for health and disability care by DHBs are made clear in the NZ Health and Disability Act 2000, and other strategy documents<sup>7</sup>. These emphasise the importance of communities in planning, development and delivery of health and disability services. They reflect the Government's

<sup>7</sup> For example NZ Disability Strategy, NZ Health Strategy, The Primary Healthcare Strategy

commitment to recognising and respecting the principles of the Treaty of Waitangi and seeking improvements in the health of Maori.

- Government expectations set through strategies, policy settings, and legislation;
- Historical health service provision and the relationships between funders and services, which underpin the existing arrangements;
- A long history of coping with health changes;
- Local health needs; and
- A finite budget.

### 9.2.1 The Framework

The New Zealand Health Strategy provides the framework for the Government’s direction for health. It emphasises improving population health outcomes and reducing disparities between all New Zealanders - especially Maori people and Pacific people - and requires active involvement of consumers and communities at all levels of planning.

Our Strategy emphasises:

- Population-based approaches;
- More effectively targeted local services to reduce health inequalities; and
- Promoting the integration of health services.

The Government expects significantly improved health amongst:

- Maori;
- Pacific peoples, and
- Other New Zealanders on low incomes, experiencing significant health inequalities.

To do this, the Government expects DHBs to:

- Effect change for low health status populations;
- Reconfigure services;
- Redirect funding where necessary;
- Strengthen primary care; and
- Develop more outcome-focused and evidence-based care.

The NZ Disability Strategy outlines the Government’s policy to promote inclusion, independence and participation for people with disabilities.

**Medium Term Priorities of  
New Zealand Health Strategy**

Reduce smoking

Improve nutrition

Reduce obesity

Increase the level of physical activity

Reduce the rate of suicides and suicide attempts

Minimise the harm caused by alcohol and illicit and other drug use to both individuals and the community

Reduce the incidence and impact of cancer

Reduce the incidence and impact of cardiovascular diseases

Reduce the incidence and impact of diabetes

Improve oral health

Reduce violence in interpersonal relationships, families, schools and communities

Improve the health status of people with severe mental illness

Ensure access to appropriate child health care services, including well child and family health care and immunisation

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**Government Service Delivery priorities**

Public health

Primary health

Reduce waiting times

Improving mental health services responsiveness

### **9.2.2 History of Health Provision**

Since the 1980s there have been several re-structurings of the health sector - from Hospital Board, to Area Health Board, to Regional Health Authorities and Crown Health Enterprises, to the Health Funding Authority and Hospital and Health Services and now the District Health Board.

Each re-structuring has sought:

- Greater integration and coordination of services;
- Efficiency; and
- Improved responsiveness to the community's needs.

Several important trends have remained constant, in particular:

- The development of Maori providers and Pacific providers;
- Increased focus on primary care;
- The involvement of communities, and community groups, in decision-making;
- Rapid developments in the scope and use of health and information technology;
- Development of standards for practice and the delivery of quality care;
- A focus on improving integration in the delivery of health services; and
- Increased efficiency of services, especially hospital services.

Examples include increased numbers of Maori providers and Pacific providers, growth in ethnic/culture specific services, the formation of Independent Practitioner Associations (IPAs) to improve the performance of general practice, the development of funded union<sup>8</sup> and other clinics so people with high health needs and low incomes have better access to services. These developments have increased the sophistication, quality and choice of primary care services.

A feature of our District, particularly in Porirua, is the strength of community development and its positive impact on health services, demonstrated by the active and formal involvement of community groups in service planning and delivery; for example, the Healthlinks projects in Kapiti and Porirua areas.

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<sup>8</sup> Union clinics evolved from the trade union movement but are operated and funded independently.

### ***9.3 Regional Hospital consultation***

We recently completed a proposal to build a New Regional Hospital, which generated rigorous debate. It is important the consultation messages are remembered in the planning process as they revealed tensions between:

- Building a new high-class hospital with its consequent emphasis on centralising services for quality, safety, and financial reasons;
- The trend towards more walk-in services – outpatients, day-stay surgery, investigations being delivered closer to the community;
- The need to improve the effectiveness of primary health care services through additional resources; and
- The communities' wish for service delivery, including hospital beds, close to where people live.

### ***9.4 Wider responsibilities***

In common with other DHBs, our responsibility is broader than the geographical limits of our District (Wellington, Porirua, and Kapiti). Services provided to other DHBs include heart surgery, plus care for cancer and mental health patients. Similarly, other DHBs provide services to us, including Hutt Valley, which provides much of our public health services.

These broader relationships and their regional implications must be remembered in our planning and funding activities.

## 10. LOCAL HEALTH CHARACTERISTICS

### 10.1 Needs assessment

A Needs Assessment brings together all the available information on people's use of health services, the amount spent on services and identifying the users.

It indicates:

- Pockets of poor health;
- High risks or prevalence of diseases, and conditions of ill health; and
- Areas of risk that may place significant pressure on services.

