



Capital & Coast District Health Board

District Strategic Plan
2006-2012

Wellington, New Zealand

Mihi

E nga lwi, e nga reo, e nga huihui tangata

Tena koutou, Tena koutou, Tena koutou

He mihi aroha ki nga tini aitua i wehe atu ki te po, ratou ki a ratou, tatou ki a tatou.

E whai ake nei tetahi purongo e whakamarama ake ana i nga nekeneke, i nga whakarite mo te kohikohinga i whakaaro mai i nga hunga e arearehia ana o ratou oranga e nga hauora ahuatanga mahi puta noa i te Upoko Ki Te Uru Hauora

Tenei te wa mo te koha whakaaro, nga korero me nga tuhinga mo te ara tika mo te hauora o te tau 2011.

No reira

Tena koutou, Tena koutou, Tena koutou

Acknowledgement

To the people, to the many languages and to those who have gathered.

Greetings to you all.

A loving greeting to those who have passed before us, them unto themselves, the living unto ourselves.

As we follow the objectives that will make clear for us to move carefully, thoughts need to be gathered and compared from the people, in order to clear the concerns for their health within the health systems of Capital & Coast District Health Board.

Now is the time to gather the thoughts and words in designing the direction for health until 2012.

Therefore, again, warm greetings to all.

The Purpose of This Document

Kia ora, Talofa lava, Fakaalofa atu, Kia Orana, Bula Vinaka, Malo e lelei, Malo ni, Namaste, Ni Hau and greetings.

This plan is a statement of our goals for the health of people in our district, together with the strategies we will use to achieve them. It is a high-level strategy document that will shape the development of other Capital & Coast District Health Board (C&CDHB) strategies as the following diagram shows.



The Minister of Health has developed two overarching strategies. The *New Zealand Health Strategy 2000* is focussed on the New Zealand health sector, while The *New Zealand Disability Strategy* focuses on disability and provides a vision for a fully inclusive society.

Under these overarching strategies sit a number of population strategies that also guide the work of the District Health Board (DHB). These include:

- *The Child Health Strategy;*
- *Te Puawaitanga: Maori Mental Health National Strategic Framework;*
- *The Health of Older People Strategy;*
- *He Korowai Oranga Maori Health Strategy;*
- *Pacific Health and Disability Action Plan;*
- *Actions to Reduce Inequalities;*
- *Positive Ageing to 2010; and*
- *The Youth Health Strategy.*

There are also 25 disease or service strategies completed or in development, including the *New Zealand Palliative Care Strategy*, the *Primary Care Strategy* and the *Child Health Information Strategy*. There are a number of other strategies in development also impacting on health. Many of these have an inter-sectoral focus.

While we will focus on six major strategies to achieve our health goals, we will continue with ongoing work to advance the Minister's priorities and priorities identified in the *New Zealand Health Strategy* and the *New Zealand Disability Strategy*.

Consulting with people of the district

In order to prepare the plan we had to decide what is most important to people and to their health. We approached the people of the district to learn their views, then prepared our new District Strategy Plan (DSP). We consulted with our communities from 14 June to 29 July 2005.

Our consultation included opportunities for people to:

- Attend and express their view at any of the advertised meetings, hui and fono.
- Request a special meeting (focus group) with the Board.
- Provide a response on the form provided in the submission booklet published by the Board.
- Provide a response on the form provided in Annual Check-Up, an annual publication of the Board.
- Present an oral submission.

We received 104 written submissions¹ and 1 oral submission. 299 people attended a meeting, focus group, hui or fono. Overall there was a high level of agreement with the approaches outlined in the consultation document including six strategies. The revised plan is shaped by our communities' valuable input.

This DSP is for the period 1 July 2006 to 30 June 2012. We will revise the plan after three years. However, before we revise we will update our assessment of the health needs of people in our district and we will consult with communities as we did for this DSP. Each year we will develop annual plans to implement the directions outlined in this document.

Our commitment to the Treaty of Waitangi

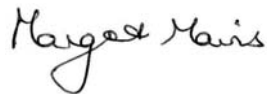
We acknowledge and are committed to the principles of the Treaty of Waitangi, within the framework of the New Zealand Public Health and Disability Act. We consider these principles fundamental to achieving better health outcomes for Maori as Maori have a higher 'burden of disease' than most ethnicities.



Bob Henare

Chair

Date:

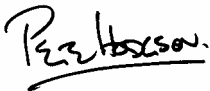


Margot Mains

Chief Executive Officer

Date:

The District Strategic Plan of the Capital and Coast District Health Board is approved on 2 May 2006.



Hon Pete Hodgson

Minister of Health

¹ 66% of respondents identified themselves as Pakeha, 8.5% as Maori, 5.5% as Pacific, 4% as Asian and 16% either identified as other or did not identify with ethnic group.

The Health Needs of People in Our District

Aspects we consider when planning to improve health

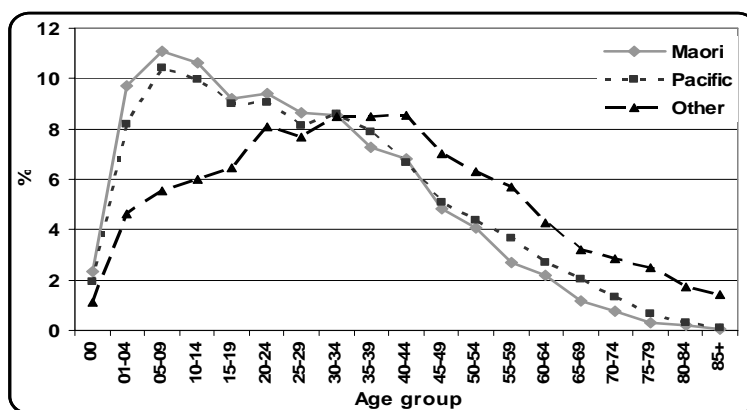
The people of our district

Among the people of the district, the Maori and Pacific population is much younger than that of other groups, as it is made up of more children and fewer elderly people, as shown in the graph.

By 2016, our population will change as number of people will increase in some age groups and decrease in others.

Over the next ten years:

- the number of people aged over 65 in the district will increase by 32%.
- the number of people aged under 14 in the district will decrease by 10%.



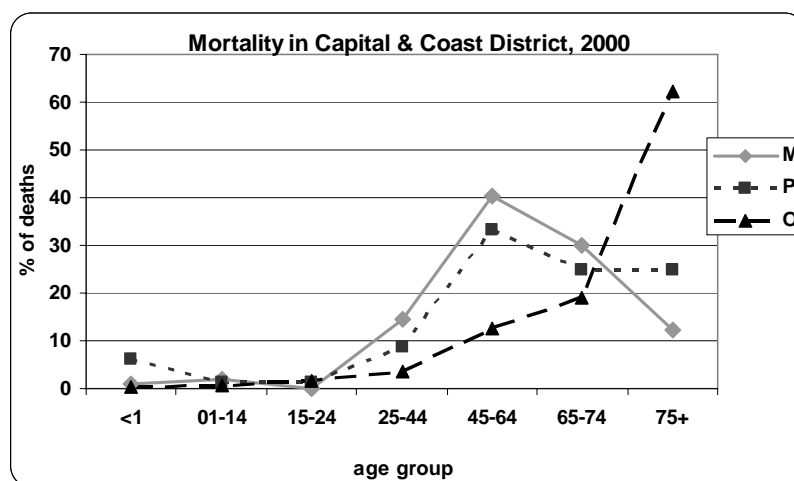
The health of people in our district

On average, our people enjoy better health and live longer than people in other districts of New Zealand. However when looking groups within this average, it is clear that the health of Maori and Pacific peoples in our district is not as good as others, although it is better than for Maori and Pacific peoples in other districts.

This graph shows the percentage of deaths in each age group. It shows that on average, Maori and Pacific people die up to 20 years earlier than non-Maori and non-Pacific people.

Key themes about the health of people in our district are:

- People continue to improve their health;
- People are ageing but living longer;
- Among people in the district there are several groups with particular health needs.



Major causes of illness in our district

The key factors that lead to differences in health and to ill-health among people are social and economic, eg housing, poverty, employment, education and the urban environment. This is important when considering that 45% of all Pacific people in the district are living in areas considered to be among the most deprived in New Zealand (New Zealand Deprivation Index 10) and a further 17% of Pacific people live in areas nearing those that are most deprived (New Zealand Deprivation Index 9).

Another important factor for people who have an ongoing illness or disease is the support they receive from family and the community that helps them to manage their illness and care for themselves. For example support to change their lifestyle or manage their medication.

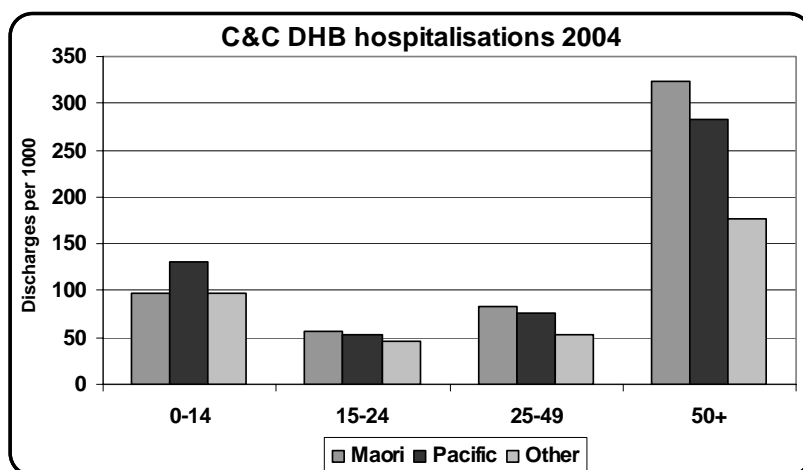
While the people of the district are healthier on average than those in other areas of New Zealand, there are the following health concerns:

- Heart disease;
- Lung cancer;
- Diabetes;
- The health of Pacific children;
- Gaining access to services, including mental health services.

This graph shows the number of people admitted to hospital from different groups across a range of ages.

It is clear that children in Pacific communities are more likely to need hospital care and treatment than children of other ethnicities.

Older Maori and Pacific adults are also more likely to be admitted to hospital than other adults, particularly when they are over 50 years of age.



