

# **Comprehensive Primary Community and Rural Operating Framework**

Draft for Comment

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## Forward

Te Pae Tata 2022, as the interim New Zealand Health Plan, leads and guides the mahi covered within this document. In setting the scene, Te Pae Tata notes the complexity and importance of the primary and community healthcare sector. “The primary and community healthcare sector is complex and wide-ranging, including services such as aged care, midwifery, pharmacy, Whānau Ora, mental health, tāngata whaikaha, district nursing, allied health, and primary care. Services are delivered through a mix of private, public and NGO entities with a range of philosophies and models of care, including Te Ao Māori and Pacific providers, and services to support people to age well at home. Every year there are over 20 million consults or other encounters in primary care<sup>1</sup>”.

This document describes the potential of a strong and resilient primary and community sector as demonstrated through the following “strengthening primary and community care is one of our opportunities to reduce the risk and

burden of disease, reduce demand for more costly and intensive specialist care, and achieve better and more equitable health and wellbeing outcomes for all New Zealanders<sup>1</sup>.” This means that to achieve equitable health and wellbeing for all New Zealanders, approaches for diverse communities must be targeted, purposeful and culturally appropriate to meet the specific needs.

The foundation of this development is the implementation of comprehensive primary and community care teams. The relationship of these teams with localities has been described as follows, “the implementation of comprehensive primary and community care teams is a key part of the locality approach, designed to broaden access to health services in the community. In localities, comprehensive primary and community care teams will be commissioned to deliver high-quality care in accordance with community needs. In some cases, this could mean that you get immediate access to a physiotherapist who

works with your primary care provider, and in other cases, it could mean having access to a specialist diabetes nurse<sup>1</sup>.”

Te Pae Tata requires consideration of:

- Integrated primary and community care
- Funding and accountability arrangements
- Addressing barriers to access
- Addressing unscheduled care in primary care
- Supporting healthy ageing

To assist understanding of the collective impact of the changes to support wellbeing and extended care in the community, a range of vignettes are provided (Appendix 1 of this document) to tell the story from a people, whānau, community and workforce point of view.

This document is intended to provide guidance to parties involved in the CPCT planning, development, and change management.

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<sup>1</sup> Te Pae Tata [Te Pae Tata Interim New Zealand Health Plan 2022 – Te Whatu Ora - Health New Zealand](#)

# Section 1: Comprehensive Primary Community & Rural Care Operating Framework

## 1.1 Context

This is the first Comprehensive Primary Community and Rural Care Operating Framework arising from Te Pae Tata 2022. Te Pae Tata as the Interim New Zealand Health Plan 2022-2024 following the newly introduced Pae Ora (Healthy Futures) Act 2022 came into effect on July 1st, 2022. The Act establishes three new entities; Te Pou Hauora Tūmatanui the new Public Health Agency within Manatū Hauora, Te Whatu Ora (Health New Zealand) as the national organisation to lead and coordinate delivery of health services across the country and Te Aka Whai Ora, the Māori Health Authority as an independent statutory authority to drive improvement in hauora Māori.

This Operating Framework (“the Framework”) supports the priorities of strengthening primary and community care and involves integrating primary and community care within localities, applying new roles, new funding, and accountability arrangements, addressing barriers to

access, and addressing unscheduled care in communities.

The Framework covers the following priority areas

- Te Tiriti o Waitangi
- Equity
- Roles and responsibilities
- Comprehensive Primary and Community Care Teams (CPCT)
- New Roles into Comprehensive Primary and Community Care Teams
- Refocusing Community Nursing, Allied Health, and Needs Assessment Service Coordination
- Extended Care through CPCT
- Clinical Governance
- Outcome accountabilities

## 1.2 Purpose and Scope

The Framework leverages off Te Pae Tata Early Actions, with the expectation that services will develop flexible, local, and responsive supports to enable individuals

and whānau to access primary and community care with a focus on increasing equity, improving health outcomes, and avoiding unnecessary hospitalisation whenever appropriate.

The Framework provides direction and guidance for organisations and providers, involved in the implementation of Te Pae Tata, by enabling services and communities to develop in innovative ways to meet local needs including:

- Implementation of CPCTs
- Introducing new roles into CPCTs
- Refocusing of community nursing, allied health and NASC services to CPCTs
- Provision of extended care by extended CPCT, such as community acute care/hospital avoidance.

This Framework has been developed for health and wellbeing support providers. This includes (but is not limited to) iwi, Māori and Pacific providers, providers of general practice, primary care and

community nursing and allied health, and NASC (age related) services. The Framework is also of interest to Hospital and Specialist Services, relating to activities such as hospital avoidance, early supported discharge, Aged Residential Care and Home-Based Support Services (HBSS). Further, as Localities continue to evolve, this Framework can contribute to guidance for place-based planning to meet the needs of local communities. Finally, NGOs, welfare providers, health education, and professional bodies are key to this mahi and may find value in this Framework.

Te Whatu Ora - Health New Zealand and Te Aka Whai Ora - the Māori Health Authority have a shared expectation that health providers will work collaboratively to develop their services, and that each organisation will have its own processes and ongoing commitment to local collaboration and coordination.

During any period of change or transition, there is the potential for increased clinical

risk as team members understand new roles, accountabilities, and ways of working. To ensure that there is quality, accountability, and cultural safety across this implementation of change, strong clinical governance including clinical leadership, mentoring and support must be in place. Section 9 of this Framework outlines the expectations for CPCTs relating to clinical governance during implementation of comprehensive primary and community care.

Implementing comprehensive primary and community care teams will require the support and building of collaborative partnerships where they may not exist today. These partnerships will have a focus on health and, wellbeing, and some may relate to addressing the wider social determinants of health to provide responsive, whānau ora oriented models of care. Section 5.4 outlines how local partnerships can be developed.

This mahi is underpinned by Te Pae Tata key priorities that signal a shift in thinking and functioning to support whānau and communities to experience their best health and wellbeing. Underpinning the changes is the intent to refine models of care so that individuals, whānau, and communities are empowered, and communities are party to decisions for changes. Self-management is promoted and actively supported, so that CPCTs promote the ecosystem of support around individuals and whānau, using community development principles where applicable.

This framework identifies attributes and minimum requirements for each of the priorities described. In this context, attributes are defined as a feature or characteristic inherent in the priority, with the minimum requirement being those features or characteristics that are required.

## Section 2: Te Tiriti o Waitangi and Māori Health Equity

Meeting the obligations under Te Tiriti is necessary if the health system is to achieve the overall aim of Pae Ora (healthy futures for Māori) under He Korowai Oranga (the Māori Health Strategy). Demonstrating a commitment to Te Tiriti o Waitangi and the achievement of Māori health equity remains a critical priority in Te Pae Tata. The five principles (below) are how practical effect to Te Tiriti is achieved. Below describes how these principles should be applied in the implementing of CPCT.

Table 1: Applying Te Tiriti o Waitangi and Māori Health Equity in CPCT

Principle	Action
Equity	Assert an equity approach to all planning and operational activities. Identify sufficient funding dedicated to Māori specific systems and approaches to providing comprehensive primary, community, and rural services to whānau.
Active Protection	Confirm Māori outcome measures and transparent monitoring processes that are accessible to iwi/hapū/Māori stakeholders.
Tino Rangatiratanga	Tino rangatiratanga must be resourced appropriately to be 'enabled.' Ensure Māori leadership at all levels of the implementation of CPCTs (Comprehensive Primary and Community Teams). Enable Māori communities and providers to lead, design and deliver locally driven solutions for and with Māori to complement and/or embed into the CPCT model.
Options	Support and nourish Kaupapa Māori support services across the motu recognising that they are best placed to provide holistic, culturally appropriate, safe, and responsive supports to whānau Māori. Ensure auraki/mainstream services are supported to deliver Māori health equity.
Partnership	Central agencies build genuine partnerships with Māori in the policy and strategy design and decisions. Establish referral pathways for holistic, culturally appropriate, safe, and responsive support and services between Māori and mainstream services and providers.

The mahi of implementing CPCTs and re-refocusing community nursing, allied health and NASC services can build upon the learnings from the COVID-19 response with the focus on outcomes, the protection of whānau, hapū and iwi and hapori Māori and supporting whānau resilience. These outcomes are separated under two key enablers that focus on targeting information for whānau and increasing access to integrated health services. The Whakamaua: Māori Health Action Plan 2020–2025 (Whakamaua), sets out the sector's commitment to and expression of Te Tiriti in the context of the health and disability system and includes the Ministry's Te Tiriti framework.

## Section 3: Equity

Equity is at the heart of Te Pae Tata and is the essence of this Framework. This change programme seeks to ensure that systems are in place to meet the needs of the communities, particularly those who are at a higher risk of poor health outcomes.