The picture is neither perfect, nor accurate. Information is collected from many sources, in particular from:

- Providers - hospitals, general practitioners, pharmacies, and laboratories;
- Large databases - the Department of Statistics, Public Health Surveillance information; and
- Qualitative information from patients (eg: surveys, research).

#### Ethnicity Recording

We are particularly concerned about the completeness and accuracy of ethnicity recording. This information is vital for planning reviews and reducing disparities. Improving ethnicity recording in the District is an important task for the DHB.

Some of the underlying data is poor, which limits the understanding of our health needs. Improving information collection is an important task for the DHB.

### 10.2 Who lives in the District?

The Capital and Coast District is made up of three main geographic areas, Wellington, Porirua, and most of the Kapiti Coast, each with distinct characteristics reflecting the area's health status diversity. The population of each area is made up of different communities with distinct health needs.

#### Population Analysis of Wellington, Porirua and Kapiti<sup>9</sup>

Area	Maori	Pacific Peoples	Others	Total
Wellington	9,820	5,884	140,417	156,121
Porirua	8,520	9,460	25,643	43,623
Kapiti <sup>10</sup>	2,241	126	29,011	31,378
<b>Total</b>	<b>20,581</b>	<b>15,470</b>	<b>195,071</b>	<b>231,122</b>

<sup>9</sup> Numbers based on 2000 projections from 1996 Census

<sup>10</sup> Parts of Kapiti within Capital & Coast DHB boundary

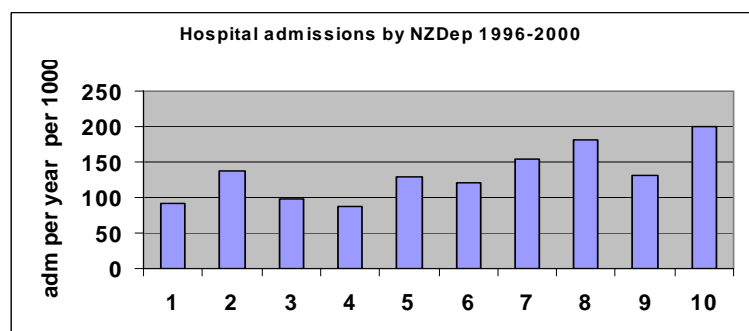
The population groups with the highest health needs are:

- Maori;
- Pacific;
- Low income people;
- The young and old (as hospital admissions for these groups are more than double that of other people within the district);
- Those at risk of diabetes and heart diseases, particularly Maori people and Pacific people; and
- The majority of these people are concentrated in parts of Porirua and Wellington South and East.

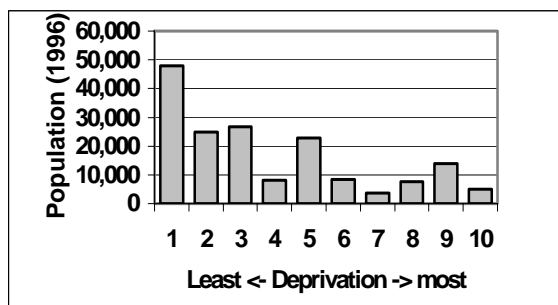
### 10.3 Health status and deprivation

High health need has been linked with poverty, which is measured by factors such as income, and access to telephone and transport services.<sup>11</sup>

A brief outline of each of the three areas focusing on deprivation, age and ethnicity follows.

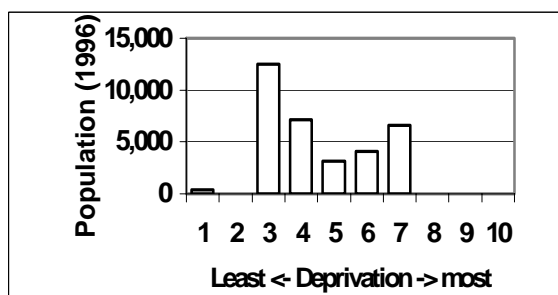


This graph shows the relationship between poor health (measured by hospital admission rate) and high levels of deprivation. 1 is the least deprived 10% of the community and 10 the most deprived



#### Wellington City

Most of Wellington City is well off and enjoys good health; however, there are pockets in central, south and east Wellington where people are relatively poor and in poor health. There are significant numbers of Maori populations and Pacific populations in these deprived areas.



#### Kapiti

Kapiti Coast has fewer working-age people and more older people; with a significant number of Maori, but very few Pacific people. In general, Kapiti people are moderately well off, healthy and are located in the middle deprivation categories.

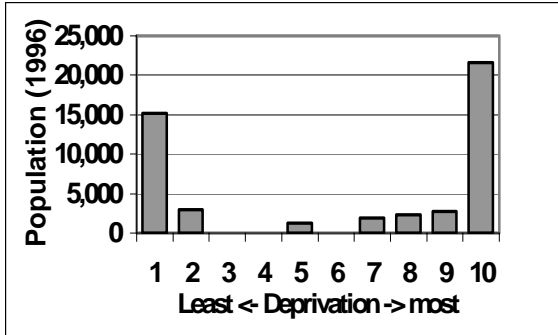
<sup>11</sup> Statistics NZ calculated a Deprivation Index ranging from 1 – 10 with 1 representing those people living with the lowest level of deprivation through increasing levels of deprivation with 10 the most deprived.