Further details of our population and assessment of health needs on our website at www.ccdhb.org.nz

Past consultations

Since our last DSP was released we have consulted people about our future direction and health services for the district. From these consultations we have:

District wide after hours

- Established an Accident and Medical Clinic at Kenepuru Community Hospital so that people in the north of the district have improved access to primary care and after hours services.
- Agreed that further work should be completed to improve access to primary care after hours services for people in Wellington and Kapiti.
- Agreed to gradually reduce user part-charges for after hours primary care services across the district.

Te Plan

- Continue to work towards the priorities identified in *Te Plan*.

Home and community care

- Gradually introduce an integrated system for home and community personal health care for people over 16 years old. This system includes:
 - Care manager services;
 - A care coordination centre;
 - A specialist stroke team and specialist services for older people;
 - The development of a single assessment process.

What Can We Do?

Our Vision

Better health and independence for people, families, and communities

Our Mission

Together, improve the health and independence of the people of the district

Our Values

Innovation

Action

A focus on people and patients

Living the Treaty

Professionalism

Leadership

Honesty

Integrity

Collaboration

Excellence

Effectiveness

Efficiency

Our priorities

Our people are generally healthier than people in other parts of the country. However, death and disability that can be prevented are common in some groups, particularly Maori and Pacific peoples and people who live in areas considered to be deprived. People in these groups are also more likely to experience ongoing illness and disease and to die earlier than others in the district.

Although recent studies show that the health of Maori and Pacific peoples is now improving, a large gap remains between their health and that of other people in the district.

We plan to improve, promote, maintain and protect the health and independence of our communities through the following goals and strategies. Our health goals and strategies do not focus on specific population groups. Rather they address high health needs. The needs of specific populations straddle all goals and strategies.

While we will continue to improve and provide services for our people, our focus will be on child, youth, older people, Maori, Pacific peoples, refugees, new migrants and people on low income.

Health Goals

We are committed to following health goals:

- Reducing disparities;
- Reducing illness and disease among populations with high health needs so there is less difference in the health of people across the district (such as Maori, Pacific peoples, refugees and new migrants, and people who live in areas that are considered to be deprived);
- Reducing the incidence and impact of chronic conditions;
- Reducing the number of people who develop an ongoing illness or disease;
- Reducing the impact of illness or disease on people's lives, particularly for populations with high health needs to maximise independence and maintain or improve the quality of life.

Strategies to achieve the goals

We will focus on six major strategies to achieve our health goals. These are:

- 1 Developing our workforce.
- 2 Supporting and promoting healthy lifestyle.
- 3 Working with communities.
- 4 Focusing on people through integrated care.
- 5 Managing our money effectively.
- 6 Updating our hospitals.

The strategies are explained in more detail below. Further information is included in the background papers that accompany this DSP.

Developing our workforce

The health sector faces an international shortage of doctors, nurses, and other health workers. The health services in future may require a different mix of workforce skills to meet the changing needs of our population, to address disparities, and to take advantage of new technologies and new models of care.

Key issues include:

- Skill development to meet the need for community-based care.
- The changing health needs of an ageing population that requires more community nursing support, training and support for carers or volunteers.
- Advances in technology that require different specialist skills such as tele-medicine, and more community-based clinics run by a range of appropriately qualified health providers.
- Developing the capacity of home care support workers.
- Increasing action to reduce inequalities in health for people from low socio-economic (Decile 8 to 10) areas.
- Developing the Maori and Pacific workforce as the number of Maori and Pacific people increases.

Our key priority areas for workforce development are primary care workers, home care and community care workers, and family-based/primary care nurse practitioners. There is also a need to invest in the development of health care assistants.

The objective of workforce development is to ensure that the workforce contributes to innovative service-delivery models, as these models will drive workforce development. Within that objective, development aims to see that services are delivered by a trained and cost-effective workforce.

These workforce development priorities need to be implemented as models of care change and evolve, in collaboration with education sector. Our workforce must offer the mix of skills required to meet the changing needs of people in the district, reduce differences in the health of people and introduce new technology and models of care. We plan to:

- Expand the size and scope of the primary care workforce, particularly primary care nurses.
- Boost the numbers of Maori and Pacific People working in health.
- Improve the capacity of home care support workers.
- Develop forecasting models that will help project our future requirements for medical and other workforce.
- Develop new roles (such as care managers) to effectively deliver in the community, with a key focus on the development of care co-ordination roles.
- Improve the retention and skills of the mental health workforce including a key focus on developing roles for mental health therapists.
- Encourage the re-entry of nurses into workforce.
- Contribute to national targets for RMOs and SMOs.
- Work with tertiary institutions to adapt training programmes for future workforce needs.

Supporting and promoting healthy lifestyles

The increasing incidence and impact of chronic disease has led to economic and social costs that are increasing at an alarming rate in our district. These costs are particularly apparent among Maori and Pacific peoples who die much earlier from conditions such as cardiovascular disease and diabetes type 2 (particularly for people from low-income areas).

By controlling lifestyle choices and social or community influences, we can reduce the impact and incidence of these illnesses and others that have a debilitating impact on our populations eg diabetes, stroke, and heart disease.

There are risk factors that can be reduced or mitigated, such as tobacco use, low physical activity, poor nutrition, drug and alcohol misuse.

Promoting the development of strong social networks and empowering people to participate in decisions that affect their health can have a positive influence on our ability and motivation to make lifestyle changes. Evidence suggests that promoting healthy lifestyles will have a significant impact on the health of children and young people. These population groups are a priority for promoting healthy lifestyles and behaviours. We plan to:

- Work with people, communities, agencies and organizations to reduce the factors that lead to illness.
- Work with the Regional Public Health Unit at Hutt Valley DHB to implement the public health programme for priority areas such as
- implementing Healthy Eating Healthy Action (HEHA);
- controlling tobacco and reducing the use of alcohol and drugs;
- working with iwi and each Pacific nation to support healthy lifestyles;
- reducing the cost of visiting a doctor for people on low income;
- preventing injuries.

Working with communities

The health outcomes we are seeking can be significantly improved only by a 'whole of society' approach. We plan to build on the past gains achieved by working jointly to improve societal outcomes.

Over the next five years we will develop communities so that people are more able to prevent illness, manage chronic illness and reduce the factors that contribute to poor health. To make it easier for people to stay healthy, we plan to:

- Work with people, communities and organizations so that people are more able to stay healthy, manage ongoing illnesses and reduce the factors that lead to poor health. This is likely to include work with the Department of Work and Income, Housing, local councils, Ministry of Social Development and other community agencies.
- Develop resources that people can use to look after their health.
- Develop whanau/family-based services with people from low-income areas and Maori or Pacific communities, so that it is easier to look after their health and the health of family members.
- Establish community clinics that are lead by nurses.
- Fund more Maori and Pacific support services.
- Work with other Government agencies and organizations to develop healthy public policy such as healthy housing, a healthy urban environment that promotes physical activity and is safe, child and youth-friendly policies.
- Improve the flow of information between health agencies, communities and users.
- Encourage community participation in Primary Health Organisations.

Focusing on people through integrated care

Services have grown in a haphazard and isolated fashion over the past 50 years. This has often led to duplication or gaps between services and different approaches to care by different providers. As a result, people may be given conflicting advice or may fall into the gaps between one service and another.

Services are oriented to deal with acute or episodic illness but may not have good processes to deliver continuity of care over time, a focus that is required to effectively manage chronic conditions. Integrated care is about providing the right service at the right time by the right provider. Achieving integration often requires

- the redesign of processes to make them patient centred;
- good electronic information systems so that essential information is available to those providing care;
- coordination services to broker solutions that fit the needs of individuals
- a 'whole of DHB' perspective to ensure that services fit needs across providers and settings;
- a primary care-focused model to promote holistic management of conditions and risk factors.

Our immediate priorities for developing integrated services include:

- Implementing the home and community services model with coordinated home-based packages of care that incorporate therapy services.
- Implementing the Mental Health Services strategy (The Journey Forward).
- Integrating laboratory services.
- Providing after-hours services.
- Cancer control.
- Services for chronic diseases such as Diabetes, Heart diseases and Asthma.

- Improving information flows, referral and discharge processes between hospital services and primary care services.

It is our intention to see that integrated care extends beyond health and disability services to develop links with other agencies such as the Department of Work and Income, Housing, local councils, and the Ministry of Social Development.

Collaborating with Primary Health Organisations (PHOs) will become a more important part of our strategy to improve health outcomes and reduce inequalities. All PHOs in our district are working towards an integrated approach and enhanced community participation. Some PHOs already incorporate mental health, maternity, Well-Child, pharmacy, disability support and social services.

Managing our money

As a Government organisation we are prudent in the way we spend money on health services. There is never enough funding for the services that could be provided and we have to live within the funding we have.

We always look for a better way to use the funding we receive from Government so that we can deliver more with our existing budget. Our financial objective is to have a sound financial base to fund and provide health services.

We have to make sure our spending doesn't exceed our income. Our funding comes through a formula that allocates the Government's health budget between District Health Boards. Living within budget is never easy and sometimes requires tough choices. Our strategy to manage our money involves:

- Working with other DHBs to reduce the costs of our organisation.
- Working with the Ministry of Health to improve the way hospital services are funded.
- Continually looking for better ways to use our funding and provide services.
- Encouraging responsible management of services that are driven by demand such as medication and laboratory tests.

Updating our hospitals

We are developing new buildings at Kenepuru and Newtown to ensure that staff, patients, and visitors have a safe and pleasant environment that meets the needs of a modern healthcare system.

We have completed the development of new facilities at Kapiti. Over the next three years we will complete the new main building at Kenepuru together with the Short Stay Unit, Blood and Cancer Centre buildings and the new main building at Newtown, and refurbishment of buildings at both sites.

Our plan for the new regional hospital service involves:

- Focusing hospitals on serious illness and emergencies by moving some services into the community where this can be done safely (such as rehabilitation, outpatient and community health services).
- Using technology to record, co-ordinate and share health information through the use of an enhanced electronic health record.
- Developing consistent systems and processes such as those for admission, treatment and discharge.
- Locating services that work together near each other.
- Improving hospital buildings so they fit the future of hospital care in the district.