It is expected that organisations design system enablers to drive equity and provide culturally safe care and approaches to service delivery for priority populations by:

- Ensuring systems are in place and coordinated to identify people and whānau at greatest risk of inequities of health outcomes including those most under-served by the health sector, such as whānau Māori, Pacific peoples, tāngata whaikaha, people with co-morbidities, people living with mental illness and/or addiction, some ethnic communities, people and whānau who live rurally, and our older population.
- Work alongside and support the mahi of Locality development, to build community infrastructure by enabling communities to identify changes that will improve health and wellbeing and drive local responses.
- Ensuring that CPCTs build on, connect with, and align to other providers that support the holistic needs of whānau inclusive of welfare, health, and broader support services. This means enabling communities to design tailored and targeted models of care that are holistic and culturally responsive. It also means building systems that enable better cross-agency collaboration and coordination, and that the needs of whānau come first.
- Embed agile, flexible, and high trust commissioning and contracting arrangements to enable local innovation and responsiveness.
- Ensure clear communication and support from national and regional bodies, whilst enabling localised campaigns and drives.
- Strengthening data collection, data utilisation and sharing to underpin equity prioritisation processes, monitoring, and evaluation of care, ensuring that appropriate data governance supports the whole information and data journey / life cycle, from collection through to use in interactions with individual people and whānau, and strategic 'sense making' and use of information for system level decision-making.

## Section 4: Roles and Responsibilities

This section outlines the roles and responsibilities of the health sector in coordinating and implementing CPCTs within communities, at a national, regional, and local level.

There is a wide range of stakeholders within the broader health sector that play a key role in CPCTs and supporting the objectives of the Pae Ora Healthy Futures Act 2022. This includes (but is not limited to):

- Localities
- Primary Health Organisations (PHOs)
- General practice teams
- Health and community care providers, including iwi and Māori, Pacific, hospital and specialist services, urgent care services, community nursing, allied health and NASC
- Private and public sector community providers such as community pharmacy, physiotherapy, dental, optometry, emergency services, NGOs, aged care community and residential services, tāngata whaikaha services and Kahu Taurima / maternity and early years services
- Other funders of services in the community such as ACC (Accident Compensation Corporation)
- Public Health Units
- MSD (Ministry of Social Development), Kainga Ora and other social sector partners

CPCTs bring together integrated care and support, at a national, regional, and local level. At the national level, Te Whatu Ora - Health New Zealand and Te Aka Whai Ora co-lead this mahi. The table below

describes the functions and accountability for implementing CPCTs and refocussing of Te Whatu Ora community services.

Table 2: Roles and responsibilities in developing CPCT, implementing new roles and refocussing services

Function	Accountable entity
Health funding	Te Whatu Ora, Te Aka Whai Ora
Digital enablement	Te Whatu Ora
Public messaging and communications	Te Whatu Ora, Te Aka Whai Ora
Primary and community health sector engagement	Te Whatu OraTe Aka Whai Ora
Clinical governance	All organisations working within primary health and community services, Regional Coordination, Local clinical hubs, PHOs, Te Whatu Ora, Clinical teams.
Iwi/hapū/Hapori Māori engagement, partnership, and commissioning	Te Aka Whai Ora, supported by Te Whatu Ora
Regional planning and coordination	Regional Wayfinder, in partnership with PHOs, localities, communities and primary care partners, (supported by EAP in the initial phases)
Health care coordination and delivery	Māori and Pacific providers, Pharmacy, GP teams, Primary Care Providers, community services including nursing, allied, NASC, community mental health teams, NGOs, and community providers, including safety nets for people without a primary care provider



## Section 5: Comprehensive Primary and Community Care Teams

Comprehensive Primary and Community Team (CPCT) development and functioning is a key deliverable of Te Pae Tata. CPCT development serves as a mechanism for coordinating and delivering care to people living in the community, with a focus on those persons and whānau who experience poor health outcomes. These teams also serve to manage the health needs of populations in the community wherever it is appropriate to do so, with the overall aim of reducing unnecessary hospitalisations.

Budget 22 appropriation has funded new roles into CPCT as outlined in Section 6, and gives attention to the refocusing of community nursing, allied health and NASC into CPCTs as outlined in Section 7.

The COVID-19 experience has highlighted the value to people, their whānau, and the health system of bringing together healthcare and manaaki support. As such, the development of CPCTs will combine with a model of care in the community that has a wider focus on health and wellbeing through connection and collaboration of primary, community, and social service providers. The development of these teams

will be locally led, regionally coordinated, and nationally supported.

### 5.1 Equity, Te Tiriti, Māori, Pacific, Disabled Peoples obligations/requirements

Establishment of CPCT and the required collaborative and partnership-based approach will be undertaken in accordance with Te Tiriti o Waitangi and Pae Ora Legislation.

This shared vision will be built on by whānau and communities' aspirations for health, including equitable access and outcomes for Māori, Pacific people and Tāngata whaikaha with the following focus:

- Te Tiriti and Māori cultural safety
- Te Whare Tapa Whā and whānau ora approaches
- Pacific models of care and cultural safety
- Rural models of care for those communities
- People, whānau, household, community centred approach
- Wellness focus, preventative care, life course approach

- Condition management; extended planned and acute care
- Hospital avoidance and early supported discharge.

CPCT partners will be able to demonstrate a mutually agreed organising framework to inform local priorities, including how collaboratives may operate together. This relates to the provision of service and supports delivered by workforces that may be employed by a variety of entities for example the kaiāwhina workforce, may be employed by an hauora Māori, or Pacific provider.

Through these collaborations, CPCTs will be able to demonstrate a focus on those at greatest risk of poor health outcomes including Māori, Pacific, isolated rural communities and Tāngata whaikaha. CPCTs will coordinate health and wellbeing care to ensure barriers to access for those at greatest risk are mitigated and services prioritised, inclusive of a focus to connect people to appropriate supports to address the social determinants of health.

## 5.2 Defining Comprehensive Primary and Community Teams

For this mahi, it is useful to provide definition of both core primary care (including other professional community services) and CPCTs. Consistency and clarity of language is important to the programme of work when implementing Te Pae Tata. Ensuring there is congruence to the emerging Locality operating model is also key.

### Core Primary Health Care Teams

This is the current predominant team structure. As defined by Manatū Hauora Ministry of Health, this relates to “the professional health care provided in the community, usually from a general practitioner (GP), practice nurse, nurse practitioner, pharmacist, or other health professional working within a general practice.” For the purposes of this mahi, this is specific to the above team members and other health care workers that are employed to meet the primary health needs of the enrolled population for a contracted provider. This team serves to meet the requirements of the current PHO Services Agreement.

Wider primary care does include other providers of health services in the community such as community pharmacies and dentists.

### Comprehensive Primary Health and Community Care Teams

In addition to the Core Primary Health Care team, comprehensive teams will have additional roles such as those relating to Te Tumu Waiora (Access and Choice), practice pharmacists, physiotherapists, and Extended Care Paramedics. These teams may have relationships with other providers or agencies to provide comprehensive primary health services for their enrolled population. Comprehensive team members may or may not be co-located on site and will frequently include Māori or Pacific partners. To enable a CPCT, collaboration and collaborative ways of working will be required across a range of health and wellbeing providers.

### 5.3 Objectives of CPCT

The following are objectives of CPCT:

- Improve equity of access and health outcomes for Māori, Pacific Peoples, Tāngata whaikaha, rural people and others at greatest risk of health inequity.
- Enable assessment, early diagnosis, treatment and condition management, extended care services, hospital avoidance/early supported discharge activity as well as acute, planned, and preventative care.

- Build a sustainable primary and community sector through operating in a collective and collaborative manner to meet the priorities and needs of the people served.
- Deliver services and supports to enhance the wellbeing of whānau, including having a focus on health, manaaki or wellbeing and the social determinants of health.
- Implement new roles and ways of working across primary and community services to have an increased focus on people, whānau, and have a community-centred approach.
- Develop and strengthen partnerships with other providers and organisations, for example, organisations that employ kaiāwhina, or collaborations with other private health providers such as pharmacists or physiotherapists within private practice, whānau ora providers.
- Focus on a seamless experience of care and support for the person and their whānau.

CPCT team mahi is underpinned by ensuring there are Tikanga Māori and Pacific models of care and culturally appropriate approaches to whānau wellbeing. There is a strong focus on support for the most vulnerable whānau and communities, evidenced by a whānau-

centric and strength-based intervention approach. Locality and community-based coordination will require working with local communities and enhancing their resources to deliver high quality service provision and clinical excellence.

#### 5.4 Description of CPCT

The CPCT composition will be flexible and agreed within the Locality to reflect the priorities and needs of the community, and limitations of current and available workforce. It is noted at the time of writing this Framework, that the Localities are not fully operational. It is expected that persons involved with the establishment of CPCT will understand the direction of development for each Locality.

CPCTs are expected to develop in stages, with initial change support and skill development for existing teams a primary step. Indicative stages include:

- New roles including that of practice pharmacist, physiotherapist, kaiāwhina and care coordinator will be implemented into the core primary care team to form CPCT
- In some areas the role of an Extended Care Paramedic may be introduced, especially to support rural workforces.