This rating may be misleading for many of Kapiti residents, as there are areas of poverty; plus older people living in small homes or retirement villages are not necessarily hard up.

**Porirua**

Porirua area represents two extremes. Residents around the Pauatahanui Inlet (north of Porirua city) are well off, with good health and access to resources. The high health status of this group is often overlooked in the average for Porirua.

By contrast, people living in Porirua city and Cannons Creek are poor, with high health needs and an increasing rate of health problems related to crowded housing.



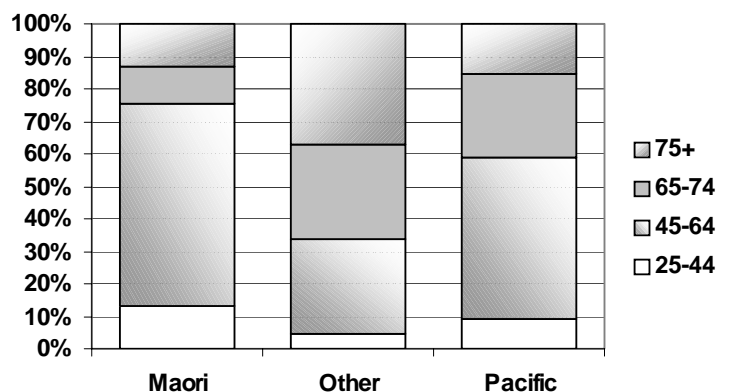
**10.4 Health status analysis**

Our Health Needs Assessment<sup>12</sup> identified six areas needing particular attention, which is consistent with the NZ Health Strategy and the NZ Disability Strategy analysis.

**10.4.1 Cardiovascular disease**

Cardiovascular disease (heart disease and stroke) is the leading cause of death for adults over 45 in the District, a rate higher than the national average. Maori people and Pacific people are affected by cardiovascular disease 20 years earlier than people of other ethnicities.

Age of Admission to Hospital with Myocardial Infarction (heart attack)



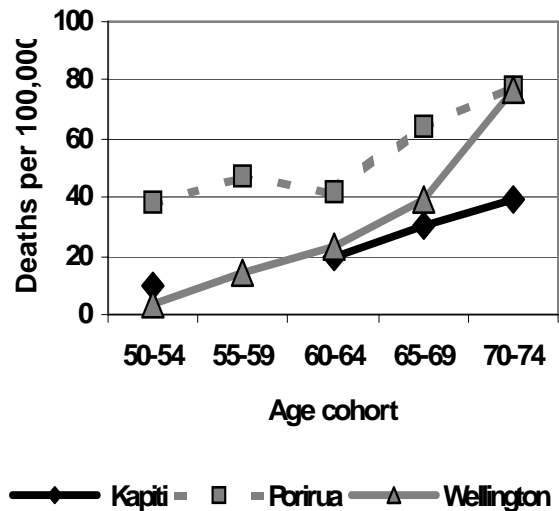
Maori and Pacific people are admitted to hospital for heart attacks at a much younger age than others

<sup>12</sup> Capital and Coast District Health Board (2001). *Initial Health Needs Assessment: Draft*. Wellington: Capital and Coast DHB.

### 10.4.2 Diabetes

The rate of diabetes (especially Type 2) is increasing rapidly and affects Maori people and Pacific people more frequently - and at an earlier age - than other ethnic groups.

Age of People dying from Diabetes



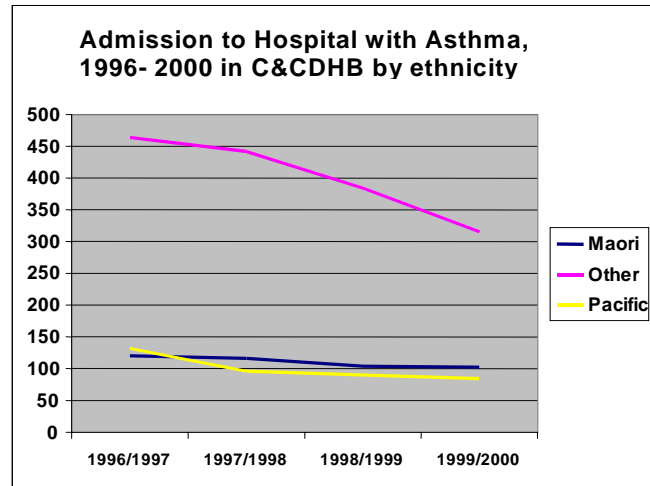
The graph shows that people in Porirua with diabetes die earlier than people with diabetes in other areas.

The major health problems in the district are:

- Diabetes;
- Heart Diseases;
- Increasing suicide;
- Child Health;
- Oral Health; and
- Smoking.

