

**Capital & Coast District Health Board's  
(C&CDHB)**

**Primary Care Framework**

**(DRAFT)**

**September 2003**

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## Introduction

The purpose of this plan is to present strategies for primary health care services that support the overall strategic direction of Capital & Coast District Health Board (C&CDHB), as identified in its District Strategic Plan 2002 – 2005

In February 2001, the Government released the “Primary Health Care Strategy.”<sup>1</sup> Under the current legislation, it is C&CDHB’s responsibility to implement this strategy.

*“People will be part of local primary health care services that improve their health, keep them well, are easy to get to and coordinate their ongoing care.*

*Primary health care services will focus on better health for a population, and actively work to reduce health inequities between different groups”.*

This vision involves a new direction for primary care with a greater emphasis on population health and the role of the community, health promotion and preventive care, the need to involve a range of professionals, and the advantages of funding based on population needs rather than fee for service.

Six key directions for primary health care were identified in the Primary Care Strategy to achieve this vision:

1. Working with local communities and enrolled populations;
2. Identifying and removing health inequalities;
3. Offering access to comprehensive services to improve, maintain and restore people’s health;
4. Co-ordinating care across service areas;
5. Developing the primary health care workforce; and
6. Continuously improving quality using good information.

## Primary Care Strategies

Two main themes that underpin C&CDHB strategic priorities are:

- reducing health disparity within communities: The majority of people in the district have very good health but there are pockets of our population that have poor health; and
- population based approaches to health: We acknowledge the different population groups, and the challenge to tailor services to meet this difference. We want to

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<sup>1</sup> Minister of Health

expand from services focused on individuals to services focused on the population as a whole. This will mean an emphasis on unmet need and access.

In the District Strategic Plan, C&CDHB describes a community-centred model and states:

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

## Environment

The New Zealand Public Health & Disability Act 1996 gives District Health Boards overall responsibility for assessing the health and disability needs of communities in their districts, and managing resources and service delivery to best meet those needs. This includes resource allocation to facilitate optimal Primary Health Organisation development, improve primary care service delivery and support the population health objectives in the Primary Care Strategy.

A key direction identified in the Ministry of Health's Primary Health Care Strategy is to "identify and remove health inequalities". Reducing inequalities in health status particularly for Maori, Pacific and low income populations has been identified by government as a priority. C&CDHB's Health Needs Analysis has identified Maori, Pacific and low income populations, particularly those of Porirua and Wellington South/East as high need.

The relatively poor health status of Maori has been well documented. In particular, the relatively high amenable mortality, premature mortality and high level of ambulatory sensitive admissions requires urgent action. He Korowai Oranga, the Maori Health Strategy, "*places whanau at the centre of public policy and challenges us to create environments that are liberating and enable whanau to shape and direct their own lives.*"<sup>2</sup> This creates a markedly different policy environment with significant implications for primary care development.

Pacific populations have relatively poorer health status and evidence again points premature mortality and high levels of avoidable admissions, requiring effective action. Pacific communities have contributed to a strong policy direction and explicit action plan<sup>3</sup> that will drive primary care in C&CDHB.

Young and old people in areas of high deprivation are hospitalised more often than their less deprived neighbours and children, youth and the elderly, particularly those with low income require a range of innovative approaches to build stronger primary care access and provision.

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<sup>2</sup> King A, Turia T. He Korowai Oranga. Maori Health Strategy. Wellington: Ministry of Health. 2002.

<sup>3</sup> Ministry of Health. Pacific Health and Disability Action Plan. Wellington: Ministry of Health 2001.

Diabetes is a major concern for the District, with deaths increasing by 12% per year. It is the third most common cause of death for people aged 45-65 in Porirua. Cardiovascular disease is a leading cause of premature mortality in the adult population.<sup>4</sup>

Other subgroups within the population require tailored services to meet their particular needs and there needs to be flexibility at a local level to address the special needs of populations such as new migrants and refugees, people with chronic illnesses, people experiencing barriers to appropriate and timely service delivery.