- If not already completed, adding, in stages, the re-focused roles of community nursing, community allied health, and NASC to be part of the Inter-disciplinary Team (IDT) and CPCT.
- If not already present, adding other health or intersectoral roles such as diabetes nurse specialist, paramedics, rongoā Māori practitioners and traditional healing approaches to enhance the comprehensive team. These additions will be a response, according to the needs of the community.

**Collaborations:** The creation of CPCTs, will require collaborations. These collaborations will be supported to form by the change management support to introduce CPCT and are likely to be supported by Locality Network Support Services in the future. Of note, collaborations may be required to include the role of kaiāwhina to the CPCT, who may be employed by Māori or Pacific organisations. The collaborations, once formalised, will apply a co-design process with parties to:

- Agree on how the organisations will partner together, including responsibilities, accountabilities, and the model of care.
- Integrate all personnel into an IDT.

- Clarify internal structures, ensuring appropriate policies, procedures, delegation frameworks, communication systems, etc. are in place, to support CPCT members to integrate, collaborate and work at top of scope.
- Utilise inter-professional training and education opportunities to improve the understanding of roles and competencies across disciplines, and to encourage sharing of inter-professional clinical knowledge and skills.

**Implementing CPCT:** The inclusion of additional roles, beyond the traditional Core Primary Care Teams, will required either direct employment, or have formalised agreements and arrangements with partners including:

- Kawenata or memorandum of understanding between partner agencies.
- Interdisciplinary teamwork as a foundation.
- Virtual options for comprehensive ways of working, including inter-disciplinary team (IDT) functioning if co-location is not an option.
- Formal approaches for assigning responsibilities, accountabilities, and communication between parties,

- including but not limited to IDT models of care.
- Role clarity balanced with flexibility, including the use of delegation frameworks and the possible use of skill sharing frameworks.
  - CPCTs outside of formed Localities will have strong relationships to Māori or Pacific providers to ensure inclusion of kaiāwhina within CPCT.

### **5.5 Staffing requirements/obligations**

Identifies a commitment to the ongoing development of comprehensive CPCT, including the re-focused roles of community nursing, allied health and NASC.

Commitment to a constructive team culture, featuring:

- trusting relationships
- connection to community
- connected and invested in the service
- commitment to Te Mauri o Rongo – The New Zealand Health Charter
- commitment to a 'one system' approach

- commitment to addressing equities for whānau Māori, and Pacific, and tāngata whaikaha

Robust orientation processes will be required to ensure there are:

- Clear role definitions and understanding of roles across the team
- Agreed tasking and communication processes
- IDT support systems in place
- Space for clinical and non-clinical work, where relevant
- Access to shared records and decision support tools
- Identification of an appropriate mentor within the workplace to provide orientation and support
- Ensuring appropriate coaching, cultural and clinical supervision is in place.

## 5.6 CPCT Attributes

There are 9 key attributes (below) of CPCTs.

Table 3: Attributes of a CPCT

1	Evidence of the deliberate prioritising of care for people and whānau at <b>greatest risk of inequitable health outcomes</b> , using data and evidence, and that care is provided in line with Te Tiriti o Waitangi principles.
2	There are clear processes and systems for <b>same day access to care</b> including, but not limited to: <ul style="list-style-type: none"> <li>• Clinical triage of calls requesting same day appointments, with telehealth options where appropriate</li> <li>• Delegation frameworks and policy supporting top of scope working for all persons within CPCT which may require introduction of assistant roles and skill sharing</li> <li>• Available options that are easily accessible for telehealth or other virtual health consultations</li> <li>• Access to extended hours on weekdays / weekend / public holidays</li> <li>• Digital enablers to enhance models of care, including acute monitoring</li> <li>• Daily stand-up meetings to maximise opportunistic care</li> </ul>
3	A focus to <b>improve access</b> . Using risk stratification tools (including nationally consistent tools when available) to identify people / whānau at risk of hospitalisation, or poor health outcomes. Models of care that support achieving equitable health outcomes and may involve health and social sector providers collaborating to provide a comprehensive response to the person / whānau's needs. The approach to health and well-being support may require linking with Kaiāwhina and other community providers of care and support.
4	Evidence of strong linkages to hospital and specialist services, including CPCT strategies to support <b>hospital avoidance and early supported discharge</b> through case management and care coordination from within the CPCT, or partners for those at greatest risk or who have complex needs using an IDT approach. This includes identifying member roles, responsibilities, and using IDT meetings to plan care for persons at greatest risk.
5	<b>IDT</b> functioning underpins the model of care delivery, with access to systems, processes and enabling technology. This includes but is not limited to: <ul style="list-style-type: none"> <li>• Access, including remote (for off-site health professionals covered by the HPCAA) access for viewing and documenting clinical notes within the clinical record system</li> <li>• Regular IDT meeting to be held with a focus on priority populations and those whānau with complex needs and at risk of hospitalisation</li> <li>• If co-location of the team is not possible, ensure there are virtual enabling technologies to create virtual IDT operations including, but not limited to: <ul style="list-style-type: none"> <li>○ Systems/processes are in place for CPCT to work in a collaborative, connected way, e.g., electronic communication or messaging</li> <li>○ Electronic tasking of actions and handover of care.</li> <li>○ Commitment to progress towards a single care record between all members of the CPCT</li> <li>○ Ensure access to clinical information, within PMS or a shared care record to all CPCT members.</li> </ul> </li> </ul>
6	A clearly defined and active <b>Clinical Governance</b> function is in place, within the CPCT cluster or network to ensure that quality and safety is prioritised, and that objectives of Te Pae Tata are being met. Further information is included in Section 9.

7	<b>Clinical leadership</b> actively supports the CPCT implementation and functioning.
8	CPCT members have access and are supported with <b>profession specific membership, peer groups and on-going professional development.</b>
9	Especially, but not limited to rural and remote areas, be committed to work collaboratively with other providers such as iwi, Māori, and Pacific to support the development and implementation of <b>new models of care that utilise kaiāwhina to support access.</b>

Table 4: Minimum Requirements for CPCT

Area	Requirement
Focus on Equity	Use of nationally consistent risk stratification tools that have equity as a focus when available.
Collaborations	Evidence of formalised collaborative agreements with partners to enable CPCT, including iwi, Māori, and Pacific providers, and other primary and / or community providers.
IDT functioning	<p>IDT processes are in place including regular IDT meetings for persons and whānau at risk of poor health outcomes and inequities. IDT tools are used to enable tasking and messaging between team members for communication and to support care transitions, including virtual meeting options for those not co-located.</p> <p>Processes are in place to coordinate care for those on hospital avoidance, early supported discharge or undergoing planned or extended care procedures in primary care.</p> <p>Practitioners covered by HPCAA have read access as a minimum to the PMS, working towards a single electronic record.</p> <p>For individuals and whānau where there are higher risk of poor health outcomes, inequities, or hospitalisation – IDT processes that involve shared care planning, collaboration and accountabilities are in place.</p>
Roles	<p>Team members understand and can describe their own role and that of others in the team in terms of scope and expertise.</p> <p>The skill mix of the team has been considered, with processes in place to support top of scope working for all, including skill sharing and delegation frameworks.</p>
Model of care	Supports participation of individuals and their whānau working in a collaborative manner, promoting inclusion in decision making, top of scope for persons and their whānau, and a self-management approach.
Responsiveness	<p>Strategies are evident to be responsive to acute and urgent needs, including the management of long-term conditions. This will include but not be limited to clinical triage of calls, other team members undertaking first assessment within scope and skill for role, such as physiotherapists for musculoskeletal issues</p> <p>Hospital avoidance is prioritised within the CPCT, with coordination of response from within the team and across community providers.</p> <p>Early intervention for persons and whānau with mental health and addiction is prioritised.</p> <p>Evidence of collaborations or partnerships for acute care responsiveness, including availability daily of acute or urgent appointments.</p>
Clinical governance	<p>Evidence of active clinical leadership and governance, during both implementation and ongoing across the wider CPCT.</p> <p>Evidence of connection of health professionals with profession specific peer groups, professional leadership connections and / or interdisciplinary peer reviews.</p>

## Section 6: New roles into CPCT

Budget 22 appropriation allocated funding is focused on four new roles in CPCT. The four newly funded roles include kaiāwhina, practice pharmacist, physiotherapist, and care coordinator, with Extended Care Paramedics applicable in some settings. Workforce development funding is available to support the introduction of these new roles, including the Extended Care Paramedics.

This section will outline key features, provide guidance on role scope and description, inclusive of how the role will contribute to the team. This section will not cover commissioning or allocation.

### 6.1 Kaiāwhina

The role of kaiāwhina is a non-regulated role, described by the Kaiāwhina Workforce Action plan. Although this definition is broad, for the purposes of the mahi of the EAP, it is defined as the workforce that represents the community they work in, have strong cultural safety for that community and work in a whānau-oriented, wider health and wellbeing approach. They will be usually employed by Māori or Pacific providers.