### 10.4.3 Child health

Respiratory and ear infections are common, and increasing, for children in poor areas. Asthma management is improving with an overall decline in the number of related admissions to hospital. The immunisation rate is close to national targets. The incidence of “cot death” (Sudden Infant Death Syndrome – SIDS) has decreased dramatically since 1988. The Maori population and Pacific population is much younger than other ethnicities so child health is an important priority for them.



This graph shows overall good improvement in people with asthma, but the improvement has not been seen in Maori & Pacific people.

### 10.4.4 Suicide

The suicide rate in the District is above national levels and slowly increasing.

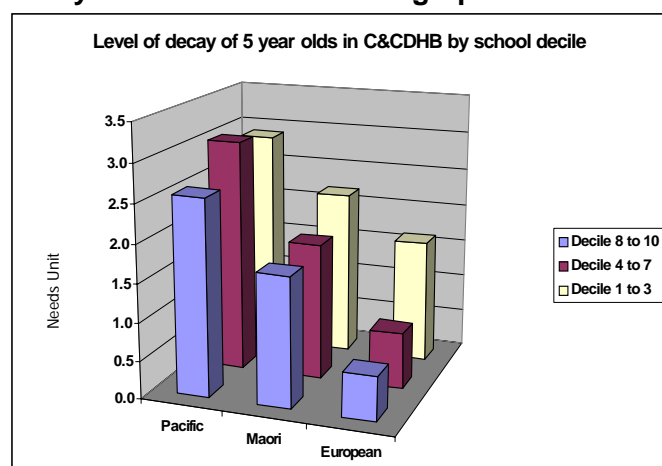
### 10.4.5 Reducing smoking

The District smoking rate is above the national average. Maori people and Pacific people have a higher smoking rate than others. In Porirua, 21 percent of deaths are directly related to smoking.

### 10.4.6 Oral health

The oral health of children in some areas is very poor. It is measured by the number of 5 year olds with decay, the number of 12 year olds with missing / filled, and the percentage of children who are caries free. This graph shows wide differences in the oral health of 5-year-old children. This graph is based on decile scales (1 shows the poorest schools and communities, 10 indicates the highest socio-economic areas).

The School Dental service actively targets the 20 percent of children with 80 percent of the decay, which includes many Maori children and Pacific children. As a result the gap between children of differing ethnicities is largely closed by year 8. The improvement is not sustained, however, as only a relatively small number of this group of children take advantage of the free care provided by a private dentist during secondary



The graph clearly indicates Maori and Pacific children (and those in low decile schools) have, on average, more decay than children of European origin across all deciles.

school.

#### ***10.4.7 Mental health***

Further work is needed to establish specific local needs in mental health. Our discharge rate is above the national average, but this requires further analysis to understand whether this is due to higher need or better access or some other reason. Historically, the focus has been on the 3 percent of people with severe mental illness and services are designed to ensure this group can access treatment and rehabilitation.

It's important to understand other people's mental health needs so there is an increasing focus on providing mental health services in primary care (with a particular emphasis on early intervention and detection) and in public health (mental health promotion and prevention).

#### ***10.4.8 Disability***

C&CDHB currently has very little information on the need for disability services. Nationally, spending on disability services is increasing annually as the population ages. There are increased community-based support programmes and increased demand for services, triggered by the formalisation of needs assessment and service coordination. A regional group, including community representatives, has been meeting to develop a direction to meet our future needs.

#### ***10.4.9 Summary***

If we are to achieve our goal of reducing disparities between populations and improving the health of Maori, Pacific peoples and those with low incomes the differences in health status across the district cannot be ignored.

*The full description and analysis of population and health needs can be found in the report of the Needs Assessment on our website ([www.ccdhb.org.nz](http://www.ccdhb.org.nz)).*

## 11. ACKNOWLEDGEMENT

C&CDHB acknowledge the co-operation and contribution of management and staff to the preparation of this draft Strategic Plan. More importantly, we would like to record our gratitude to the many people in our communities who dedicate themselves to services within the health sector.

## **APPENDIX 1: CAPITAL & COAST – A VISION FOR AN INCLUSIVE SOCIETY**

Capital and Coast District Health Board (C&CDHB) has developed, by way of its response to the New Zealand Disability Strategy, a number of vision components which will guide the planning and actions of the DHB over the next 3 to 5 years.

The six vision components were agreed following three strategic planning workshops, hosted by the C&CDHB Disability Support Advisory Committee (DSAC), held during October and November 2001. Present at those sessions were the committee members including external appointees, Planning and Funding representatives and a number of disability and mental health sector representatives.

From the planning sessions the following six vision components for disability were agreed to by the group as strategic goals:

### **A Web of Information**

The key themes underpinning this goal, consistent with the New Zealand Disability Strategy (NZDS) include participation, ownership, accessibility, collaboration and connectivity. The web is both broad in terms of a community web at a local, regional and national level, and narrow in terms of an individual's web. The DHB is the primary facilitator for the information and the information itself is available in a variety of accessible formats (intra/internet, audio, braille, pictorial, and booklet style), and provided by a variety of groups, organisations or agencies (needs assessment, voluntary agencies, national bodies, providers, and government).