Full implementation of the Government's Primary Health Care Strategy, including District wide coverage of populations enrolling in PHOs will, for the first time, allow an accurate assessment of coverage, access and utilisation. To date, we have only been able to draw comparisons against Census information on populations but future health needs analysis will be strengthened with PHO information.

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## **Treaty of Waitangi**

The Treaty of Waitangi established the special relationship between Maori and the Crown. The Treaty relationship carries reciprocal responsibilities and is based on principles of good faith, equity, co-operation, reciprocity, partnership, protection and active participation. C&CDHB recognises that the Treaty of Waitangi provides a fundamental framework for Maori development and health.

### **Partnership**

C&CDHB will work together with local whanau, hapu, iwi and Maori communities to recognise, develop and implement initiatives for Maori health gain and appropriate Maori health and disability services

### **Protection**

C&CDHB will protect the gains made in Maori-led service delivery and promote the growth and development of 'by Maori' service provision. We will develop robust mechanisms to support and monitor the effectiveness of all services for Maori and safeguard Maori cultural concepts, values and practices.

### **Participation**

C&CDHB will promote and support whanau, hapu, iwi and Maori community participation at every level of service governance, design and delivery. C&CDHB recognises the importance of rangatiratanga and positive Maori development to achieve health improvement.

### **Equity**

C&CDHB will promote an equal standard of health care to Maori and recognise that general equality of health outcomes for Maori is one of the expected benefits of the citizenship granted by the Treaty<sup>5</sup>.

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<sup>4</sup> C&CDHB Health Needs Analysis. (2001) [www.ccdhb.org.nz](http://www.ccdhb.org.nz).

<sup>5</sup> Waitangi Tribunal (2001). Wai 692 The Napier Hospital and Health Services Report.

## Key Goals and Objectives

It is C&CDHB's intention to address primary care issues from a community perspective, with strategies and actions specifically involving communities and providers (including primary health organisations), in planning, service delivery and evaluation.

In order to achieve significant reductions in premature mortality, the causes of chronic disease will need to be tackled. These causes include not only disease states such as diabetes, high blood pressure and behavioural/ lifestyle patterns but also underlying socio-economic and environmental factors that limit the ability of individuals and whanau to achieve improved health.<sup>6</sup> This requires innovation, a paradigm shift, reorientation of health services and a renewed focus on both the social policy level and on families/whanau/community to drive development.

Implementation of He Korowai Oranga is at the centre of primary health care's strategic direction. Implicit in this Strategy is a strengths-based approach to whanau. This requires a culture-shift from the 'deficit' thinking. C&CDHB's Maori Health Plan, "Te Plan" reflects the strategic direction of He Korowai Oranga and has been developed in consultation with iwi, Maori community, Maori providers and other stakeholders.

The national Pacific Health and Disability Plan and C&CDHB Pacific Health Action Plan are central to primary care development to address the needs of Pacific populations. Pacific-led services have been identified as a key mechanism to achieve health gains. Improving the ability of all providers to appropriately facilitate access to quality service delivery and effective population health interventions is required to impact on Pacific health status.

Equitable resource allocation, equitable access and improved primary care delivery are necessary prerequisites for achieving equitable health outcomes. Improved health information systems and analytical ability are essential to monitor progress.

New models of care, consistent with the approach to managing chronic disease agreed by WHO<sup>7</sup>, expanded roles for primary care nurses and general practitioners, opportunities provided by PHOs incorporating population health approaches including structural/policy level interventions and supporting community development all need to be brought together.

People using services and service providers need to be included in discussions about the way forward. Different ways to share ideas and plan together are being utilised. These include forums, advisory groups and issue specific meetings.

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<sup>6</sup> Ministry of Health. Our Health, Our Future. The Health of New Zealanders. Wellington:Ministry of Health. 1999.