This section will outline key features, provide guidance on role scope and description, inclusive of how the role will contribute to the team. This section will not cover commissioning and allocation of this resource.

**Core Activities** are based on models of care that support Pae Ora. They range from navigation support, early intervention and prevention focus, advocacy, navigation of care pathways and culturally appropriate support to people and their whānau.

Kaiāwhina are often the first point of contact for whānau coming into the health system, providing appropriate and acceptable support to whānau. This could include cultural needs assessment, supporting health management plans, advocacy and support for Māori or Pacific people and their whānau.

Kaiāwhina enable connection and access to services, supports and government agencies; including for whānau not enrolled or engaged with health, supporting enrolment, appointment attendance, maintenance of contact, travel

support and working with Kaupapa Māori providers.

In some instances, kaiāwhina will undergo additional training and micro credentialling to take on the functions of a health care assistant (HCA), mental health support, or support CPCT by collecting vital signs, measurements, and support digital health access. As such there is opportunity to support new models of care, connecting services to those at greatest risk of health inequities.

The Kaiāwhina Workforce Plan 2020-25 is a guiding document and is the result of work through Careerforce, the Industry Training Organisation. Two sponsor organisations that oversaw the development of this plan – the Manatū Hauora - Ministry of Health and Toitūte Waioara, the Workforce Development Council for Community, Health, Education and Social Services. See link in appendices.

The kaiāwhina education and qualification pathway is aligned to NZQA (New Zealand Qualifications Authority) Qualifications including New Zealand Certificate in Health

and Wellbeing Levels 2&3, and New Zealand Apprenticeship in Health & Wellbeing (Social and Community (Level 4). Opportunities exist for micro-credentialling with the Workforce Taskforce undertaking this mahi.

There is no current post graduate training, but opportunities exist for stair-casing into other health professional roles through a qualification pathway such as nursing, social work, and allied health.

The current kaiāwhina workforce is varied. The COVID-19 response has led to many kaiāwhina working within the primary and community setting with some employed by primary care, others by PHOs (Primary Health Organisations), iwi, Māori, or Pacific providers. There is opportunity to re-orient Covid-19 kaiāwhina workforce to working within CPCT.

Current funding models for these roles includes both FTE and service, usually commissioned through Māori or Pacific Providers. Consideration for access to vehicles is essential, as is time for supervision and professional development, as learning and professional development is usually workplace based.

As part of CPCT, the kaiāwhina term embodies the core of a workforce that is passionate, resilient, diverse, skilled, and committed to supporting hauora (holistic wellbeing) outcomes of all in Aotearoa New Zealand. Based on mutual trust with the person they care for, confidence, positive relationships and communication are essential elements. This relationship is based on manaakitanga and whānau ngatanga. The kaiāwhina workforce can navigate across te ao Māori (the Māori world) and te ao Tauīwi (the non-Māori world) to understand the hauora of a tāngata (person).

Kaiāwhina represent all people within the health and disability sectors who support tāngata (people) to live well, embrace and exercise tino rangatiratanga (self-determination) in navigating their own journey to pae ora, a healthy future.

In the comprehensive team, they are often a trusted person with the whānau and support equity of access to health and facilitates access to social service and other agencies as required.

An exemplar of a position description for this role is included in Appendix Four. This position description serves the function of a basis for employers of kaiāwhina to use, should they choose.

In addition to the attributes outlined in table 3, attributes of CPCT, the following includes attributes of teams with kaiāwhina as an inclusive member.



Table 5: Attributes of a CPCT with Kaiāwhina

1	Kaiāwhina, regardless of employer are considered part of the CPCT with formalised agreement between employers that outline that agreement. This will include clarity on reporting lines and supervision for this role.
2	The kaiāwhina are part of the IDT. They will attend meetings, have access to tasking and messaging systems and have role delineated access to information from the PMS (Practice Management System) system.
3	Systems, processes, and actions of the CPCT recognise the expertise that kaiāwhina bring as specialists of their community, culture, and navigation support.
4	Clear orientation and familiarisation within the CPCT have occurred with clarity of communication and responsibilities.
5	The mahi of kaiāwhina will lie with supporting access and equity within the population, working closely with other NGOs, community providers and government agencies.
6	Kaiāwhina contributes to the Needs Assessment process for individuals and whānau they are supporting where relevant.

Table 6: Minimum Requirements for Kaiāwhina within a CPCT

Area	Requirement
Focus on Equity	Evidence that the primary focus of this role is to improve access for those at greatest risk of health inequities or poor health outcomes. This will be evident within those whānau they are tasked to engage with and the whānau they support to access health care.
IDT	The kaiāwhina is recognised as an equal partner within the IDT.  There is access to electronic enablers for virtual attendance at meetings if applicable, tasking, documentation, and messaging.  Role delineated access to PMS is available.
Model of care	Recognition of Te Whare Tapu Whā or other culturally appropriate models of care underpins their mahi, and the strong cultural and connections that this role brings to CPCT.
Clinical governance	Kaiāwhina activity is included in clinical governance processes.
Supervision	Evidence of regular supervision with protected time allocated. This function may be undertaken by the employer, or by others within the CPCT with clarity over responsibility for this.

## 6.2 Care Coordinator

Alternate job titles include case manager, transitional care nurse, integration coordinator or care coordinator. Care Coordination facilitator is the term preferred for this framework, to emphasize that care coordination is a process rather than the responsibility of one person. This approach enables evaluation of a process, rather than individuals, to identify gaps that require systemic enablers<sup>2</sup> (e.g., teamwork, health IT, medical home models of care, and medication management). For the Early Action Programme, the need for protected time for this function has arisen to this being identified as a role.

This role may be directly employed by the core primary care team or included within the CPCT through formalised collaboration.

It is noted that these functions may, in some settings, be undertaken by unregulated workers. Within this framework, the non-regulated component is covered by the kaiāwhina. For the

purposes of the Early Actions Programme this role has been determined to be a clinical role with the scope of practice being defined through the professional body of the person performing the role. Since care coordination occurs in the health sector, where more comprehensive services require registration (e.g., prescribing, treatment deliver, etc.), the scope of a care coordinating role is broader for those with a registered health background (e.g., registered nursing, social work, or other allied health backgrounds).

This facilitator's role is to enable and conduct activities required for a high-quality care coordination process. Activities range from intermittent navigation support through to case management (providing the most intensive support to individuals and whānau, with the highest needs). Case management may also involve the direct provision of care. The care coordination facilitator's responsibility is to identify requirements of

care coordination, ensure these activities occur, and identify gaps that need addressing. The extent of a care coordination facilitator's role in conducting these activities will be influenced by the availability of other roles, e.g., navigators and kaiāwhina. The specific required activities of the care coordination process are to:

- Ensure timely and complete transmission of information and accountability for aspects of care, when a transfer of care occurs such as acute community care, early supported discharge, attending outpatient treatment, and hospitalization.
- Determine patient and whanau goals and assess (incl. NASC assessment) or review health and wellbeing need to achieve the goals.
- Identify all participants in a person's care (i.e., the 'circle-of-care') and negotiate who is responsibility for key care activities.

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<https://www.ahrq.gov/ncepcr/care/coordination.html>

- Participate in communication so that all involved in the 'circle-of-care' have the information they need.
  - Proactively monitor identified needs, the impact of health or treatment on daily life, and review progress on goal achievement. Respond to gaps and change by facilitating appropriate follow-up.
  - Facilitate identification of individuals / whānau who receive care from multiple providers, in multiple settings (e.g., social, allied health, community medical, hospital medical, mental health, etc). Episodes of care transitions (e.g., hospitalisation), are important events when care coordination occurs. This enables resource alignment for those with the greatest need for high quality care coordination.
  - Provide tailored support and education for self-management that considers patient and whānau preferences, and other factors impacting the person / whānau wider determinants of health
- Facilitate and ensure a proactive Plan of Care (PoC) exists and is refined and updated, to accommodate latest information or circumstances, with input from the 'circle-of-care'/CPCT. The PoC covers the goals and needs of persons / whānau, including accountabilities and responsibilities for routine care tasks, and anticipates progression of medical needs.
  - Assist connections to available community resources and refer as required.
  - co-ordination of acute community care and responses which enables unnecessary hospitalisation, or facilitates and early supported discharge
  - facilitating identification of individuals / whānau at risk of hospitalisation or with complex health and social needs that would benefit from care coordination
  - assessing (incl. NASC assessment) or reviewing health and wellbeing needs, self-management knowledge and
- other factors impacting the person / whānau wider determinants of health
  - establishing a proactive care plan with CPCT in response to persons / whānau needs, aspirations and goals, including accountabilities and responsibilities for delivery to the plan and its review.
  - Supporting interdisciplinary team functioning and collaboration of the CPCT and other services

The education and qualification pathway are dependent upon professional registration of the person undertaking role. There are no specific pathways, however Case Management Australia and New Zealand have resources including self-assessment frameworks<sup>3</sup>.