### **Sector Leadership by People with Disabilities**

Underpinning this goal is the notion of empowerment of people with disabilities, - “of the people, by the people, for the people”. Original cast as leadership across the sector by the people with the lived experiences, the breadth of this strategic vision component transcends a number of agencies and funding streams. The importance of everything from scholarships to access education, to data collection and analysis, to organisations (including DHBs) human resources policies are seen as influences on this goal. The need to use the current collective capacity to evolve a framework to both support leadership and foster new leaders is the key implementation strategy towards achieving this strategic goal.

### **Overcoming a Disabling Society**

Consistent with the NZDS vision of removing barriers for people with disabilities this is a long-term attitudinal goal in strategic terms. From an annual planning perspective however it provides the DHB with a leading role across a number of its key priorities including: community engagement and consultation, implementing the NZDS, planning for an integrated model of aged care, workforce development, and intersectoral collaboration.

### **The Person is at the Centre**

This goal is core to the entire strategic plan from a disability perspective. It influences C&CDHB planning and performance with regards to service development and evaluation being in conjunction with people with disabilities including the development of holistic assessment programmes and models of integrated aged care.

### **A Whole of Life Approach**

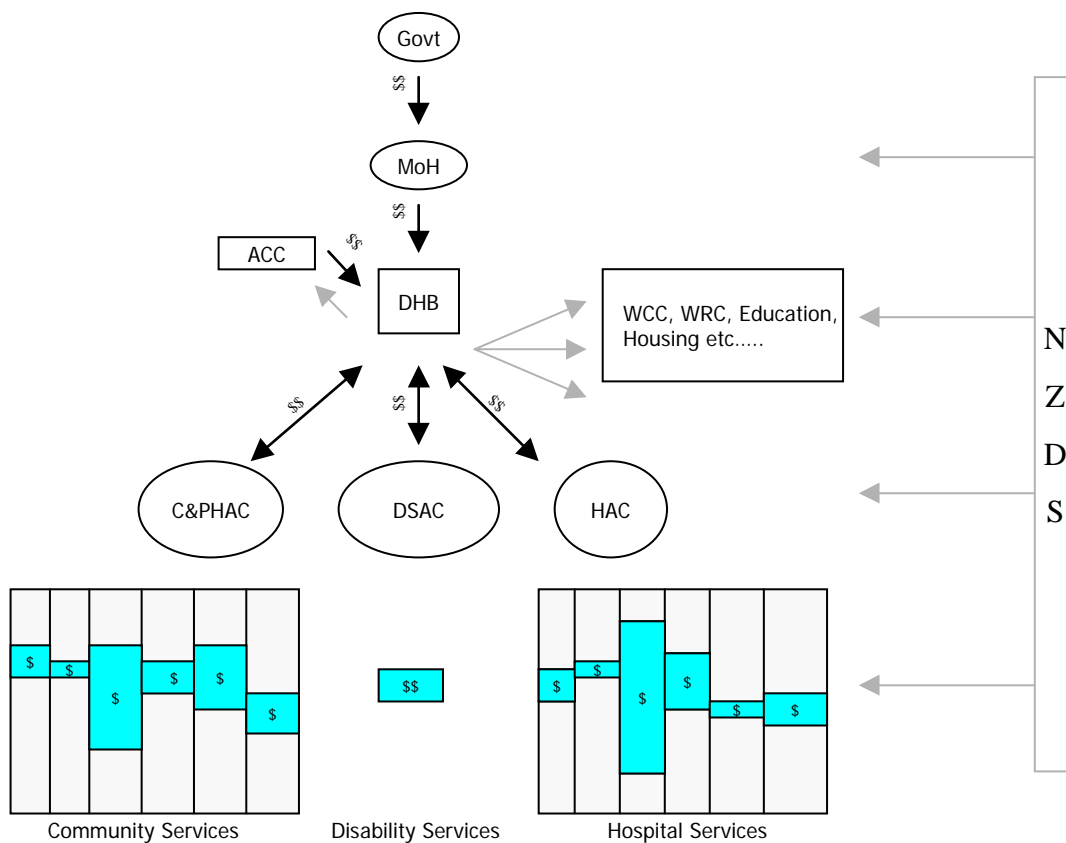
This goal calls for the DHB to recognise integrated approaches to service delivery. A fundamental concept is the recognition of the diversity among people with disabilities and the implications of this for health and disability service planning and integration. For many there are minimal health considerations beyond those common to the rest of the population. For others health issues are intertwined and integral to their disability, or at various points on the spectrum between these extremes. The DHB is an

important change agent in terms of how health services are currently being delivered, and how they ought to be in the future for people with disabilities.