<sup>7</sup> WHO Innovative Care for Chronic Conditions: Building Blocks for Action. WHO: Geneva. 2001.

Also available on [http://www.who.int/ncd/chronic\\_care/index.htm](http://www.who.int/ncd/chronic_care/index.htm)

Newsletters and meeting together to feedback progress and new developments is an integral part of C&CDHB's approach to primary care development.

C&CDHB's primary care framework recognises the need to rebuild strong links and trust between communities and institutional/decision-making structures in the health sector. This will take time. C&CDHB is committed to open dialogue with communities and providers so that the strategic direction is clear, priorities are explicit and significant decisions are informed by community and provider input.

STRATEGY MAP: Summary of GOALS (Ends) and STRATEGIES (Pathways) and OBJECTIVES (Milestones)			
<b>KEY GOALS</b>			
<b>G1</b> Reduce health inequalities by addressing barriers to accessing primary health care services.			
<b>G2</b> Improve community access to health service information and enhance community participation in Capital & Coast District Health Board's primary health care development.			
<b>G3</b> Work with whanau, hapu, iwi and Maori communities to promote whanau health and wellbeing and address systemic barriers to health care.			
<b>G4</b> Actively work towards achieving integration and coordination of care across the health services continuum.			
<b>G5</b> Foster intersectoral action on health issues, within our District.			
<b>G6</b> Provide active support in the development of the primary care workforce, in particular, supporting capacity building for Maori and Pacific primary care providers.			
<b>G7</b> Effectively engage with all primary care providers ensuring the delivery of quality primary health care services within the allocation of resource.			
<b>G8</b> Collect primary health care information at patient data level to enable Planning & Funding to plan effectively and fund health services that make a positive difference to health outcomes and reduce inequalities.			
<b>KEY OBJECTIVES</b>			
<b>O1</b> Establish and support Primary Health Organisations providing maximum coverage within the C&CDHB District by June 2004.	<b>O2</b> Build effective working relationships with external health/non-health related agencies, supporting intersectoral action on health issues	<b>O3</b> Establish stronger community voice within South/East Wellington, with similar advisory/link role as Healthlinks groups in Porirua and Kapiti	<b>O4</b> Ensure community participation is effective at all levels in PHOs established in our district.
<b>O5</b> Support C&CDHB's implementation of Whakatataka and 'Te Plan' including whanau centred models of service delivery	<b>O6</b> Support C&CDHB's implementation of Pacific Health Action Plan including Pacific-led PHO development.	<b>O7</b> Establish streamlined, effective and consistent monitoring processes for all contracted primary care providers.	<b>O8</b> Obtain data from contracted primary care providers, in a form that can be used for future planning and funding

<p><b>09</b> Link with C&amp;CDHB's strategy for information technology to ensure needs of primary care providers and community incorporated.</p>	<p><b>10</b> Actively support and invest in training opportunities for all primary care providers. Support undergraduate training in primary care.</p>	<p><b>11</b> Support development of broader primary care team, including expanded role for primary care nurses.</p>	<p><b>12</b> Invest in integrated care initiatives that result in improved health outcomes for C&amp;CDHB region</p>
<p><b>13</b> Develop a strategy for maternity services and facilitate integration with primary care development including PHOs</p>	<p><b>14</b> Improve linkage between mental health services, A&amp;D services and primary care, including recognition of/growth of primary mental health services.</p>	<p><b>15</b> Continue to work with the sector in the management of demand driven expenditure</p>	<p><b>16</b> Improve linkages with NGO and voluntary sector and develop partnerships to support health gain and reduce inequalities.</p>

### Key Strategies

These key strategies have been derived from the above goals and objectives and take into account desired stakeholder outcomes, particularly, for all communities of C&CDHB.

### Strategy 1

Move from one size fits all approach to allow for a range of service delivery models and practices by taking an innovative approach in how services are developed, configured and funded.