In Summary

Our health goals are:

- Reducing disparity (reducing differences in peoples' health)
- Reducing the incidence and impact of chronic disease (reducing the amount of ongoing illness and it's impact on peoples' lives)

Our Strategies to achieve these goals are:

- Developing our workforce
- Supporting and promoting healthy lifestyles
- Working with communities
- Focusing on people through integrated care
- Managing our money effectively
- Updating our hospitals

How will we know if we have achieved our goals?

We have a set of measures for our health goals that allow the Board, staff and communities to monitor and evaluate our progress. These will also be used to monitor and evaluate what we achieve.

We will develop annual targets for these performance measures for each District Annual Plan in the future. The performance measures and targets are presented below.

Reducing disparity

Performance measure	Current Status	Target for 2012
Increase percentage of Maori enrolled in PHOs	71% (at 30 June 2005)	95%
Reduce childhood (under 5 years) avoidable admission ² rate (eg Asthma and skin infections)	Maori 6% Pacific 8% Other 5%	Maori 4% Pacific 6% Other 4%
Improve percentage of children passing school entry hearing tests	Maori 93% Pacific 87% Other 95%	Maori 95% Pacific 92% Other 95%
Number of people accessing community support services through care coordination centre	Service will start during 2005	100%
Reduce the number of people who do not attend out-patient appointments	9% (at 30 June 2005)	5%
Number of people receiving specialist assessment within six months	92% (at 30 June 2005)	100%
Number of people receiving treatment within six months	93% (at 30 June 2005)	100%

² Ambulatory Sensitive Hospitalisation

Reducing the incidence and impact of chronic disease

Performance measure	Current Status	Target for 2012
Reduce avoidable admission rates ³ for older people (65 to 74 years)	Total 4.77%	Total 3%
Increase percentage of people with diabetes who have good blood glucose level (HBA ^{1c} <8)	73% (at 31 December 2004).	90%
Increase percentage of people at risk of heart disease that is recorded and managed to meet practice guidelines	Data collection will start during 2005/06.	75%
Increase percentage of people with care plans for heart disease and stroke with individual specific goals	Data collection will start during 2005/06.	85%
Increase percentage of people attending rehabilitation after heart disease	Data collection will start in 2005/06.	85%
Reduce readmission rate ⁴ for stroke for people who are aged 55 and above	7.3% (for the twelve months ending 30 April 2005).	4%
Reduce mental health readmission rate ⁵ in acute mental health unit	19% of all admissions.	12% of all admissions.
Improve the number of people accessing mental health services	1% of population.	3% of population.

The Board and Advisory Committees (of the Board) will consider additional performance measures as part of the annual planning process.

District wide performance measures

We are working with various Councils to develop performance measures for health improvement areas, which we are collectively trying to achieve.

The DHB and local Councils will monitor these performance measures jointly.

³ Ambulatory Sensitive Hospitalisation

⁴ Unplanned readmissions

⁵ Unplanned readmissions



Capital & Coast District Health Board

Background Information

District Strategic Plan

2006 - 2012

Background Information

The information in this document either informs the District Strategic Plan (DSP) or is required by the Ministry of Health.

Development of the District Strategic Plan and Consultation

The consultation plan focussed on seeking public input through a variety of means with a key focus on utilising existing networks and community meetings. The consultation plan was informed by recommendations from the community consultation steering group following our last major consultation (District-Wide After Hours Services). The group recommended that we (Capital & Coast District Health Board):

- Involve a group of “ordinary people” in an independent review of our public consultation document prior to seeking Board approval;
- Establish a community consultation committee to provide expertise on the specific consultation process we plan to complete;
- Target “focus” groups and existing meetings as a key mechanism to gather their input into the consultation process;
- Provide an independent note-taker at both public and focus group meetings as well as an independent review of the submissions.

We consulted with our communities from 14 June to 29 July 2005, with late submissions received up to 5 August 2005. The consultation included opportunities for people to:

- Attend and express their view at any of the advertised meetings, hui and fono;
- Request a special meeting (focus group) with the Board;
- Provide a response on the form in the submission booklet published by the Board;
- Provide a response on the form in the Annual Check-Up, an annual publication from the Board;
- Present an oral submission.

We received 104 written submissions⁶ and 1 oral submission. In addition, a total of 299 people attended a meeting, focus group, hui or fono. The level of public and staff engagement compares favourably to the consultation process previously completed on the draft DSP in 2002 where only sixteen submissions were received.

Overall there was a high level of agreement with the approaches outlined in the consultation document. The revised plan has been shaped by the valuable input received from our communities.

⁶ 66% of respondents identified themselves as Pakeha, 8.5% as Maori, 5.5% as Pacific, 4% as Asian and 16% either identified as other or did not identify with ethnic group.

The Purpose of Our DSP

The DSP initiates a process of development to achieve the Board's objectives and statutory obligations. Through this plan the vision, mission and desired outcomes for our people will be achieved within the funding provided by Government. This DSP addresses the Board's:

- Responsibilities outlined in the New Zealand Public Health and Disability Act, further details of which can be found in Appendix I;
- Responsibilities under the Treaty of Waitangi. Further details about how we discharge these responsibilities can be found in Appendix C;
- Requirements specified in the key strategies developed by the Ministry of Health;
- Framework to link strategies from the Ministry of Health and other Government organisations with the health needs of our people, and the specific service and population strategies agreed by the Board (C&C DHB);
- Medium to longer-term goals for the health of our people, consistent with the New Zealand Health Strategy and the New Zealand Disability Strategy.

Over the next five years this DSP will shape the development of District Annual Plans and Statements of Intent with any review of the DSP completed in accordance with the New Zealand Public Health and Disability Act.

Appendix A:

About Capital & Coast District Health Board

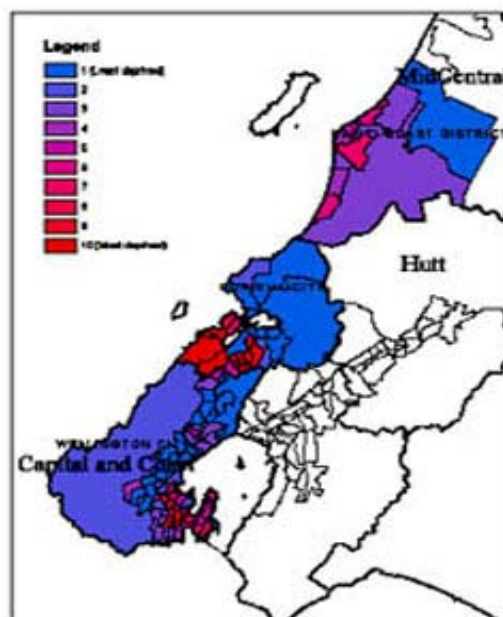
Capital & Coast District Health Board (C&C DHB) is the health organisation responsible for funding most health and disability services in Wellington, Porirua and most of Kapiti district. DHBs operate under the New Zealand Public Health and Disability Act 2000, which sets out their objectives and obligations.

The *New Zealand Health Strategy* (2000), sets the platform for the Government's action on health. The Strategy identifies areas of priority and aims to ensure that health services are targeted to ensure the highest benefits for the population, focusing in particular on tackling inequalities in health. The Strategy also integrates the eight Maori Health Gain Areas.

The *New Zealand Disability Strategy* (2001) presents a long term plan which focuses on changing New Zealand society to become inclusive of people with disabilities. It aims to ensure that people with disability have meaningful partnerships based on respect and equality with Government, support agencies and communities.

Other Government strategies and pertinent documents considered in developing this DSP are:

- *The Maori Health Strategy;*
- *The Primary Health Care Strategy;*
- *The Health of Older People Strategy;*
- Strategic documents for mental health services such as *Looking Forward & Moving Forward;*
- *The Pacific Health & Disability Action Plan.*



We are funded by the Government to improve the health and independence of people living in our district by providing services, funding other organisations to provide services, and by working with other agencies and communities. It is up to the District Health Board (DHB), after considering the district's health needs in consultation with communities of the district, to decide what health services are needed and the best use of our limited funding within the directions given by Government. We must consider Government priorities and various strategies like the *New Zealand Health Strategy* and the *New Zealand Disability Strategy*.

In addition to these services we also provide specialist hospital services to people in our district and other parts of New Zealand (a population of approximately 900,000), from Wellington Regional Hospital in Newtown and Kenepuru Community Hospital in Porirua. We employ more than 3,500 people.

Current Service Configuration

We recognise that national consistency is required in the use of service specifications, pricing, and purchase units, to monitor equity of access and the quality of services provided in New Zealand. Therefore we use national specifications wherever appropriate and consistent with the requirements of the Operational Policy Framework developed annually by the Ministry of Health. The range and level of services funded by the DHB will meet the quality and timeliness required by the national Service Coverage Schedule, also developed annually by the Ministry of Health.

Funding services

We are responsible for planning and funding the following services:

- Primary care;
- Hospital services;
- Mental health services;
- Support services and residential services for people over 65, and those considered close in interest (50-64) who have disabilities;
- Services for older people;
- Maori health services;
- Pacific health services.

The Ministry of Health funds most public health services, most community-based maternity services, disability services for persons under 65, and some Well-Child services.

Role of Various Providers

There is a wide range of health and disability providers in the district. A variety of services are delivered by general practice and primary care services, Maori providers, and by Pacific providers.

We have been particularly successful in supporting the development of Primary Health Organisations, with more than 95% of the population enrolled in six PHOs. The PHOs provide a range of primary health care services and health promotion designed and delivered in collaboration with iwi and local communities.

Collaborating with (PHOs) will become a more important part of our strategy to improve health outcomes and reduce inequalities. All PHOs in our district are working towards an integrated approach and enhanced community participation. Some PHOs already incorporate mental health, maternity, Well-Child, pharmacy, disability support and social services.

Hospital and Health Services

The Hospital and Health Services (HHS) will continue to deliver outpatient, day programmes, secondary and tertiary services funded by the Planning and Funding arm, other DHBs, ACC, and the Ministry of Health. Our HHS will explore reasons for disparities in access to services and develop innovative approaches to overcome these access barriers.

In addition to HHS there are other providers who deliver a variety of health and disability support services to people in our district. These providers are a mix of private, religious, welfare and other non-government organisations (NGOs). The services they provide include mental health, rest homes, primary care (GPs, laboratories, pharmaceuticals), maternity, Well-Child and Kaupapa Maori services.