### Leading Intersectoral Collaboration

This goal foreshadows the DHB as a leader in building partnerships, relationships, and trust with sector organisations as well as other government agencies. The magnitude of this task is recognised in terms of the need for a fundamental attitudinal change by some organisations. The key agencies are initially seen as Ministry of Health, Department of Work and Income (DWI), Ministry of Housing, City and Regional Councils, Accident Compensation Corporation (ACC), and Ministry of Education.

In addition to the vision components a key message to be reflected in the DSP is the need for a sense of connectivity with community to maintain and enhance both the process and the document's integrity. The importance of disability being reflected throughout the document rather than being assigned a single chapter is another key emphasis. The primary audience of the document is seen as the community and the following diagram was agreed by the planning group to be a useful illustration of the breadth of disability issues for this DHB.



## APPENDIX 2:

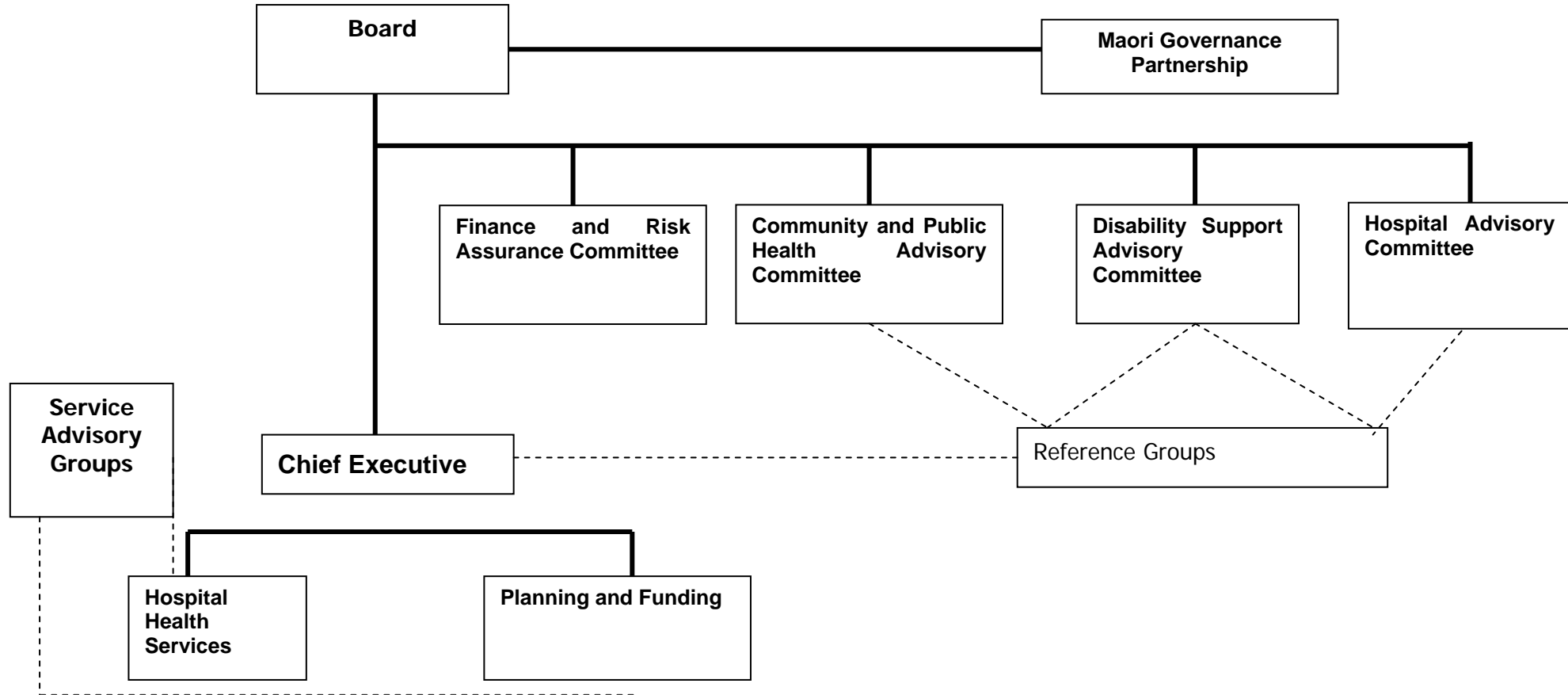
Capital & Coast Health Needs Analysis  
Capital & Coast Information Management Strategy  
A Picture of Health. Strategic Plan for our provider arm

These documents are available on our website: <http://www.ccdhb.org.nz>

New Zealand Health Strategy  
New Zealand Disability Strategy  
Maori Health Strategy  
Pacific Health and Disability Action Plan  
Primary Health Care strategy  
From Strategy to Reality (the *WAVE* project)  
Burden of Disease  
The Social, Cultural and Economic Determinants of Health: Action to Improve Health  
Porirua City Health and Disability Report and Plan  
Kapiti District Health and Disability Report and Plan

These documents are available on the Ministry of Health's website:  
<http://www.moh.govt.nz>

**APPENDIX 3:**



**NB:**  
**Reference Groups** are external community (usually geographic) groups that already exist in their own right with which the Board has formed a relationship. *(eg: Kapiti Healthlinks, Vaiola)*  
**Service Advisory Groups** consist of community, providers, and DHB peoples and focus on services *(eg: Maternity Service Advisory Group)*

## APPENDIX 4: Financial Information

The 5-year financials in the table below, include the 3-year funding track through to 2004/05 combined with the budgeted costs and savings associated with the new regional hospital business case. Changes due to implementation of the Population Based Funding Formula (PBFF) for DHBs have not been taken into account.