<b>Critical Success Factors</b>	<b>Key Performance Indicators</b>
<ul style="list-style-type: none"> <li>➤ Adequate and sustainable funding</li> <li>➤ Strong Leadership</li> <li>➤ Good strategic and operational skill mix within planning and funding team</li> <li>➤ Collaborative and effective relationships with iwi, communities, providers and intersectoral agencies.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Implementing Whanau Models of Care for whanau affected by diabetes</li> <li>➤ Implement family models of care for Pacific families with diabetes.</li> <li>➤ Supporting community development initiative in Wellington South</li> <li>➤ Supporting a new Youth service for Wellington</li> <li>➤ Develop and participate in intersectoral fora/initiatives that seek to improve health outcomes for our population</li> <li>➤ Support Porirua Health Cluster</li> <li>➤ Work with WINZ and other agencies on income support.</li> </ul>

As with any innovative approach, this strategy carries some risk and will take time to implement. It requires valuing existing, successful provision and building on this where health gain is evidenced. C&CDHB's is committed to working alongside communities,

providers and intersectoral agencies, in order to make changes where necessary to improve health outcomes and reduce inequalities.

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## Strategy 2

Establish trust as a funder, with primary care providers, by engaging in open, honest and equitable relationships

Critical Success Factors	Key Performance Indicators
<ul style="list-style-type: none"> <li>➤ C&amp;CDHB employees honest in declaring conflicts of interest</li> <li>➤ All providers treated equitably in the contract management and monitoring processes</li> <li>➤ Make a sustainable investment in primary care services</li> <li>➤ Support workforce stability and morale by inclusive approach to service development.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Effective contract monitoring process.</li> <li>➤ Streamlined contract reporting requirements to ease burden for providers.</li> <li>➤ Regular contact and positive relationship management.</li> <li>➤ Equitable access to funding for priority areas of service delivery and development (guided by District Strategic Plan).</li> <li>➤ GPs, nurses and other health professionals engaged in planning and service developments.</li> </ul>

As a publicly accountable organisation, C&CDHB's processes/relationships must be professional and transparent. The organisation's values of professionalism, leadership, honesty and integrity support this strategy.

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## Strategy 3

Actively develop primary care services, including services to improve access, population health approaches/health promotion

Critical Success Factors	Key Performance Indicators
<ul style="list-style-type: none"> <li>➤ Adequate and sustainable funding</li> <li>➤ Collaborative relationships with providers</li> <li>➤ Establish trust as a funder</li> <li>➤ Support workforce stability and development.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Establish PHOs to obtain maximum coverage of district</li> <li>➤ Agree with PHOs, initiatives for 'Services to improve Access' and 'Health Promotion' funding for the long-term</li> <li>➤ Implement Whanau Models of Care.</li> <li>➤ Youth service for Wellington and range of youth-friendly services across District.</li> <li>➤ Implement health promotion/population health according to plans agreed with Ministry of Health and Regional Public Health.</li> <li>➤ GPs, nurses and other health professionals actively engaged in new service models, working with communities and on population health issues.</li> </ul>

This strategy directly supports the Government’s Primary Health Care Strategy directions for reducing health inequalities and improving health outcomes. It is made real by the additional funding that has been approved by Government for PHOs and the joint decision-making process developing with Ministry of Health and Regional Public Health.

**Strategy 4**

Continue to work formally with Healthlinks and other community groups, but also consult with wider community, over health and/or service delivery decisions.