There is no specific or required post-graduate training, but there is general agreement on value of competencies related to people / whānau centredness such as motivational interviewing, care planning and goal setting, advanced and effective communication, skills to support self-management and IDT facilitation.

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<sup>3</sup> [Case Management Society of Australia and New Zealand - Case Management Society of Australia & New Zealand & Affiliates \(CMSA\)](#)

There is opportunity for alignment with the framework and activities of care coordination outlined in the Care Coordination Measures Atlas (2014), and Case Management Australia & New Zealand - National Standards of Practice for Case Management, National Self-Assessment for Case Management Practice, National Code of Ethics for Case Management and National Skill Set for Effective Case Management in AUS & NZ (New Zealand)<sup>2</sup>. There are no other specific professional networks or organisations or key regulatory framework.

The current workforce is varied with challenges quantifying the workforce because of the diverse roles providing a care coordination function across the health system. There are a small number of care coordinators currently working in primary care, however these functions also

lie within Māori and Pacific providers, community health services, disability providers, mental health, and addiction providers and HBSS providers.

COVID-19 saw an increase in this role through the Care in the Community (CitC) hubs, attracting many nurses close to or recently retired back into the workforce. There is opportunity to refocus this workforce to that of CPCTs.

The care coordination facilitator, irrespective of their employer will work as an integral part of the CPCT. They will be actively involved in IDT meetings and processes, often facilitating IDT case meetings for identified individuals. They will have strong relationships across the health and well-being spectrum that involve 'diverse but dense' networks and relationships including with social sector agencies. When this role is defined as a

function of another role, for example an allied health or practice nurse, protected time is required to ensure other pressures do not take priority.

Key enablers for care coordination are access to digital tools for coordinating care, care planning and IDT functioning such as virtual meetings and access to records across the care continuum. Further tools include Risk Stratification tools to support targeting priority populations to support equity and hospital avoidance.

In addition to the attributes outlined within the CPCT, the following are attributes of teams where there is access through direct employment, or collaboration with employers of care coordination facilitators to form part of the CPCT.

Table 7: Attributes of a CPCT with Care Coordination Facilitator

1	Care Coordination facilitators, regardless of employer, are considered part of the CPCT with formalised agreement between employers when required that outline that agreement.
2	Care Coordination facilitators are an integral part of the IDT. They will attend (and often facilitate /lead) meetings of key people contributing to a person / whānau health and wellbeing (i.e., ‘circle of care’) and have full access to the electronic enablers of IDT.
3	Care Coordination facilitators within CPCT will have full read access to clinical notes as a minimum across the systems, preferably write access also.
4	Systems, processes, and actions of the CPCT recognise the expertise that care coordination facilitators bring in terms of coordinating the care for those with the greatest complexity of care needs, who require their care to be frequently transferred between providers and across services, which includes hospitalisations. Facilitating care coordination improves quality of care, reduces unnecessary hospitalisations (e.g., ASH rates), and reduces the risk of perpetuating the health inequities this population contends with.
5	Clear orientation and familiarisation within the CPCT have occurred with clarity of communication channels and responsibilities.
6	Strong relationships with hospital and specialist services, and community nursing, allied health and NASC, through the care coordination facilitation will focus on responsive hospital avoidance, extended, and planned care in the community including collaborations across iwi, Māori and Pacific providers, community, and social service agencies / NGOs. This may include undertaking Needs Assessments.
7	Tools and processes to stratify population needs to identify people / whānau with greatest need for high quality care coordination including those who receive care from multiple providers, in multiple settings (e.g., social, allied health, community medical, hospital medical, mental health, etc).
8	Commitment to facilitating and providing integrated and coordinated care that is responsive to the needs as identified by the person / whānau, including undertaking needs assessments.

Table 8: Minimum Requirements for care coordinator within a CPCT

Area	Requirement
Responsiveness	<p>Same day response is prioritised for all requests to facilitate timely and complete transmission of information and accountability for aspects of care, when a transfer of care occurs such as acute community care, early supported discharge, attending outpatient treatment, and necessary hospitalizations. This responsiveness aims to reduce unnecessary hospitalizations (e.g., reduce ASH rates), avoid re-hospitalizations and missed outpatient appointments (e.g., reduce DNA rates), and increase appropriate community-based care, closer to home.</p> <p>Coordination of services and supports is comprehensive and inclusive of CPCT, hospital and specialist services, community nursing and allied health, NASC, iwi, Māori and Pacific providers, and NGOs.</p>
IDT	<p>Arrange, facilitate, and lead, if required, IDT meetings to coordinate care among the ‘circle-of-care’ for people and whānau with complex needs, receiving care from multiple providers, in multiple settings.</p> <p>Ensure Plans of Care (PoC) are:</p> <ul style="list-style-type: none"> <li>• Interdisciplinary</li> <li>• Documented in agreed systems and shared with relevant parties, including the person (and their whānau where appropriate), as part of the ‘circle-of-care.’</li> </ul> <p>Facilitate and ensure a proactive Plan of Care (PoC) exists and is refined and updated, to accommodate latest information or circumstances, with input from the ‘circle-of-care’/CPCT. The PoC covers the goals and needs of persons / whānau, including identification of accountabilities and responsibilities for routine care tasks, and anticipates progression of medical needs.</p> <p>The PoC should include tasks that promote self-management, empower natural supports, and promote the ecosystem of supports for the individual and their whānau.</p>
Model of care	<p>Approach is mana enhancing for people and their whānau, and culturally appropriate.</p> <p>Plan of Care (PoC) is comprehensive and aligns with the “Objectives of CPCT” Section 5.</p>

### 6.3 Practice Pharmacist & Pharmacist Prescribers

The role of a practice pharmacist is within the pharmacist scope of practice but is not separately defined by the Pharmacy Council. The qualifications, experience, and attributes “deemed necessary” to work in a primary care team are described within the profession.

A Pharmacist Prescriber is a separate regulated scope of practice requiring specialised clinical, pharmacological, and pharmaceutical knowledge, skills and understanding relevant to a defined area of prescribing practice. This allows a Prescriber Pharmacist to provide individualised medicines management services, including the prescribing of medicines to patients across a range of healthcare settings and models.

Core activities for practice pharmacists are aligned with that described by the profession, including:

- medicines management and optimisation
- evaluation of safety and efficacy of pharmacological therapy against best practice guidelines, and relevant

clinical investigations e.g., ECG, laboratory results

- clinical outcome focus including modifying treatment and/or dosing as applicable
- prescribing of modified treatment (Prescriber scope) OR referral and recommendation to prescriber (if not a prescriber)
- deprescribing/rationalisation of unnecessary, harmful and/or potentially harmful treatments
- Identification, assessment and management of medication-related problems such as adverse drug effects/reactions, drug-drug interactions, drug toxicity
- medicine reconciliation. This is particularly important following transfers of care e.g., hospital admissions and discharges, or if seeing multiple prescribers e.g., outpatient specialist
- Supporting long term condition management through education, medication review, adherence assessment and repeat prescribing (Prescriber scope)

Practice pharmacists are also commonly involved in educating and supporting people to understand their medications, either on an individual basis or as part of multi-disciplinary group education sessions.

The education and qualification pathway for a pharmacist is a 4-year Bachelors’ degree through Auckland or Otago Universities. Registration with the Pharmacy Council of New Zealand requires one further year of supervised practice (intern pharmacist scope of practice). There are different pathways for overseas graduates.

Practice Pharmacist requirements are not clearly defined and vary – but commonly require interdisciplinary clinical practice experience. Postgraduate training through mandatory postgraduate/post-registration formal education pathways is not required to be a ‘practice pharmacist,’ although holding, or working towards a postgraduate clinical qualification (certificate, diploma) is preferred. The provision of some medicines may require additional training/credentialling in

accordance with their specific regulation (e.g., medicine classification).

Pharmacist Prescribers must complete a one-year post-graduate Certificate in Clinical Pharmacy in Prescribing, with a two-year postgraduate clinical diploma being a prerequisite for entry. This is followed by registration with the Pharmacy Council in the Pharmacist Prescriber Scope of Practice.

–The Pharmacy Council of New Zealand is the Responsible Authority. Professional networks and organisations include the Pharmaceutical Society of New Zealand (professional body) with regional branches, Māori Pharmacists Association, Pacific Pharmacists Association, Clinical Advisory Pharmacists Association (organisation closely aligned with practice pharmacists and primary care prescribers) and NZ Hospital Pharmacists Association (primarily for pharmacists working in hospitals – but includes primary care and community pharmacist members. Has special interest groups for some specific clinical areas).