Primary Care and PHOs

We have a broad range of primary health care services across Wellington, Porirua and Kapiti. These include general practice services, primary care providers, Maori health services, Pacific health services, Well Child and tamariki ora providers, pharmacists, allied health services, youth health services, school clinics, primary mental health services, and prison health services, to name a few.

Many of these providers are members of a PHO. PHOs are a key vehicle in implementing the *Primary Health Care Strategy*. PHOs in the district allow for community representation at governance level to make them more community orientated. PHOs will continue to improve access to services, which will assist people to look after their own health.

Non-Government Organisations (NGOs)

NGOs are very important as they deliver services along with the HHS and commercial providers. As service providers, NGOs offer an alternative to the commercial or government sector, especially in primary care, mental health and disability support services. NGOs and the DHB work together at several levels:

- Networking to provide a flow of information to communities, consumers and back to the DHB;
- Representing specific areas of interest;
- Advocacy;
- Initiating and participating in inter-sector work;
- Providing training.

Service Issues, Provider Capacity and Capability

Mental Health

We fund the entire range of mental health services identified in the Service Coverage Schedule. It is acknowledged nationally that at any given time 3% of the population requires treatment and support services for people with severe mental illness. It is also acknowledged nationally that there is a gap between the funding available and that required to deliver on the targets set.

As the funding for mental health is not sufficient to meet the needs of target populations, there are gaps in access to services. We will maintain the current service coverage within the level of funding currently available to the DHB.

Provider Development

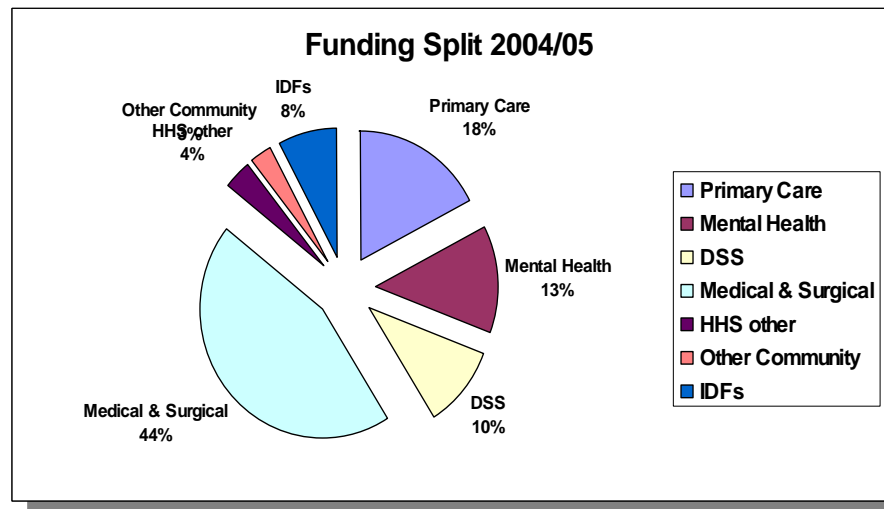
One challenge for the DHB is funding the development of providers who deliver services to high need populations. We have encountered barriers due to national decisions in Well-Child services, the funding of small PHOs, and funding for Maori and Pacific providers, due to the implementation of the *Well-Child and Primary-Care Strategy*. In both cases new funds have largely flowed to mainstream providers, bypassing high need populations.

Access issues

Major access issues include access to PHOs and GP practices with low fees. This is accentuated by a shortage of GPs in the district. We also have access issues regarding elective services.

Service Utilisation and Expenditure

Although more people see a GP than are admitted to hospital, the cost of hospital services is **much higher** than the cost of primary and community services.



Appendix B:

Planning process

The purpose of our DSP is to provide a framework that links strategies from the Ministry of Health and other Government organisations together with the health needs of our people, and the specific service and population strategies agreed by the Board of C&C DHB.

This DSP sets out the DHB's medium to longer-term goals for the health of our people. These goals are consistent with *The New Zealand Health Strategy* and *The New Zealand Disability Strategy*.

Over the next five years this DSP will shape the development of District Annual Plans and Statements of Intent. Any review of the DSP will be completed in accordance with the New Zealand Public Health and Disability Act. These links can be illustrated as shown by the diagram below.



Appendix C:

Responsibility to Maori

We acknowledge and are committed to the principles of the Treaty of Waitangi, within the framework of the New Zealand Public Health and Disability Act. We consider these principles fundamental to achieving better health outcomes for Maori, as Maori have a higher 'burden of disease' than most ethnicities.

We are committed to improving the health of Maori, as we have highlighted in our Maori Health Strategy, *Te Plan*. Maori are an "at risk and high need" population in our district. We aim to address these needs and reduce risks through services and systems that produce optimal benefits for Maori and the wider DHB population.

Treaty of Waitangi

We have identified the following means to enact our Treaty responsibilities, within the framework of the Act. We have:

- appointed Maori members to the Board of the DHB;
- established the Maori Partnership Board (MPB);
- co-opted Maori representatives onto the Advisory Committees of the Board;
- appointed a Director, Maori Health Development Group as part of the DHB's Executive Management team.

Our Treaty responsibilities will be measured by the following mechanisms.

Governance

- a demonstrated commitment to improve Maori health outcomes and reduce disparities;
- operational plans to increase Maori capacity in the DHB;
- evidence of the principles of the Treaty in service planning.

Planning

- resources are allocated to achieve improved Maori health outcomes;
- analysis is undertaken to identify Maori health needs;
- information is gathered to support future planning for Maori health;
- strategies are developed to monitor, review and evaluate effectiveness of services for Maori.

Workforce development

- planning to increase Maori workforce and capacity in the DHB;
- evidence of a commitment to bi-cultural training relevant to services.

Joint Work Programme of the DHB and MPB

The Maori Partnership Board convened a first hui of stakeholders to develop priorities for Maori community during August 2004. The following issues and priorities were identified:

- fostering Maori development;
- reducing disparity;
- building robust relationships;
- improving mainstream responsiveness/effectiveness;
- implementing Maori Health policy.

The MPB has developed a work programme that will be pursued jointly with the Board of the DHB and includes:

No.	Components	Action
1.	Monitoring and evaluation (Assessment)	Develop a Maori Health Dash Board (One page indicators report).
2.	Oversight of implementation of Maori Health policy (Action).	Develop a Maori Health policy milestones (add to Dash Board).
3.	Oversight development of new Maori Health Strategy (Direction).	Agree process and working party (Due in 2007).
4.	Joint communication (Discussion and feedback).	Agree mechanisms and future engagements between the Board and MPB.

Appendix D:

Ongoing work

The Minister of Health has developed two overarching strategies. *The New Zealand Health Strategy 2000* focuses on the health sector, while *The New Zealand Disability Strategy* focuses on disability and provides a vision for a fully inclusive society.

Under these overarching strategies sit a number of population strategies that also guide the work of the DHB. These include:

- The Child Health Strategy;
- Te Puawaitanga: Maori Mental Health National Strategic Framework;
- The Health of Older People Strategy;
- He Korowai Oranga Maori Health Strategy;
- Pacific Health and Disability Action Plan;
- Actions to Reduce Inequalities;
- Positive Ageing to 2010;
- The Youth Health Strategy.

There are also 25 disease or service strategies completed or in development, including the *New Zealand Palliative Care Strategy*, the *Primary Care Strategy* and the *Child Health Information Strategy*. A number of other strategies that are currently in development also impact on health. Many of these have an inter-sector focus.

C&C DHB will focus on six major strategies to achieve our health goals. We will continue with ongoing work to advance the Minister's priorities and priorities identified in the *New Zealand Health Strategy* and the *New Zealand Disability Strategy*.

Child Health

What is the current situation?

- On average, children of the district have better health than children from other parts of the country.
- Maori and Pacific children are admitted to the hospital with injuries, asthma and pneumonia, more frequently than children of 'Other' ethnic groups.
- Maori and Pacific children are more likely to fail hearing screening tests than children of 'Other' ethnic groups.

What will we do?

- Work with communities and other agencies to improve factors which affect health like income, housing, food security, and education.
- Improve coverage of Well-Child checks and immunisation.
- Ensure access to free or low cost primary care
- Ensure access to appropriate and timely maternity care, neonatal support, and support for breastfeeding.
- Work with schools, public health services, communities to improve the health and health services for children.
- Promote integration of public health services with primary and hospital level care.

Youth Health

What is the current situation?

- Young people are actively involved in health planning with the DHB and are taking an active role in many initiatives.
- Specific initiatives for Maori and for Pacific communities are in place, as are school-based and youth-led services.
- High school students have higher smoking rates than the national average.
- Injury and poisoning are major reasons for death and illness.

What will we do?

- Ensure effective mechanisms for youth participation and input in the DHB's planning processes.
- Increase youth-friendly settings of health services.
- Focus on youth development models and youth specific approaches in health promotion, mental health, primary health care, sexual health etc.
- Continue to support Maori-led and Pacific-led (ethnic specific) approaches, and recognise the particular needs of refugee communities.

Health of Elderly

What is the current situation?

The district has a significant older population that is growing. Our overall age 65+ population is expected to rise from 11% of the total at present, to 15% of our district population by 2021.

Planning for both an older group of consumers and an ageing workforce is crucial to successfully support consumer preferences to age in place. As the population ages and people live longer with chronic illnesses and disability, we need to recognise that diseases such as Alzheimer's and dementia will become more common. Service planning requires an holistic approach, recognising that older people sometimes live with multiple health problems and disability.

A new model of care and service delivery has been implemented in the district, emphasising more options for pro-active, preventative, and rehabilitative community and primary based health care and support.

What will we do?

We will continue to develop higher quality community based services to support older people in the settings of their choice. This will require ongoing workforce development, especially for home and community support workers, and the integration of services and health professionals around the older person.

Mental Health and Addictions

What is the current situation?

- Approximately one in five New Zealander has an identifiable mental illness or addiction problem. About 3% have a serious ongoing mental illness, requiring specialist care and treatment by a range of health and social services.
- People who experience ongoing mental illness can live well in the community.
- Services are diverse but also fragmented, with some 50 entities funded to provide mental health services to the people of our district.
- Services are fragmented, with no complete view of person's needs as oppose to treatment need from a narrow perspective of provider.
- NGO, Primary and Secondary service provision is currently not integrated, leading to duplication and service gaps.
- There are significant workforce shortages in areas of Child, Youth, Maori and Pacific mental health services.
- Suicide accounted for 1.8% of all deaths in the district in 2000 with a rate of 11 deaths per 100,000 population.