<b>Critical Success Factors</b>	<b>Key Performance Indicators</b>
<ul style="list-style-type: none"> <li>➤ Dedicated Community consultation resource within C&amp;CDHB</li> <li>➤ Established relationships with key consumer and other community groups</li> <li>➤ Key community contacts Database that is updated and maintained regularly</li> </ul>	<ul style="list-style-type: none"> <li>➤ Establish stronger community links in South/East Wellington</li> <li>➤ C&amp;CDHB newsletters quarterly</li> <li>➤ Information for community on PHOs updated regularly through website and pamphlets, as well as, C&amp;CDHB newsletter and attendance at community meetings.</li> <li>➤ Participation in community meetings, including those with local government, with NGOs and other community groups on specific issues.</li> <li>➤ Utilisation of networks of SPF Maori Health team and iwi/Maori community meetings for information sharing/input.</li> <li>➤ Utilisation of networks of Pacific Health team and Pacific community consultation to share information and gain feedback from Pacific communities.</li> <li>➤ Utilisation of networks of SPF Mental health team, including Local Advisory Group to share information/gain input.</li> <li>➤ Utilisation SPF Aged Care and Disability team networks and meetings to share information and gain feedback/input.</li> </ul>

C&CDHB has made a commitment to ‘work together’ to improve the health of the community it serves and has already established consultation processes around service planning decisions. Formal MOUs are now in place for Healthlinks in both Porirua and Kapiti. Establishing stronger links in South/East Wellington is a priority, as this area has high health needs. It is also important to utilise existing networks, meetings and opportunities to reduce the ‘consultation overload.’

**Strategy 5**

Continue to use mechanisms, such as service advisory groups and fora/workshops to optimise community voice/provider input in critical areas of planning and service development

<b>Critical Success Factors</b>	<b>Key Performance Indicators</b>
<ul style="list-style-type: none"> <li>➤ Dedicated Community consultation resource within C&amp;CDHB</li> <li>➤ Established relationships with key consumer and other community groups</li> <li>➤ Open and transparent processes for community involvement</li> <li>➤ Mechanisms to consult with and share information with providers and other key stakeholders.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Establish service advisory group for Health of Older People.</li> <li>➤ Establish PHO Advisory Group.</li> <li>➤ Regular meetings with consumer/community groups about their issues.</li> <li>➤ Workshops for input about issues requiring specific decisions.</li> <li>➤ Information sharing mechanisms that are inclusive of a wide range of community stakeholders.</li> <li>➤ Six monthly forum with Board.</li> <li>➤ Primary care newsletter bi-monthly.</li> </ul>

Service Advisory Groups, fora/workshops and community consultation have provided C&CDHB with valuable advice and it is important to continue with such processes

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### **Strategy 6**

Build on/develop intersectoral relationships, seeking opportunities to work together to improve health outcomes for C&CDHB's funded population

<b>Critical Success Factors</b>	<b>Key Performance Indicators</b>
<ul style="list-style-type: none"> <li>➤ Effective relationships at both strategic and operational levels with intersectoral agencies</li> <li>➤ Effective staff mix of strategic and operational skill sets</li> <li>➤ Leadership</li> </ul>	<ul style="list-style-type: none"> <li>➤ Develop and participate in intersectoral fora/initiatives that seek to improve health outcomes for our population</li> <li>➤ Identified projects in Wellington, Porirua and Kapiti with evaluation/explicit outcomes reported annually.</li> </ul>

There is both the recognition and understanding within the organization, that a variety of social determinants impact on health, so if C&CDHB is to achieve improvement in our population's health, then intersectoral initiatives are an important aspect for long term planning

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### **Strategy 7**

Focus on and invest in integrated care projects that cross the primary/secondary health continuum and that will make a difference in health outcomes

<b>Critical Success Factors</b>	<b>Key Performance Indicators</b>
<ul style="list-style-type: none"> <li>➤ Adequate and sustainable funding</li> <li>➤ Strong Leadership</li> <li>➤ Good strategic and operational skill mix of planning and funding team</li> <li>➤ Collaborative and effective relationships with and between providers.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Establish Congestive Heart Failure (CHF) project in Porirua</li> <li>➤ Implement Maori Whanau Models of Care for both Maori and Pacific families that are affected by Diabetes</li> <li>➤ Elder Health pilot for integrated services</li> </ul>

<ul style="list-style-type: none"> <li>➤ Primary care clinicians and hospital clinicians engaged in planning and evaluating progress in integrated care.</li> <li>➤ Consumer/family/whanau/community input into planning.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Develop an integrated care framework and contracts with key maternity/tamariki ora providers</li> </ul>
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This is a patient/whanau focused strategy for improving health service delivery, towards seamless and tailored services for patients. Adequate and sustainable funding, as well as provider relationships will be key to this strategy's success.