Key regulatory frameworks that are important for the role of a Practice

Pharmacist includes Medicines Act and Regulations, Misuse of Drugs Act and Regulations, including controlled drugs permitted to be prescribed by pharmacist prescribers listed in Schedule 1B, Medicines (Designated Pharmacist Prescribers) Regulations 2013, Medicines permitted to be prescribed by a Pharmacist Prescriber listed in schedule and Health Practitioners Competence Assurance Act 2003 (HPCAA).

Whilst there are no specific clinical frameworks for practice pharmacists, the clinical use of medicines is guided by ‘best practice.’

The current workforce in primary care settings (excluding community pharmacy) as per 2021 Workforce Demographics (PCNZ) include pharmacists working primarily in: General practice: 45 (1%), PHOs: 35(1%), of which 26 are Pharmacist Prescribers.

As part of CPCT, the core knowledge and practice of pharmacists focuses on the safe and optimal use of medications. Pharmacists identify and support management of issues that can impact on

optimal medication treatment (individual, medication, and system-related factors). Pharmacists advise and support the patient/consumer’s understanding and experience of medication treatment, how it can affect their health and wellbeing – including lifestyle, how this can affect adherence, and issues that may occur with administering medications.

In the comprehensive team, they are a trusted source of knowledge and advice for managing treatment effectiveness, complexity, and actual/potential harms. They also conduct clinical reviews and audits of medication prescribing and treatment to support best practice.

Key enablers for Practice and Prescriber pharmacists include clinical leadership, agreed priorities, and agreed internal referral pathways within CPCT.

In addition to the attributes outlined within the CPCT, the following are attributes of teams where there is access through direct employment, or collaboration with employers of practice pharmacists to form part of the CPCT.



Table 9: Attributes of a CPCT with Practice Pharmacist

1	Practice Pharmacists, regardless of employer, are considered part of the CPCT with formalised agreement between employers that outline that agreement. This will include clarity on reporting lines and supervision of this role.
2	Practice Pharmacists, operate as part of the IDT. They attend meetings, have access to tasking, messaging systems and virtual meeting options and access to the clinical record for a minimum of read access, but preferably write access.
3	Systems, processes, and actions of the CPCT recognise the expertise that Practice Pharmacists bring as medicines specialists.
4	Clear orientation and familiarisation within the CPCT have occurred with clarity of communication and responsibilities.
5	Evidence of a focus on the effectiveness of treatment against best practice and clinical outcomes, through modifying treatment and/or dosing as applicable of medicines.
6	Pharmacists without prescribing scope task prescribers with recommendations for medicine modifications; or if prescriber scope, prescribes.
7	Practice Pharmacists support prescribers with deprescribing of unnecessary, harmful and/or potentially harmful treatments, and the assessment and management of medication-related problems such as adverse drug effects/reactions, drug-drug interactions, or drug toxicity.
8	Provide medication reconciliation, including compiling the most accurate list of a person's medication treatment, in addition to allergies and adverse drug reactions, comparing with what is documented – discrepancies documented and reconciled. This is particularly important following transfers of care e.g., hospital admission, or outpatient appointments.
9	Provide medicines education & advice, including adherence support at either individual or group levels. This includes lifestyle advice, and non-pharmacological management of conditions.
10	Prescribing Practice Pharmacists can support the management of persons and whānau with long-term conditions through repeat prescribing.
11	Provide clinical advice on pharmacotherapy to prescribers, and other health professionals within the CPCT.
12	Support quality improvement activities within the CPCT such as use of medicines, medication use, audit, and evaluation at a population level. This may include oversight of CPCT medicine policies.
13	Contribute to the Needs Assessment process where appropriate.

Table 10: Minimum Requirements for Practice Pharmacist within a CPCT

Area	Requirement
Focus on Equity and Hospital Avoidance	Prioritisation on supporting hospital avoidance through professional pharmacy services
IDT	Practice Pharmacists, regardless of employer, are considered part of the CPCT with formalised agreement between employers that outline that agreement when employed by different entities. Practice Pharmacists are considered an integral part of the IDT. They will attend meetings and have full access to electronic enablers of IDT. Practice Pharmacists within the CPCT will have full read access to clinical notes as a minimum across the systems, preferably write access. Clear orientation and familiarisation within the CPCT have occurred with clarity of communication channels and responsibilities
Professional	At a minimum for the first six months, new practice pharmacists are supported by professional clinical leadership and cultural support to deliver culturally appropriate care. Time is allocated within the CPCT for appropriate professional development, mentoring and support.
Clinical governance	Professional representation at a minimum of allied health, preferably profession-specific, forms part of CPCT clinical governance.

## 6.4 Physiotherapist

Practicing Physiotherapists can obtain registration under the following scopes of practice, general, advanced and specialist. Physiotherapists can refer to Radiology.

The core activities for Physiotherapists include the assessment, diagnosis, and treatment of various acute and chronic conditions including the provision of individualised exercise or rehabilitation

programmes, manual therapy, self-management, and education. This includes conditions including musculoskeletal, pain management, long term conditions, pelvic health, respiratory and neurological. Physiotherapists also have expertise in falls management, and pre and post operative prehabilitation and rehabilitation.

The education and qualification pathway for a Physiotherapist is a 4-year bachelor's degree. Registration is with the Physiotherapy Board of New Zealand.

Post-graduate training for advanced scope of practice, includes clinical training and demonstrated competence to practise clinically beyond the level of a general scope physiotherapist in a specified

vocational area. The advanced scope requires a minimum of a master's degree, is relevant to clinical physiotherapy practice; and at least five years of post-qualification full-time equivalent (FTE) clinical experience with at least three years of full-time equivalent clinical experience relevant to a nominated area of physiotherapy practice in the six-year period immediately prior to the date of the application.

Specialist Physiotherapists require a minimum of a master's degree where there is a Bachelor of Physiotherapy (or equivalent) for entry to the degree programme; is relevant to clinical physiotherapy practice; and successful completion of the assessment set by the Physiotherapy Board for registration as a Physiotherapy Specialist. The scopes of practice for a Specialist Physiotherapist currently available include the following defined fields of practice: Cardiorespiratory, Pelvic Health, Hand Therapy, Musculoskeletal, Neurology, Occupational Health, Older adults,

Paediatrics, Pain, and Sports. Additionally, there are post-graduate qualifications available including, but not limited to, Pain and Pain Management, Musculoskeletal Management and Acupuncture.

Professional networks and organisations include the Regulating Authority – Physiotherapy Board of New Zealand, Physiotherapy New Zealand, Tae Ora Tinana (Māori physiotherapists), New Zealand Manipulative Physiotherapists Association and Sports & Exercise Physiotherapy New Zealand.

The key regulatory frameworks include Health Practitioners Competence Assurance Act 2003 (HPCAA), The Code of Health and Disability Services Consumers' Rights 1996. Physiotherapists can administer medication under standing orders: Medicines Act 1981, s 3(c) (i)(ii) and NZ Government Medicines Regulations (Standing orders) 2002.

The specific clinical frameworks for Physiotherapy practice thresholds

“Physiotherapy Thresholds – Physiotherapy Board<sup>4</sup>,” “Physiotherapy Standards – Physiotherapy Board and Physiotherapy Code of Ethics<sup>5</sup>,” and Professional Conduct Code of Ethics and Professional Conduct.

There are currently approximately 7500 registered physiotherapists in NZ in 2021-22, with just under half Physiotherapy New Zealand members. Of the 6038 holding an annual practising certificate as of 31/3/22, 13 are registered as 'Specialist' scope- 7 of which are MSK specialist. 55% work in private practice (business owner/employee); 27% in hospital/health service.

Current funding models are usually based on FTE, employed by Te Whatu Ora, PHOs, private clinics, or contracting of private services to a primary care provider. ACC, and private insurance companies are alternative sources of funding (often with surcharges) for physiotherapy services.

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<sup>4</sup> [Physiotherapy Thresholds – Physiotherapy Board \(physioboard.org.nz\)](https://physioboard.org.nz)

<sup>5</sup> [Code of Ethics and Professional Conduct – Physiotherapy Board \(physioboard.org.nz\)](https://physioboard.org.nz)

As part of CPCT, the core knowledge and practice of physiotherapist can enable this role to take on the first assessment for a range of clinical presentations. Physiotherapists focus on assessment, diagnosis, treatment, and rehabilitation for a range of musculoskeletal, neurological, respiratory, and pelvic health conditions as examples. They have a strong role with the prehabilitation and post operative rehabilitation, especially to conditions such

as osteoarthritis and other areas where deconditioning is present.

Physiotherapists provide both group and individual programmes, where education and support of a self-management approach is a key focus.

Consideration of introducing the role of Physiotherapist into a CPCT is the interface with ACC funded services, where

physiotherapists already act as the first specialist assessing clinician.

In addition to the attributes outlined within the CPCT, the following are attributes of teams where there is access through direct employment, or collaboration with employers of physiotherapists to form part of the CPCT.