What will we do?

- Invest in addiction services and the integration of addiction services with mental health services.
- Develop an enhanced co-ordination service that will improve the matching of consumer needs with services.
- Develop alternative models for acute care.
- Progressively integrate mental health services with primary care and promote access to evidence-based short interventions.
- Develop the workforce, especially in priority areas such as child and youth mental health services.
- Implement our strategic plan for the mental health and addiction services (*The Journey Forward*).

Disability

What is the current situation?

Promoting the participation of people with disabilities is a challenge for everyone involved in the delivery, management, and governance of health and disability services in the DHB.

We have taken many steps to implement the principles of the *New Zealand Disability Strategy*, including surveys and audits of accessibility, disability equity training, and policy and procedure reviews such as our equal employment opportunity policy.

What will we do?

We will continue to take action to identify and eliminate barriers to participation by people with disabilities through concepts such as universal design and the accessible journey.

Our priority areas for 2006/07- 2011/12 are:

- providing disability competence training;
- improving physical access;
- communication and access to information;
- enhancing employment opportunities;
- improving community/consumer engagement.

Maori Health

What is the current situation?

Improving the health status of Maori and reducing disparities is a priority objective identified in the *New Zealand Health Strategy* (NZHS), He Korowai Oranga (HKO) and within our Maori Health Strategy entitled *Te Plan*⁷ for long term implementation.

Insufficient information regarding Maori health (including poor quality ethnicity recording) makes it difficult to analyse needs and measure health outcomes. It is well documented that Maori have a higher burden of disease and poor access to health services when compared to other population groups. They are also less likely to access mainstream primary and hospital services. Maori are therefore an “at risk and high need” population and we are committed to addressing their needs and reducing health risks through services and systems that produce optimal benefits for Maori.

What will we do?

Implement *Te Plan* by:

- developing a social marketing strategy that communicates messages to Maori in a way that is meaningful to whanau and communities;
- developing Maori health priorities and including them in the framework for prioritising services;
- supporting and building the capacity and capability of Maori Health providers;
- developing appropriate whanau models of care and service;
- building the capacity of our Maori workforce;
- strengthening services that care for whanau in the HHS;
- developing and implementing approaches to reduce chronic care conditions;
- increasing shared responsibility for Maori Health;
- supporting developments that impact on Maori Health outcomes;
- developing approaches that promote and improve equity of access to services by Maori.

Pacific Health

What is the current situation?

- Pacific people on average have poorer health status compare to people of other ethnic groups.
- Life expectancy of Pacific peoples is less than 65 years.
- Incidence of Diabetes is twice that of Europeans.
- Pacific children (0-14yrs) have 35% more admissions compared to children of ‘Other’ ethnicity for conditions such as respiratory and cellulitis.
- Pacific children have a higher rate of tooth decay.

What will we do?

We will develop ethnic specific approaches that incorporate three overarching initiatives, which are:

⁷ C&C DHB Maori Health Strategy

1. Relationship management
 - communicate effectively to achieve responsiveness across the organisation and in the mainstream;
 - build and maintain relationships with each Pacific Community.

2. Workforce development
 - identify regional and local workforce gaps and increase the capacity and capability within Pacific Workforce;
 - develop workforce in areas such as child health;
 - work across sectors with a focus on health and disability.

3. Research & Development
 - identify ethnic specific data wherever possible;
 - develop indicators that are based on evidence and incorporate a 'whole of family' approach for service development and service delivery.

Primary Care

What is the current situation?

We have supported a range of primary care providers and achieved over 95% enrolment in PHOs.

The emphasis has been on more effective and inclusive planning, strengthening relationships between providers and coordinating the implementation of new initiatives with existing services. There has also been a focus on expanding the traditional primary care team and supporting providers with experience in multidisciplinary teamwork. More pharmacists are involved formally in PHOs. Other health professionals, NGO providers and link workers are also evident in PHO initiatives.

The appointment of a Director of Primary Care Nursing is advancing the opportunities for nurses. General practitioners are actively involved in PHO development including clinical governance, innovative service delivery and supporting governance.

Cooperation across PHOs is happening in many areas and the involvement of Regional Public Health from all PHOs has supported robust health promotion planning. Challenges remain around the capacity of primary care services, particularly in Kapiti and Porirua. Achieving and maintaining low cost access and After Hours care are also an area of continuing challenge.

What we will do?

- support PHOs to strengthen their focus community participation and on population health, including strategies to address inequalities;
- support multidisciplinary teams, strengthening the role of nurses in particular;
- invest to expand the primary care workforce;
- invest in Maori services;
- strengthen NGO sector involvement in PHOs and their links with primary care;
- increase the capacity of Pacific providers;
- increase primary care services that are specific to youth;
- invest in primary mental health care and improve the coordination of services for people experiencing mental illness;
- support services that address the needs of children and families with high or unmet health needs;

- improve services that support people living with chronic illness.

Diabetes

What is the current situation?

- It is estimated that 4% of New Zealanders suffer from diabetes.
- The death rate for diabetes is generally low at 4% of deaths in the district and in last 15 years it is increasing at 9% a year.
- Maori and Pacific peoples have higher rate of diabetes and develop diabetes earlier than other ethnic groups.

What will we do?

- Increase investment and action across sectors around healthy eating and healthy action in our district, particularly those initiatives that address environmental factors influencing nutrition and physical activity.
- Improve the detection of diabetes including the uptake of annual checks and eye screening.
- Increase Maori-led and Pacific-led approaches.
- Improve integration of services across public health, and primary and hospital level care.
- Improve support for self/whanau management of diabetes.
- Build workforce skills and capacity to identify and manage diabetes.

Cardiovascular Diseases

What is the current situation?

Heart conditions account for 40% of all deaths and a third of avoidable deaths in the district.

Heart conditions affect Maori and Pacific at an earlier age than people of other ethnic groups.

Hospital admissions for chronic rheumatic heart diseases in this district are higher in than national rates, and are increasing.

What will we do?

We have identified three priority actions to reduce cardiovascular disease. These are:

- Support national initiatives to reduce risks to the overall population, such as encouraging a low salt diet, reducing smoking, reducing fat food alternatives and encouraging greater exercise.
- Implement the New Zealand Guidelines Group's cardiovascular risk factor modification guidelines, with a focus on reducing inequalities for Maori and Pacific peoples.
- Review new technologies in the context of the overall community benefit.

Cancer

What is the current situation?

- Overall rates of cancer in the district are lower than they are nationally.
- Cancer accounts for approximately 29% of all deaths and nearly half of all deaths for people aged between 50 and 65 years.

What will we do?

- Work with the Ministry of Health, other DHBs and other health providers to implement the *New Zealand Cancer Control Strategy Action Plan*.
- Work with other DHBs and the Ministry of Health to solve problems regarding workforce issues.
- Continue to work on factors that affect cancer e.g. smoking.

Lung Diseases, Including Asthma

What is the current situation?

- Lung related conditions account for 7% of all deaths in the district.
- Lung related deaths are decreasing and still remain a significant issue for Maori and Pacific peoples.
- Maori and Pacific peoples have a higher rate of lung infection, chronic lung disease (COPD) and Asthma.

What will we do?

- Support PHOs to strengthen their population health focus including smoking cessation and the management of chronic lung diseases.
- Support the development of multi-disciplinary teams, strengthening the roles of nurses in particular.
- Work with asthma educators, hospital and primary care providers to improve information, support and access to care for people with asthma.
- Develop appropriate services for Maori and Pacific people.
- Work with the Ministry of Health, Regional Public Health and other public health providers towards better control of tobacco products and decreased rates of smoking.

Palliative Care

What is the current situation?

Palliative care is a growing area of expertise and service development worldwide due to changing population demographics and changing patterns of disease that cause death. These factors combine to place increased pressure on existing service structures. Internationally it is recognised that current service models do not adequately meet the needs of people diagnosed with life-limiting illnesses.

For DHB, there are a number of areas where the timeliness and quality of palliative care are considered less than optimal.

The main areas are:

- coordination of services;
- care planning;
- service gaps in the community;
- early identification of palliative need;
- timely referral to specialist palliative care services.

What will we do?

We will continue to develop services to improve palliative care, particularly in aged residential care, workforce development, and community education. Improving the timely referral, assessment and care for those diagnosed with life-limiting illness will allow people of all ethnicities to make active decisions about their options at the end of life, and to die in the setting of their choice.

Radiation Therapy

Access to radiation therapy has improved over the last year. Staffing levels in radiation therapy reached 100 percent in December 2005 and have been maintained. The service has also worked hard to increase the capacity and volumes post the LINAC replacement.

Elective services

What is the current situation?

Waiting times for elective services and treatment need to be reduced. In addition, people should have equal access to services.

Waiting lists have increased in several specialties due to a combination of factors. An additional 7,000 people more than planned were admitted acutely to hospital in 2004/05 which reduced the capacity to provide for elective services. This has resulted in non-achievement of the delivery targets for elective services. In some specialties there has been an increase in referrals from Primary Care which has also increased the delay in receiving assessments.

Access targets for the number of people waiting longer than six months for cardiothoracic surgery were achieved during the last six months and the expectation is that this will continue.

What will we do?

Activities are underway to more effectively manage booking systems for elective services.

These include:

- re-establishing an internal steering group for elective services;
- developing more useful reports to clinicians and managers that will effectively represent the flows into and out of the elective booking system for each clinician and service;
- increased monitoring and adjustment of the clinical treatment threshold to manage the level of clinical need at which funding allows access to a service;
- developing a more systematic approach to managing the appropriateness of referrals for specialist assessment. This includes more active screening of referrals in some specialties and the development and distribution of a list of procedures and services that are rarely provided under current funding. It is proposed that this list will be available to GPs and the public through our website.
- redesigning the process to improve electives in respect of level of service, order of service and patient flow management.

- reducing the FSA to 2% of the number of people referred.
- reducing the waiting time for elective services to 5% of people who are offered treatment.
- introducing performance indicators for elective services (ESPIs) to ensure full compliance by 30 June 2006.