(\$000)	Budget				
	2002/03	2003/04	2004/05	2005/06	2006/07
<b>Revenue</b>					
Govt & Crown	402,845	414,423	422,129	424,363	441,167
Agency Sourced	11,318	14,658	12,468	12,534	13,030
Other					
<b>Total Revenue</b>	<b>414,163</b>	<b>429,081</b>	<b>434,597</b>	<b>436,897</b>	<b>454,197</b>
<b>Cost</b>					
Personnel	192,655	197,410	201,778	189,243	187,314
Outsourced Services	5,617	5,383	5,120	4,924	4,876
Clinical Supplies	58,821	60,350	61,557	62,480	63,418
Infrastructure	64,492	64,924	75,724	75,824	110,704
Provider Payments	93,232	94,208	93,826	99,326	100,626
<b>Total Costs</b>	<b>414,817</b>	<b>422,275</b>	<b>438,005</b>	<b>431,798</b>	<b>466,937</b>
<b>Net Contribution/(Deficit)</b>	<b>(654)</b>	<b>6,806</b>	<b>(3,408)</b>	<b>5,099</b>	<b>(12,741)</b>

**APPENDIX 5:  
Funding Management Committee**

**C&CDHB PRIORITISATION  
PROCESS**

**JANUARY 2002**



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**SCHEDULE 1:**

**PROPOSAL/BID TEMPLATE**

**Service Planning and Funding**

**1. PORTFOLIO AREA:**

**Project Title:**

**Responsible Manager:**

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**2. PROBLEM DEFINITION:**

***[What is the problem? What is the need/level of unmet need?***

***What is the change that will occur after the intervention/project/proposal is completed?***

***Who is the target population?]***

---

**8. PROPOSAL:**

***[Summarise the proposed solution. Describe briefly the intervention/service/proposal. Are there other options? Why is this option the preferred?]***

## 9. FIT WITH C&CDHB STRATEGIC PRIORITIES:

Describe fit with strategic priorities in following table and score 1-3 (1= Complete fit with priority, 2= some fit 3= no fit)

<i>1.10 Strategic Priority 01/02</i>	Discuss fit	Score
Develop partnership with Maori		
Reducing inequalities in health status		
Developing primary care – implementation of Primary Healthcare Strategy		
Regional Hospital Development – assisting development of regional hospital plans		
Waiting Times – meeting MoH indicators, improving interface with primary and community based care		
Increase community participation in decisions		
Build DHB capacity to manage DSS		
Maintain confidence of present provider staff		
Promote integration and seamless care		
Quality of care and audit		
Workforce development		
Develop mental health services		
Child health/maternity		
Smoking cessation/cardiovascular disease/diabetes		

<i>2.10 Strategic Priorities 02/03</i>	Discuss Fit	Score
Disability Support Services		
Primary Healthcare Strategy: PHO Project		
Maori Strategy and Implementation		
Pacific Strategy and Implementation		
Diabetes		
Service Advisory Groups: Maternity, Elderly Peoples		
Demand Driven		
<i>3.10 Population Focus</i>		
Decrease disparities		

## 10. FIT WITH DECISION MAKING CRITERIA

Describe fit with C&CDHB Decision-Making Criteria Score 1-3 (1=Complete Fit, 2=some fit 3=no fit). This section should be filled out with the November CPHAC Decision-Making Framework paper to provide advice on what underpins criteria.

Decision Criteria	Discuss fit	Score
Improving Maori Health (identify impact on Maori Health, where possible estimate prevalence, access issues, effectiveness for Maori etc)		
Value for Money: a. Effectiveness (what is available information on effectiveness?) b. Cost		
Equity:		
Acceptability:		

Commercial Interest:		
Consistency with national priorities and documents:		
Innovation:		
Disability:		

## 11. FUNDING REQUIRED:

Funding Type	02/03yr		03/04yr		04/05yr	
	C&CDHB	Other	C&CDHB	Other	C&CDHB	Other
Service: Pilot						
Service: Ongoing						
Operational Cost (including projects, administrative cost)						
Capital Expenditure						
<b>TOTAL</b>						
Less Anticipated Savings						
<b>TOTAL (including savings)</b>						

### Workforce Development Component of Service Cost:

Funding Type	02/03		03/04		04/05	
	C&CDHB	Other	C&CDHB	Other	C&CDHB	Other
Workforce Development:						

### 1.10 Assumptions:

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## 12. CHANGE MANAGEMENT/IMPLEMENTATION PROCESS

[What are the implications for transition? Will current service delivery be affected by change? What is the transition period? How will change be managed? What are the costs?]