**Table 11: Attributes of a CPCT with a Physiotherapist**

1	Physiotherapists, regardless of employer, are considered part of the CPCT with formalised agreement between employers that outline that agreement. This will include clarity on reporting lines and supervision of this role.
2	Physiotherapists operate as part of the IDT for the CPCT. They attend meetings, have access to tasking, messaging systems and virtual meeting options and access to the clinical record for a minimum of read access, but preferably write access.
3	Systems, processes, and actions of the CPCT recognise the expertise that Physiotherapists bring within their scope such as assessment, diagnosis, requestor of diagnostics and / or treatment.
4	Clear orientation and familiarisation within the CPCT have occurred with clarity of communication and responsibilities.
5	Can provide planned care activities such as musculoskeletal interventions, pre and post operative rehabilitation at either individual or group levels.
6	Provide clinical advice on rehabilitation and management of long-term conditions to other health professionals within the CPCT.
7	Contribute to the Needs Assessment process where appropriate.

Table 12: Minimum Requirements for Physiotherapist within a CPCT

Area	Requirement
Focus on Equity and Hospital Avoidance	Prioritisation on supporting hospital avoidance through professional physiotherapy services.
IDT	<p>Physiotherapists working within a CPCT, regardless of employer, are considered part of the IDT with formalised agreement between employers that outline that agreement.</p> <p>Physiotherapists are considered an integral part of the IDT. They will attend meetings and have full access to electronic enablers of IDT.</p> <p>Physiotherapists within the CPCT will have full read access to clinical notes as a minimum across the systems, preferably write access also.</p> <p>Clear orientation and familiarisation within the CPCT have occurred with clarity of communication channels and responsibilities.</p>
Models of Care	<p>Consideration of role as first assessor for people presenting to CPCT for at a minimum, reported musculoskeletal issues.</p> <p>Line of sight between prescribed activity programme and kaiāwhina input where relevant.</p>
Professional	<p>At a minimum for the first six months, new physiotherapists into CPCT are supported by professional clinical leadership.</p> <p>Time is allocated within the CPCT for appropriate professional development, mentoring and support.</p>
Clinical governance	<p>Systems, processes, and actions of the CPCT recognise the expertise that physiotherapists bring to CPCT.</p> <p>Professional representation at a minimum of allied health, preferable profession specific forms part of CPCT clinical governance.</p>

## 6.5 Extended Care Paramedic (ECP)

Job titles include Extended Care Paramedic (in ambulance services and primary care) and Advanced Community Paramedic (in primary care).

The Paramedic scope of practice is broad and enabling. As defined by Te Kaunihera Manapou, Paramedics are registered health practitioners who use their clinical knowledge, skills, and judgement to provide healthcare services primarily in the provision of urgent and/or emergency assessment, diagnosis, and treatment of patients, including provision of clinical advice, referral and, where required, transport. The Extended Care Paramedic (ECP) role falls within the Paramedic scope of practice and is not separately defined by Te Kaunihera Paramedic Council.

The core activities and opportunities within CPCT may include:

- clinical assessment and treatment for people requiring urgent care and same day appointments (including out of hours)
- the provision of treatments such as urinary catheterisation, wound closure, management of constipation, and supply of oral antibiotics
- telephone triage to determine who needs to be seen face-to-face, how quickly and by whom, and managing appropriate clinical problems over the phone
- telephone consultations for people who do not need a face-to-face assessment
- managing simple repeat prescription requests
- lead in provision of care to those with life-threatening/time-critical conditions
- working alongside other clinicians to monitor the Practice inbox, determining which referral letters and test results require follow up, and filing documentation that does not require further action
- providing home visits if required to increase access to care
- support hospital avoidance in those recently discharged and providing treatment to enable people to stay well in their own home.

The education and qualification pathway for ECPs (Extended Care Paramedics) involves completing a Postgraduate Diploma in Health Science (Paramedicine) with ECP specialisation, after gaining experience as a paramedic working in an emergency ambulance service.

To work as an ECP in an ambulance service, paramedics must have obtained (or be about to obtain) an ECP role and are required to complete a clinical internship (period of supervised clinical practice) over 6-9 months. After an internship has been completed, ECPs are authorised to utilise the Ambulance Sector ECP Clinical Procedures and Guidelines (available [here](#)). The Clinical Procedures and Guidelines function as Standing Orders, enabling ECPs to administer/supply a range of medicines interventions.

The ECP role in primary care is very new, and requirements for on-the-job clinical supervision and support are not tightly defined. ECPs newly employed in primary care have preferably worked for at least five years in an emergency ambulance

service. ECPs in primary care typically undergo a period of mentoring and clinical supervision within the Practice, over at least 6-months. This enables ECPs to become familiar with the primary care context, develop their clinical assessment skills, become proficient with skills and procedures (e.g., wound care), and providing autonomous care for people with urgent and unscheduled health needs. Clinical support and supervision usually involve a combination of case review, audit of clinical notes, ECPs' consultations being observed, and protected 1-1 time with a clinical supervisor for teaching. Training in the use of Standing Orders issued to the ECP is also required.

Continuing professional development (CPD) requirements for ECPs involves the completion of 30-hours of CPD within each APC renewal year.

Te Kaunihera Paramedic Council is the Regulating Authority, and the professional bodies include the Australasian College of Paramedicine and Australasian College of Paramedic Practitioners (ACPP).

ECPs use key regulatory frameworks including:

- Standing Orders Regulations: Standing Orders enable ECPs to administer/supply prescription medicines and must be issued by a medical or nurse practitioner. The ECP Clinical Procedures and Guidelines used by ambulance services (which function as Standing Orders) are available [here](#). These can be utilised by CPCT if required.
- Misuse of Drugs Act and Regulations: Enables controlled drugs to be carried by ECPs and sets legislative requirements relating to the handling, recording, administration, and disposal of controlled drugs.

The current workforce is approximately 1800 practising paramedics in NZ, with 60 ECPs working in the ambulance service and 15 in primary care. There are also 8 paramedics working in primary care.

ECPs employed by ambulance services are centrally funded by the National Ambulance Sector Office (NASO). Service provision within primary care/urgent care is only partially funded and remaining costs

are met by the Practice. Examples of funding sources include urgent care clinic/after-hours consultation fees, general practice co-payments, General Medical Services (GMS) funding, immunisations, and POAC (Primary Options for Acute Care) funding.

As part of CPCT, the core knowledge and practice of ECPs is valuable, especially in rural areas. Within a CPCT, ECPs provide ability to scale up (or commence) telephone triage services, see people requiring same day appointments, and provide in and out of hours urgent care. Their expertise and experience in providing mobile care in the community supports both health community health screening and home visits to support hospital avoidance for whānau at greatest risk of hospitalisation. The ability for ECPs to administer and supply medicines using an extensive set of Standing Orders enhances the contribution to the CPCT and supports top of scope working for GPs (General Practitioners) and NPs (Nurse Practitioners). Given their expertise in acute care, ECPs are regularly utilised to manage clinical emergencies within the

practice, including taking the lead when required.

At a Practice level, key enablers include role clarity for ECPs (avoiding replication of other roles), enabling ECPs to learn about the role of each person in the CPCT, a comprehensive induction, and ensuring an adequate period of clinical supervision (at least 6-months). Clinical supervision should include regular, protected GP/NP time for case review, audit, 1-1 teaching, and observing ECPs' consultations. It is also important that ECPs are issued with fit for purpose Standing Orders that enable them to be utilised to their full potential.

Key system-related enablers for this role as part of CPCT includes resolving current funding and system barriers such as:

- Paramedics not being listed as authorised treatment providers in ACC (Accident Compensation Corporation) Cost of Treatment Regulations. This means Practices cannot claim for treatment provided to ACC clients by ECPs, and ECPs cannot respond to PRIME calls because PRIME is co-funded by ACC.
- Paramedics not being able to refer people for basic diagnostics (e.g., plain film x-rays).

- Paramedics not included in the list of approved professions to refer people for laboratory investigations.
- There is variability to whether paramedics working in primary care are approved by local Medical Officers of Health to become authorised vaccinators.

In addition to the attributes outlined within the CPCT, the following are attributes of teams where ECPs are directly employed, or where ECPs are utilised via collaboration with other employer of ECPs (e.g., ambulance services) to form part of the CPCT.