Appendix E:

Infrastructure/Engine Room - The way we do things here

In this section we describe the assumptions on which this DSP is developed and the challenges we face. We also describe the infrastructure and processes that will support our strategies to help us achieve our key population health goals.

Planning assumptions

- Chronic diseases and avoidable admissions can be reduced by improving primary and community care and encouraging health lifestyles.
- All other Government departments, agencies, and schools are promoting and contributing to 'healthy lifestyles'.
- All other Government departments, agencies, and schools are working to improve people's health and make it easier to stay healthy.
- Avoidable admissions can be reduced or minimized.
- The incidence of chronic diseases (such as heart diseases, lung diseases, cancer and diabetes) can be reduced or minimized. The incidence of neurological disorders such as epilepsy can not be reduced.
- To improve health and independence we must change the way that services are currently delivered.
- We have the ability to shift money from Hospital services to community services.
- Performance measurement and reporting systems are in place at all levels - within the DHB, primary care and national levels.
- Ongoing diseases and avoidable admissions can be reduced by improving primary and community care and encouraging health lifestyles.
- Avoidable admissions can be reduced or minimized.
- We can reduce ongoing illness and disease.
- We must change the way that health services are currently provided in order to improve people's health and independence.
- We can shift money from Hospital services to community services.
- Performance measurement and reporting systems are in place at all levels including within DHB, primary care and National level.

Prioritisation

Our current framework uses the following principles to prioritise the allocation of resources for health and disability support services:

- effectiveness (will the service result in health gains?)
- equity (will it help reduce gaps and differences?)
- value for money (is there evidence that it works and is cost effective?)
- achieving Whanau ora (will it help improve Maori health and self determination?).

During 2004/05 the areas for preferential funding identified by Community and Public Health Advisory Committee resource allocation group were identified as a guide for Boards. These are:

- shift resources into primary care services;
- shift resources into preventative care;
- shift resources into areas, which will benefit the health of Maori, Pacific peoples, and low income populations in high NZ Dep areas;
- limit the resources spent on surgery in secondary/tertiary care in favour of the shifts detailed above.

At a management level, we use a Funding Management Committee (FMC) to operate a prioritisation process which allocates resources for the whole DHB.

Financial Management/Outlook

Funding for each DHB is now based on Population Based Funding Formula (PBFF). PBFF involves using a formula set by the Ministry of Health to allocate each DHB a fair share of the Government's health funding so that each DHB has an equal opportunity to meet the health and disability needs of the District.

The Ministry of Health provides DHBs with a rolling three year indicative funding advice at the end of each year. It is difficult to predict the financial setting much beyond three years.

DHBs are expected to abide by restrictions on the uses of funding supplied for mental health purposes, which means mental health funding must be used for mental health purposes, as agreed by the Minister in the DAP.

It is anticipated that funding will continue to increase each year by at least an amount that takes account of inflation (which is called future funding track) and population growth.

Financial assumptions

- There will be no significant adverse changes in the funding levels received from or advised by the Ministry of Health.
- The growth of acute services and population remains in line with the Ministry of Health's calculations for DHB's population based funding.
- Cost growth, particularly wage and salary costs and the DHB's foreign exchange rate exposure on clinical supplies and equipment, can be contained within forecast funding levels.
- Future funding track increases (to compensate for cost growth) will be available for existing services, together with funds to compensate for compliance with specific government decisions such as pay equity, Holidays Act etc.

- All funders, including other DHBs, will pay efficient prices for all services provided by our HHS within the constraints of PBFF.

Capital plan

Sound planning for capital expenditure is essential to ensure the District Health Board can meet required service delivery levels. In 2002, the Ministers of Health and Finance approved the business case of NRH and associated developments in Newtown, Kenepuru and Kapiti.

We have completed facility development at Kapiti and substantial development at Kenepuru and have completed blood and cancer centre and short stay unit at Newtown. Over the next three years, we will complete the new main building at Kenepuru and the new main building at Newtown, and refurbished buildings at Newtown and Kenepuru.

In addition to the new regional hospital and associated developments, we are also planning to rebuild Mental Health acute ward, new ID cottages, purchase an additional Linear Accelerator, CT Simulator and equipment for HDR Brachytherapy Service for the Cancer Centre and the completion of the Electronic Health Record/Patient Management System (EHR/PMS) and the IT infrastructure projects.

Asset Management Plan

Apart from facility developments, we are also developing a strategic plan for asset management that will assist in linking service delivery with our asset base.

The details of the strategic plan for asset management have yet to be finalised. However, the high level strategy is to replace assets as they reach the end of their utility age and to invest for service growth within the limits of currently approved borrowings and free cashflow from depreciation. The replacement profiles for assets as they age take into account condition and performance.

Monitoring and Reporting

Monitoring the District Strategic Plan

The *New Zealand Health and Disability Act 2000* requires the DHB to review the District Strategic Plan every 3 years. The review will provide an update on progress in each of the key areas of strategic intent and priorities.

We have developed a set of performance measures to allow the Board, staff and wider communities to monitor and evaluate our performance. We will review progress against the targets and milestones of each priority. These targets and milestones will also form part of our future District Annual Plans and Statements of Intent. We will report progress against these to our Board and the Ministry of Health every quarter, every six months to CPHAC and DSAC and annually through the performance objectives in our annual report as we have identified in the Statement of Intent.

The Maori Partnership Board will monitor the progress of the District Strategic Plan by using key milestones set out in the Maori Health Policy. In addition to the performance measures and targets identified in the District Strategic Plan, we are currently developing the Maori Health for Maori health performance indicators.

We are working with various councils to develop performance measures for the health improvement areas we are collectively trying to achieve. These performance measures will be monitored jointly by the DHB and Councils. We are also working with the local councils to develop joint performance measures for health gain

Monitoring service agreements

Monitoring of devolved contracts is one of key functions of DHBs. Monitoring includes service outputs, outcomes, quality of service, payment, and audit.

We are responsible for ensuring that the performance of providers against the service specifications is monitored (including those relating to quality and standards), and action is taken as required on the basis of monitoring information. This responsibility also includes ensuring that collected monitoring information is available at a national level to inform policy analysis and decisions. Our approach to monitoring includes two broad facets:

- the routine collection of information reported by providers against the agreed indicators. This task is primarily carried out by HealthPAC (business unit of the Ministry of Health) for DHBs.
- action taken by the DHB (or Central TAS) to identify any non-compliance with service agreements by providers, and follow up when information is received that suggests at provider may not be complying.

Implementing a framework to effectively monitor the performance of all service agreements against priority areas will be critical to achieving demonstrable health gains for Maori, Pacific peoples, and other communities (i.e. refugees, migrants and people from low socio-economic groups).

Collaboration

We work collaboratively with other agencies to perform the DHB's role for the community and Government.

This collaboration occurs at various levels including strategic and operational levels. We currently have inter-agency relationships with the Mental Health Commission and other mental health advocacy organisations, disability agencies; and Government agencies including, Child, Youth and Family, Housing, Education, ACC and Department of Work & Income, Ministry of Social Development and Department of Correction. We work collaboratively with Wellington City Council, Porirua City Council, Schools, Sports Wellington and SPARC.

We actively participate in forums across sectors for key Government initiatives such as the Youth Offending Strategy and the Prison Health Project. We also participate in a number of national and regional initiatives to improve health workforce development. These initiatives include membership of the Workforce Development sub-group of DHBNZ, DHBNZ National Leadership and Development programme, participation in regional human resource processes and the Regional Maori Workforce Plan.

We have important strategic relationships with Healthlinks in Porirua and Kapiti. Key directions agreed in the draft DSP ensure their continuing involvement in projects within their respective regions. In Wellington, we are working very closely with the Wellington City Council and health sector related groups to devise mechanisms for closer collaboration. We have also invested in an inter-sectoral worker for Wellington South to strengthen community links and input.

National

Ministry of Health

At a national level, we work closely with the Ministry of Health. Contact with the Ministry is predominantly through the designated DHB Account Manager. We actively participate in national projects led by the Ministry of Health, which include:

- the Cancer Working Party;
- the National Benchmarking Exercise;
- the Haemophilia Working Party;
- Primary care;
- the Ministry of Health/Department of Corrections Working Group;;
- Whanau ora
- the Pacific National GMs meetings.

At a national level, we also participate in projects for pricing, and work with the Health Sponsorship Council.

District Health Boards New Zealand (DHBNZ)

All DHBs support DHBNZ and continue to participate in DHBNZ activities.

DHBNZ's role is to support DHBs and to provide coordination of activity at a national level. DHBNZ maintains links with central agencies and works to confirm sector priorities through the Health Sector Work Plan and the DHBNZ Annual Plan. DHBNZ is active in a range of areas including primary health, workforce development, industrial relations, funding and accountability, service frameworks, pricing and prioritisation tools and information (WAVE).

The following projects are funded by the DHBs and coordinated by DHBNZ:

- Aged Residential Care Contract Review;
- Orthopaedic Continuous Quality Improvement Project;
- Referred Services Management Project;
- Pharmacy Strategy including section 88 Project;
- Laboratory Services Project;
- Negotiation of changes to the Standard PHO Service Agreement and Contractual Changes.

DHB Chief Executive Forum

The Chief Executive Officer regularly attends and actively participates in discussion at the DHB CEO forum.

We are also involved in national projects around quality and risk, including the development of a national quality and risk framework, implementing a root cause analysis training programme, standards development and standardizing risk processes and patient safety initiatives.

Regional

Public Health

We are working with the Ministry of Health, Wairarapa DHB and Hutt Valley DHB to implement a Regional Public Health Strategy.

The aim is to provide an integrated approach to the provision of public health services in the region. Joint planning with Regional Public Health and regular collaborative forums align the work of Regional Public Health with the DHB's priorities, optimising links with PHOs, local government, providers and communities. A key risk around this strategy is ensuring that priorities in the Regional Public Health Strategy align with our DHB priorities.

We are a member of Wellington Regional Public Health Steering Group, which identified the following priorities for service delivery:

- Tobacco control;
- Active lifestyle and nutrition;
- Alcohol and drug;
- Reducing inequalities;
- Maori community;
- Pacific community;
- Child and youth health.

Mental Health

Our representative participates in the Central Region Mental Health and Addiction Network (CRMHAN). This group is a key vehicle achieving a collaborative approach to mental health service planning and delivery between the six central region DHBs.