### Strategy 8

Collect patient data (NHI, ethnicity, age, gender and address) from all primary care providers through the contract management process

Critical Success Factors	Key Performance Indicators
<ul style="list-style-type: none"> <li>➤ Collaborative and effective relationships with providers</li> <li>➤ Effective contract management and monitoring systems</li> <li>➤ Financial investment in data collection systems</li> </ul>	<ul style="list-style-type: none"> <li>➤ Change reporting requirements for all contracted primary care providers</li> <li>➤ Establish contracted PHOs to cover district and agree reporting in consistent format.</li> <li>➤ Percentage of reporting in the required format reported annually and mechanisms to address deficits.</li> </ul>

This strategy requires adequate physical and financial resource to implement effectively. District wide coverage of populations enrolling in PHOs, will for the first time, allow accurate assessment of coverage, access and utilisation, which can be used for future planning of health services

### Strategy 9

To look for opportunities within C&CDHB to shift funding /services from the hospital to the community wherever appropriate

Critical Success Factors	Key Performance Indicators
<ul style="list-style-type: none"> <li>➤ Strong Leadership</li> <li>➤ Good strategic and operational skill mix of staff</li> <li>➤ Commitment by Senior management and Board to C&amp;CDHB's strategic plan</li> </ul>	<ul style="list-style-type: none"> <li>➤ Complete new regional hospital (NRH) by 2008, implementing new models of care supporting community models and direction</li> <li>➤ Percentage of DHB funding and total funding in primary care reported annually.</li> <li>➤ Shift in secondary service delivery to community settings reported annually.</li> </ul>

C&CDHB's District Strategic Plan identified the need to shift resources from the hospital to the community. There is a key tension that needs to be managed, however, and that is the deficit associated with providing hospital based services. The NRH will be a key factor in achieving this strategy. Leadership by clinicians toward more community based care, early intervention to reduce admissions and stronger relationships across secondary/primary interface are essential to achieve this shift.

**Strategy 10**

To keep informed of and actively apply for, all potential funding opportunities available to primary care providers in our District

<b>Critical Success Factors</b>	<b>Key Performance Indicators</b>
<ul style="list-style-type: none"> <li>➤ Networking connections</li> <li>➤ Collaborative and effective relationships with external funding agencies, in particular, Ministry of Health</li> <li>➤ Funding/contracting experience</li> </ul>	<ul style="list-style-type: none"> <li>➤ Success in identifying additional funding opportunities reported annually.</li> </ul>

In order to achieve a change in health outcomes, we need to invest adequately in the delivery of services, so any additional funding opportunities should be maximized for our district, by C&CDHB.

## **Primary care**

### **Indicators of progress**

Essential for this monitoring is an agreed data set and format for reporting and this is being agreed with providers as contracts are renegotiated.

### **Indicators**

(suggested 6 monthly report to Board)

Total spend in primary care

All of the following indicators by age, ethnicity, TLA, PHO, NZDep (where possible)

- Coverage –enrolment in PHOs.
- Utilisation -visits
- Diabetes Detection
  - Annual reviews
  - Retinal Screening
  - HbA1c
  - admissions
- Referred services (pharms, labs, radiology)
- ED presentations
- Low birth weight babies
- Immunisation at 2 years
- Breastfeeding rates (for C&CDHB as a whole)
- Hearing/vision screening
- Oral health –secondary presentations
- Avoidable admissions
- Access to elective surgery (indicator to be agreed)
- Disability support service uptake

Annual Report on workforce.