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## 13. RISK ANALYSIS

Risk Type	Discussion	High/Medium/Low
1. Financial		
2. Service		
3. Political		

## APPENDIX 6: Risk Management

Key Risks	Impact	Probability	Weighting	What can we do to minimise it?
<b><i>Information</i></b>				
Our current system do not capture the data elements required to support common reporting specifications	400	70%	280	Work with information service to identify short-term low cost solutions to ensure business needs are met.
<b><i>Coordination and Planning</i></b>				
New models of care not developed within timeframes	300	55%	165	Ensure organisational ownership via effective communication and a focus on the patient experience.
Information to support coordination and planning is inadequate	400	70%	280	Information systems ownership, internal audit of systems, data validation and quality of data input.
Lack of organisational buy in	400	55%	220	Widely communicated objectives and a focus on patient outcomes
Financial and contract targets not achieved through delays in implementation of key projects	300	55%	165	Establish key accountabilities for all major projects
<b><i>Resource Utilisation</i></b>				
Continued international shortage of key health professionals	400	70%	280	Joint venture recruitment. Focus on retention strategies.
Increasing resource cost	300	40%	120	Review contracting process in key areas to minimise risk
<b><i>Workforce Development</i></b>				
Operational demands distract from development and planning activities	300	55%	165	Prioritise workload to ensure a planning focus is achieved
<b><i>Planning &amp; Funding</i></b>				
Strategies fail through lack of commitment and resolve both by providers, our communities and us.	300	40%	120	Develop human resources and organisational processes to manage changes needed to fulfil the vision. We will avoid being distracted from the Board's vision by crises and day to day pressures.
Engagement with providers and communities not effective.	300	20%	60	We will inform communities regularly about emerging models of care, enhancements & changes in health services and reasons for the changes. Communities will be kept

				<p><b>informed of progress in new regional hospital redevelopments in Porirua, Kapiti and Newtown. This will be done through regular newsletters, community newspapers, community radio, and our formal and informal networks within communities including reference and advisory groups.</b></p>
<p><b>Failure to move from a hospital and institutional focus to a community led focus.</b></p>	<p><b>400</b></p>	<p><b>20%</b></p>	<p><b>80</b></p>	<p><b>Develop human resources and organisational processes to manage changes needed to fulfil the vision.</b></p> <p><b>Ensure the New Regional Hospital development does not absorb all our energies and detract from the Board's vision by crises and day to day pressures.</b></p>
<p><b>Our planned investment in primary and community care may be compromised by operational deficits in the hospital and health services provider arm.</b></p>	<p><b>400</b></p>	<p><b>20%</b></p>	<p><b>80</b></p>	<p><b>We will carefully prioritise our efforts and investments.</b></p>

## Appendix 7 Current Service Configuration

We are responsible for funding primary care services, hospital services, some mental health services, Maori health services and Pacific health services. The Ministry of Health will fund residential care for elderly services for people with disability, and public health services. Funding of Maternity services may devolve to DHBs during 2002/03.

**Personal and Family Health Services:** We will fund personal and family health services. Our provider arm, GPs, Pharmacists, Laboratories and other providers provide these services.

**Mental Health:** Mental health services are funded in part locally by us and in part regionally. Service provision also reflects this funding pattern as our provider arm provides local and regional services and some of the community residential services are provided by other providers including Maori providers and Pacific providers.

**Younger People with Disability:** The Ministry of Health will fund services for younger people with disability during 2002/03. Our provider arm provides some of the services for people with disability and a range of providers provide the rest. While we will not have responsibility for funding these services, we do have responsibility for promoting and implementing the New Zealand Disability Strategy.

**Disability Support Services for People Aged 65 and Above:** While the Ministry of Health funds disability support services for people aged 65 and above, private providers and religious and welfare sector provide residential care services. Our provider arm provides some of the other disability support services for people aged 65 and above.

**Public Health:** The Ministry of Health funds Public health services. Hutt Valley DHB provides regional public health services. We are working very closely with the regional public health unit at Hutt Valley DHB and the Ministry for defining the range and scope of services to be provided to our District.

**Maori Health:** Part of Maori health services are funded by the Ministry of Health and the rest will be funded by us. We have a total of seven 'by Maori for Maori' provider contracts to manage.

**Pacific Health:** Some of the Pacific peoples service contracts and funding are devolved, while the Ministry of Health funds and manages the rest of the contracts. Our District has five Pacific health service providers, three of which provide mental health services. Other providers are established under a mainstream provider umbrella to provide primary care services.

**Provider Development:** The Ministry of Health retained funds for Maori provider development. We are working very closely with the Ministry of Health to facilitate development of these important providers. The Ministry of Health has devolved part funding for Pacific provider development.