Collaboration with Hutt Valley DHB

At a regional level, we work closely with Hutt Valley DHB to improve quality and service provision for the DHB's respective populations. Both DHBs work collaboratively on a number of areas including human resources, information management, finance and operations.

Regional Funding Manager's Forum

The Director of Planning and Funding attends regular meetings of the above forum for the purpose of regional collaboration and cooperation for service development.

Educational Institutions

We work closely with a variety of educational providers. In particular, the DHB has developed strong relationships with Massey University, Whitireia Community Polytechnic and the Wellington School of Medicine.

Local Government

We have ongoing working relationships with the territorial authorities within the region.

The Chairman and CEO regularly meet with the Mayor/CEO of each council to discuss priorities and work programmes implemented to achieve improved health outcomes for the people of this region, this includes input into each councils' long term community priorities. We also participate in the Wellington Leaders Forum which is a forum for all local territorial authorities and government agencies.

We work with the Porirua City Council, actively supporting strategic initiatives to improve health and the Porirua Health Care Cluster. A particular success in 2003/04 has been the Defeat Diabetes Team's work as part of the Porirua Health Care Cluster.

Long Term Council Community Plan (LTCCP)

All councils will develop a LTCCP by the end of 2006. The plan will be a review of what the community sees as important outcomes for the council.

The Wellington Regional strategy will involve the five local councils developing a strategy for the city working forward. The strategy will also express what the regional outcomes will be and express specific issues facing the city.

The DHB will participate in a forum to discuss the outcomes of the review in detail. Collaboration currently occurs between the DHB and local councils at an operational level and the CEO regularly meets with the CEO of Wellington City Council and the CEO of Porirua City Council.

Joint ventures

Central Region Technical Advisory Services Limited

Central Region's Technical Advisory Services Limited (TAS) was incorporated on 6 June 2001 under the Companies Act 1993. It is wholly owned by the six central region District Health Boards - C&C DHB, Hutt Valley DHB, Wairarapa DHB, MidCentral DHB, Whanganui DHB and Hawkes Bay DHB.

The purpose of TAS is to support the effective functioning of District Health Boards so they can meet the objectives of the New Zealand Health Strategy and the Act. TAS supports DHBs with health information, service planning and external service audit functions. TAS primarily provides support to the Planning and Funding Divisions of the six central region DHBs. In addition, TAS has at times provided coordination and analytical support for some other projects such as the benchmarking of services.

HealthIntelligence (HIQ Ltd)

During 2004/05, we established HIQ Ltd, which is a joint venture between C&C DHB and Taranaki DHB. HIQ Ltd supports the health and information management strategies of both DHBs, maximising the quality and the quantity of the ICT services delivered for the money that is invested. HIQ provides the highest possible quality of ICT support (tools and advice) to the DHBs and their stakeholders.

Information management

We recognise that information management has only a passing relationship with information technology, and sound information management principles are built into all of our strategies. They include the collection of accurate ethnicity data and sharing information appropriately to support short, medium and long-term healthcare initiatives. Our information management strategies and plans are aligned and we are supportive of the NZ Health Information Strategy and its predecessor plan (WAVE). Major deliverables for us over the next few years are:

- an upgraded Patient Management System to support the activities of our hospitals and community health services (as opposed to just our hospitals);
- an Electronic Health Record that will be deployable outside our Hospital & Health Services and will support future population health initiatives;
- a Picture Archiving and Communications (PACS) that has been selected in conjunction with regional stakeholders including other regional DHBs and which will be tightly integrated with our EHR;
- a Common data model;
- HR systems that will support improved processes with the DHB organisation.

Our Strategic Plan for Information Management is under review and can be found at www.ccdhb.org.nz. Our strategic plan for information management is supported by our outsourced ICT service (HealthIntelligence) provider's strategic plan for information services which can be found at www.healthintelligence.net.nz.

Risk Management

The inherent nature and complexity of the DHB's activities and responsibilities mean it is exposed to a large number and variety of risks.

We manage identified risks through a systematic identification, assessment, and mitigation process. Major risks are regularly reported to the management committees, Hospital Advisory Committee, Finance, Risk & Audit Committee and the Board. We also report top three risks to the Ministry of Health to comply with the requirements of the Operational Policy Framework.

We are actively working with other DHBs and the Ministry of Health to improve risk reporting and management system for the sector. In a table below, we have identified major risks and mitigation strategies.

Risks	Mitigation Strategies
<p>Finite funding National benchmarking and pricing projects:</p> <p>Efficient pricing, possible capital adjustor and tertiary adjustor changes may impact on pricing/funding. Only efficient prices are being implemented in 2004/05 and then only through a 3 year transitional path. Efficient prices are a double edged sword, increase in IDF revenue in 2004/05 but increased prices mean reduced volumes given FFT increases are lower than price increases.</p> <p>Volume reductions in next three years.</p> <p>Inadequate Ministry of Health funding to meet expenditure risk of changes to asset testing legislation for aged residential care.</p>	<p>Co-operate with other DHBs to ensure service integration</p> <p>Service reviews and prioritisation processes to identify the level of services provided to the local population.</p> <p>Work with other DHBs to see new prices accepted/supported by other DHBs and MoH.</p> <p>Mitigation in 2005/06 through a six month assessment of actual impact and adjustment to funding levels.</p>
<p>Workforce development International shortage of workforce will make it difficult to deliver on the current level of services and current skill mix is not appropriate for changing health needs.</p>	<p>Continue to work on HWAC recommendations with other DHBs and Ministry of Health.</p> <p>Develop local recruitment and retention strategies.</p> <p>Participate in various forum to promote health sector as an employer of choice.</p> <p>Work with tertiary education providers for appropriate training developments.</p>

HHS Strategic Plan

Our provider arm is developing the strategic plan to ensure alignment of HHS's response to the health goals and strategies identified in the DHB Strategic Plan. Major initiatives identified are can be categorised as:

- patient focused service delivery (to complement Integrated care strategy of the DSP);
- efficiency initiatives (to complement managing our money strategy of the DSP);
- specific speciality redesign - models of care (to complement working with communities strategy of the DSP).

Key strategies of the HHS Strategic Plan are:

- Addressing disparities;
- Regional planning;
- New regional facilities;
- The HHS supports primary and community providers;
- Managing growth;
- Integrated care with focus on patient flows;
- Evolving health professional roles;
- Integrated service delivery, teaching and research.

Quality and Safety of the Services We Fund / Provide

Our quality framework describes our approach to quality assurance and improvement. We aim to focus on a systems approach to quality improvement. That is:

- an explicit concern for quality, vested in teams;
- the viewing of quality as the search for continuous improvement;
- an emphasis on improving work processes to achieve desired outcome;
- a focus on developing systems and investing in people to achieve high-quality outcomes.

Our Hospital and Health services have several practical quality tools that contribute to quality improvement and assurance processes. These tools are:

- accreditation and certification;
- policies, procedures and patient information publications;
- clinical governance;
- credentialing;
- reportable events and complaints.

Major Incident and Emergency Preparedness

While it has been a quarter of a century since the district last had to cope with a mass casualty incident, recent events overseas (for example the bombings in Bali in 2002, and SARS in Asia and Canada in 2003), and the ever present threats of large earthquake, all serve to reinforce the importance of maintaining a high level of emergency preparedness for a wide range of potentially serious events.

Our current emergency plans address areas such as:

- mass casualty incidents;
- epidemic or pandemic outbreaks of infectious diseases;
- earthquakes;
- fires and hazardous material incidents;
- security related incidents.

In many cases, planning, training, and exercising is undertaken in collaboration with neighbouring DHBs, Territorial Local Authorities, and other emergency services. Mutual aid arrangements are also in place with the private surgical hospitals in the District.

Currently, a number of emergency planning projects are being undertaken by the Ministry of Health. Collectively they will form a national health emergency plan, and better prepare the sector to manage large and unusual incidents such as those listed above.

The local implementation of a number of these projects will be the focus of the DHB's emergency planning in the immediate future. Significant areas of change include:

- planning to manage incidents in 4 regional groups (our DHB and the other five DHBs in lower North Island from the central region);
- the incorporation of the primary health sector into emergency readiness and response planning;
- more detailed planning for the management of infectious diseases outbreaks.

Challenges

One of the foremost challenges for this DHB is to maintain services and compliance with Government strategies and policies within available resources, while achieving 'breakeven' (zero-deficit) financial results.

In many of the following areas we are working together with other DHBs to explore a national approach to addressing these key challenges, which include:

- increasing demand for services (consumerism in medicine), the increasing burden of chronic disease and the ability to address inequalities;
- the impact of inter district flow, where we provide services to people who are usually resident of other Districts;
- a higher than anticipated escalation of construction costs in the Wellington region as created by market forces and a potential impact of the same on the cost of the New Regional hospital Project;

- impact on the provider arm of the DHB from any failure to implement full pricing package for medical and surgical services as recommended by the national pricing group, although the DHB has received additional funding for medical and surgical services;
- funding provider development for providers delivering services to high need populations;
- passing of new Well-Child and Primary-Care Strategy (largely) funds from the Ministry to mainstream providers bypassing high need populations;
- shortage of workforce especially for Maori, Pacific, community and NGO provider;
- an ageing population and increase in chronic illness has resulted in increased demand for services.

International Trends

We also face challenges that are affecting other DHBs and health systems in other countries. These challenges include:

Increasing patient demand for hospital and health services

Acute Hospital admissions continue to grow and in New Zealand have risen from 744,000 in 1999/2000 to 822,000 in 2001/2002⁸. The average price per inpatient discharge has also risen over the timeframe⁹. So more patients are requiring treatment and the cost of this treatment is rising

An aging population

Internationally, health systems need to plan for an older population.

OECD data indicate that, in the developed countries, per capita health expenditure on the 65 and over age group is typically three to five times that for the 15-64 age group. In Australia, the number of Australian aged 80+ is projected to double over the next two decades and triple over the next 50 years. Australian figures also show that the average cost of health care rises with age. In 2002/2003 the average Australian cost of care for under 65s was less than \$3000 but for people over 85 it was \$7,900.

Rising rates of chronic illness

Health systems also need to adapt to meet the needs of people with chronic conditions. In the US, 20% of Americans currently have more than one chronic condition and this percentage is expected to rise to 49% by 2030. US Hospital information shows that over 70% of people using hospitals are those with chronic illnesses and that both the length of stay and cost of care increases when people have more than 1 chronic condition such as diabetes or chronic heart disease.

Inequitable access to health services

Internationally, people from disadvantaged areas access health services at lower rates than people from advantaged areas. In New Zealand, research has shown that Maori, Pacific peoples and low income people have lower rates of access to all health services. Also, in some countries, epidemics can not be contained and the spread of these diseases is rapid across all countries. For example, SARS/ Avian Flu is a new disease that has global impact.

⁸ New Zealand Health Information Service accessed 28 February 2005

⁹ Average price per inpatient discharge rose from \$2,528 in 1999/2000 to \$2,620 in 2002/2003.

Rising cost of technology

Technological advances are continually being made across health services, saving lives and improving our quality of care. For example, over the next few years we can expect the development of artificial hearts and lungs, and genetic screening for disease management as well as implantable devices for depression, Alzheimer's and Parkinson's disease. There is a cost to introducing these new technologies.

Lasting workforce shortages

Internationally, health systems are working to employ more health professionals and New Zealand is competing against other countries to maintain our home-grown workforce and attract health professionals from other countries.

Rising user expectations

As health users, we are becoming more knowledgeable. For example, well over 50% New Zealanders access the internet in their homes and are using the internet to find out more about available health and disability services and to improve their own health. People are expecting more from our health services.

Appendix F:

Governance and Management

Role of the Board

The DHB Board is responsible for the governance of the DHB. Seven members were elected in 2004 as part of the triennial local authority election process and the Minister of Health appointed four additional members. The Board's mandate is detailed in the Act.

The DHB Board has all the powers necessary for the governance of the DHB, and is responsible to the Minister of Health. The DHB affirms commitment to "best practice" governance, this includes routine and regular consultation and engagement with stakeholders and acknowledging the DHB's obligations under the Act.

The Board's key responsibilities include:

- approving proactive and reactive strategies;
- setting long term strategic direction consistent with Government's objectives;
- developing with management and approving the District Annual Plan and other accountability documents;
- monitoring the performance of the DHB and appointing its CEO;
- corporate Governance;
- maintaining the relationships with the Minister, Parliament, Maori and the Public.

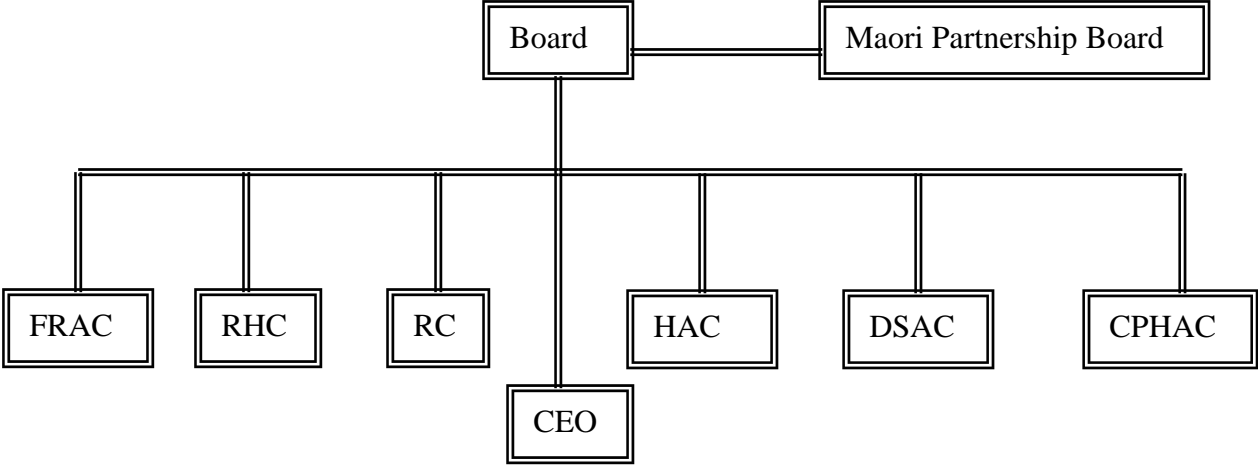
Board Committees

We have established six Board committees, including three statutory advisory committees, which assist the Board in carrying out its functions. The role of these committees is in accordance with the New Zealand Public Health and Disability Act 2000.

The committees are:

- Community and Public Health Advisory Committee (CPHAC)
- Disability Support Advisory Committee (DSAC)
- Hospital Advisory Committee (HAC)
- Finance, Risk and Audit Committee (FRAC)
- Regional Hospital Committee (RHC)
- Remuneration Committee (RC).

The following chart is a diagrammatic representation of the organisational structure at Board (governance) level:



Management

At a management level, the Chief Executive Officer leads the organisation, which is organised into two main areas:

- Planning and Funding Arm (headed by Director, Planning and Funding)
- Hospital and Health Services (headed by Chief Operating Officer).

As an effective use of resources, various teams support these arms including Maori Health, Finance, Human resources, Quality & Integrated Care, Information management, and Strategic community relations.

Appendix G:

Statutory Objectives of the DHB

Objectives of DHBs are described in the section 22 of the Act and are to:

- improve, promote, and protect the health of people and communities;
- promote the integration of health services, especially primary and secondary health services;
- promote effective care or support for those in need of personal health services or disability support services;
- promote the inclusion and participation in society and independence of people with disabilities;
- reduce health disparities by improving health outcomes for Maori and other population groups;
- reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders;
- exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of services;
- foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services;
- uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations;
- exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations;
- to be a good employer.

Appendix H: Financial information

Please note that the following financial information has been superseded by information presented in our 2006-2009 Annual Plan and Statement of Intent.

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Financial Performance										
FUNDS ARM										
Revenue										
Own Population	(419,293)	(438,853)	(452,019)	(468,317)	(481,625)	(495,313)	(509,392)	(523,872)	(538,766)	(554,085)
IDF Revenue/Inflows	(121,253)	(124,854)	(128,599)	(133,248)	(137,042)	(140,944)	(144,957)	(149,085)	(153,330)	(157,697)
Total Revenue	(540,546)	(563,707)	(580,618)	(601,565)	(618,667)	(636,257)	(654,349)	(672,957)	(692,096)	(711,782)
Expenditure (Inclusive of IDFs)										
Personal Health										
Primary Care	26,111	26,925	27,745	28,748	29,566	30,408	31,274	32,165	33,081	34,023
Referred Services	62,470	64,410	66,370	68,769	70,727	72,741	74,812	76,942	79,134	81,387
Other	315,211	328,085	336,781	348,957	358,891	369,110	379,619	390,430	401,548	412,985
Total Personal Health	403,792	419,420	430,896	446,474	459,185	472,259	485,706	499,537	513,763	528,395
Total DSS (Health of Older People)	61,123	64,378	66,781	69,196	71,166	73,192	75,276	77,419	79,624	81,892
Total Mental Health	70,410	74,546	77,416	80,215	82,498	84,847	87,263	89,748	92,304	94,933
Total Maori Health	2,616	2,693	2,774	2,874	2,956	3,040	3,127	3,216	3,307	3,402
Total Public Health										
Total Other	2,606	2,670	2,751	2,806	2,862	2,919	2,978	3,037	3,098	3,160
Total Expenditure	540,546	563,707	580,618	601,565	618,667	636,257	654,349	672,957	692,096	711,782
NET RESULT FUNDER ARM	0	0	0	(0)	0	0	0	0	0	(0)

PROVIDER ARM

Revenue										
External (eg: interest/MOH contracts)	(45,020)	(46,278)	(48,429)	(52,790)	(52,793)	(52,796)	(52,800)	(52,803)	(52,807)	(52,811)
Internal (DHB Fund to DHB Provider)	(328,136)	(341,409)	(350,540)	(358,786)	(372,839)	(387,339)	(402,302)	(417,740)	(433,670)	(450,107)
Interprovider Revenue (other DHBs)	(3,600)	(3,600)	(3,600)	(3,672)	(3,745)	(3,820)	(3,896)	(3,975)	(4,055)	(4,135)
Total Revenue	(376,756)	(391,287)	(402,569)	(415,248)	(429,376)	(443,955)	(458,998)	(474,518)	(490,532)	(507,053)
Expenditure										
Personnel Costs	222,061	236,207	244,961	260,004	268,299	274,849	281,494	288,683	295,007	302,510
Outsourced Services	6,122	6,319	6,522	6,515	6,723	6,887	7,054	7,234	7,392	7,580
Clinical Supplies	76,000	78,325	80,513	81,096	83,683	85,726	87,799	90,041	92,014	94,354
Infrastructure and Non-clinical Supplies	62,464	77,439	86,481	86,391	89,147	91,324	93,532	95,920	98,022	100,515
Total Expenditure	366,647	398,289	418,477	434,007	447,852	458,787	469,879	481,878	492,435	504,960
NET RESULT PROVIDER ARM	(10,109)	7,002	15,908	18,759	18,476	14,832	10,882	7,360	1,904	(2,093)

GOVERNANCE ARM

Internal Revenue (DHB Fund to DHB Govern & Admin)	(2,606)	(2,670)	(2,751)	(2,735)	(2,790)	(2,846)	(2,903)	(2,961)	(3,020)	(3,080)
Other Income	(2,468)	(2,539)	(2,612)	(2,735)	(2,790)	(2,846)	(2,903)	(2,961)	(3,020)	(3,080)
Total Revenue	(5,074)	(5,209)	(5,363)	(5,470)	(5,580)	(5,691)	(5,805)	(5,921)	(6,040)	(6,160)
Expenditure	6,307	6,413	6,689	6,822	6,959	7,098	7,240	7,385	7,532	7,683
NET RESULT GOVERNANCE ARM	1,233	1,204	1,326	1,352	1,379	1,407	1,435	1,464	1,493	1,523

CONSOLIDATED

Revenue	(591,634)	(616,124)	(635,259)	(660,762)	(677,995)	(695,719)	(713,947)	(732,696)	(751,978)	(771,808)
Expenditure	582,758	624,330	652,493	680,873	697,850	711,958	726,264	741,520	755,375	771,237
Net Result Consolidated	(8,876)	8,206	17,234	20,111	19,855	16,239	12,317	8,824	3,397	(571)