Table 11: Attributes of a CPCT with an ECP

1	ECPs, regardless of employer, are considered part of the CPCT with formalised agreement between employers that outline that agreement. This will include clarity on reporting lines, clinical governance (e.g., Standing Orders, audit, management of clinical complaints, clinical supervision), and role of the ECP in the CPCT.
2	ECP operates as part of the IDT for the CPCT. They attend meetings, participate in CPCT teaching sessions, and have access to tasking, messaging systems and virtual meeting options, and access to the clinical record for a minimum of read access, but preferably write access.
3	Clear orientation, induction, and familiarisation within the CPCT have occurred with clarity of communication and responsibilities.
4	<p>Systems, processes, and actions of the CPCT recognise the expertise that ECP bring within their scope such as:</p> <ul style="list-style-type: none"> <li>• Undertaking phone triage to determine which people need to be seen face-to-face, how quickly, and by whom, and managing appropriate clinical problems over the phone.</li> <li>• Providing comprehensive clinical assessment and treatment for people requiring urgent care, both independently (including treatment, referral, and discharge decisions) and in consultation with other clinicians, as appropriate.</li> <li>• Providing unscheduled primary care to people who require a same day appointment.</li> <li>• Providing extended care to enable people to be clinically managed in the community, for example urinary catheterisation, wound closure, management of constipation, and supply of oral antibiotics.</li> <li>• Providing care to patients in the Practice with life-threatening/time-critical conditions, including taking the lead when required.</li> <li>• Providing phone consultations for people who do not require a face-to-face assessment.</li> <li>• Managing simple repeat prescription requests.</li> <li>• Working with other clinicians to monitor the Practice inbox. Determining when follow up of test results and referral letters is required and filing documentation that does not require further action.</li> <li>• Providing home visits to people who are clinically inappropriate to be seen in the Practice and in cases where transport is a barrier.</li> <li>• Assessing people post-discharge who are at risk of re-admission and providing treatment to enable them to stay well in their own home.</li> <li>• Supporting local rural ambulance responses, where required.</li> <li>• Providing education/information regarding the management of high acuity patients.</li> </ul>
5	<p>Opportunities that can be explored include:</p> <ul style="list-style-type: none"> <li>• Enabling Practices to commence or scale up phone triage. This could reduce wait times for face-to-face appointments and enable simple clinical problems to be resolved without patients having to come into the practice.</li> <li>• Provision of same-day appointments and urgent care, where the current capacity to offer this is limited.</li> </ul>

	<ul style="list-style-type: none"> <li>• Provision of after-hours care, particularly in areas where existing health professionals are unavailable or the capacity to provide after-hours care is limited.</li> <li>• Providing mobile care in the community, e.g., home visits.</li> <li>• Utilising ECPs in rural areas to respond to PRIME incidents in the future (once paramedics are added to ACC Cost of Treatment Regulations), to reduce pressure on other clinicians and enable sustainability of the PRIME service.</li> <li>• Providing health screening in the community in a culturally appropriate way, e.g., at marae or Pacific health clinics.</li> <li>• Informally train other members of the primary care team in the management of high acuity patients, increasing capability to manage time-critical/life-threatening conditions.</li> <li>• After developing extensive experience in primary care, utilising ECPs to support practices with the management of chronic conditions.</li> <li>• Paramedic prescribing (if prescribing is added to the paramedic scope of practice in the future), to enhance access to essential medicines for people and whānau, and to ensure accountability and transparency of role and function.</li> </ul>
6	A period of mentoring and clinical supervision (typically at least 6-months) enables ECPs to become familiar with the primary care context, develop their clinical assessment skills, and become proficient in providing autonomous care. This usually involves a combination of case review, audit of clinical notes, observing ECPs' consultations, and protected time with the clinical supervisor for teaching.
8	Contribute to the Needs Assessment process where appropriate.

Table 12: Minimum Requirements for ECP within a CPCT

Area	Requirement
IDT	<p>ECP working within a CPCT, regardless of employer, are considered part of the IDT with formalised agreement between employers that outline that agreement.</p> <p>ECP are considered an integral part of the IDT. They will attend meetings, teaching sessions, and have full access to electronic enablers of IDT.</p> <p>ECP within the CPCT will have full read access to clinical notes as a minimum across the systems, preferably write access. Clear orientation and familiarisation within the CPCT have occurred with clarity of communication channels and responsibilities.</p>
Models of Care	Consideration of how this role contributes to the CPCT. ECPs commonly support the provision of urgent and unscheduled care.

Professional	For at least six months, new ECPs are supported and mentored by a designated clinical supervisor, including culturally appropriate care. Protected time is allocated within the CPCT for appropriate professional development, mentoring and support.
Clinical governance	Systems, processes, and actions of the CPCT recognise the expertise that ECPs bring to CPCT. Clinical supervision, support, and mentoring for ECPs forms part of CPCT clinical governance to ensure the provision of safe and effective care.

### Generalist paramedics:

Primary care teams may decide to utilise 'generalist' paramedics who have not completed postgraduate education (to become an ECP), in addition to/instead of utilising ECPs. Paramedics moving into primary care should have at least two years of experience working in an emergency ambulance service.

Paramedics have less clinical responsibilities than ECPs. They assess, treat, and refer people in consultation with other health professionals and provide initial assessment and treatment prior to the person being seen by a GP or nurse practitioner. Examples of roles that paramedics perform in CPCT include:

- Providing face-to-face triage to determine how quickly a person needs to be seen (for example, in an urgent care clinic).

- Providing initial face-to-face clinical assessment and initiating treatment (as per Standing Orders) prior to the person being seen by another clinician such as a nurse practitioner or GP.
- Supporting the CPCT with clinical tasks, for example IV cannulation, administering medicines, setting up infusions, and performing health checks (e.g., HbA1c, blood pressure) and vaccination.
- Providing home visits where transport is a barrier to access, on behalf of/in conjunction with other health professionals. This could include setting up a telehealth consultation between the person and a GP/NP from the person's home.

Paramedics do not usually require as much clinical support or supervision as ECPs (3-months is usually sufficient), however this

depends on the exact role of the paramedic within the care team.

Paramedics may be completing postgraduate education to become an ECP. As paramedics become more experienced and skilled in primary care and complete postgraduate papers, they commonly progress to undertaking more 'ECP-like' roles and responsibilities. For example, making autonomous treatment and referral decisions for simple presentations without the person needing to be seen by a GP or NP, and managing simple clinical problems over the phone when performing phone triage. Role evolution and progression to top of scope working relies on high trust and solid relationships between the paramedic and clinical supervisor.

## Section 7: Refocusing community nursing, allied health and NASC

There is wide variability in the integration and connection of community nursing, allied health and NASC services with other members of primary and community care teams, with many teams being poorly connected. This section introduces the planning and processes to re-orientate community nursing, community allied health and NASC services to be part of newly establishing CPCTs.

This section provides background information and the current situation of Te Whatu Ora and other community nursing, allied health and NASC services, describes the drivers and objectives for change that the proposed development has in conjunction with the newly developing comprehensive primary and community care teams. Although priority focus will be given to the prototype Localities, it is proposed that a phased change management approach will be suitable across the rest of the motu as comprehensive teams are developed.

**Background.** Te Pae Tata identifies that the strengthening of primary and community

care is one of our opportunities to reduce the risk and burden of disease, reduce demand for more costly and intensive specialist care, and achieve better and more equitable health and wellbeing outcomes for all New Zealanders. Extending the primary and community care team to include a more comprehensive workforce, allows a broader range of services to be delivered from within the community setting and address clinical and social complex needs earlier.

With these developments, there is opportunity to refocus Te Whatu Ora and other employed community nursing, community allied health and the Needs Assessment and Service Coordination services to be more connected and part of comprehensive primary and community care teams. For clarification, the NASC services described in this paper relate to those undertaking age-related assessments and service co-ordination.

Initial approaches to the refocusing of community nursing, community allied

health staff and NASC (older adult) staff, assumes that the main cohort of health workers being considered are employed by Te Whatu Ora hospital and specialist services with these staff being the focus of this reorientation.

The initial approach will focus on a subset of community nursing and allied health workforce only as per section 7.3. It is noted there is a wider group of community nurses and allied staff, including other specialist nurses that may work across hospital and community settings. There are also community nurses and allied staff that work in other services i.e., community trusts, NGOs, or primary care.

This development from the Early Actions Programme can provide a framework and standard approach to bring together the broader collective of community health professionals to comprehensive primary and community care teams in the future. It has been assumed that the refocus of services does not include changes to employment for any personnel, instead

following principles of working in different ways.

## 7.1 Drivers for Change

There are numerous drivers and advantages of refocusing teams to integrate with others when they currently function more separately. The following are the rewards cited in international and national literature.

- Intensifies resources where needed most
- Promotes diversity and equity
- Builds relationships and trust
- Increases understanding of roles, and capability
- Improves the ability to share tasks
- Increases collective impact
- Gives more opportunity for skill and knowledge sharing and growth
- Improves collective problem solving
- Increase collective knowledge and networks
- Improves seamless healthcare experience
- Fosters idea generation, creativity, and opportunities to enhance focus of care i.e., hospital avoidance
- Enhances motivation, boosts morale

## 7.2 Objectives of Change

There are some additional key objectives of refocusing of community nursing, allied health and NASC teams as part of comprehensive teams, as sited in the Pae Ora legislation, Te Pae Tata, and Budget '22.

**Te Tiriti** - There is the priority focus for reorientated community nursing, allied health and NASC services as part of comprehensive teams to understand and embed Te Tiriti as the foundation for care delivery. This means placing Te Tiriti at the forefront of thinking, understanding, and providing opportunities to enact Te Tiriti principles and articles to improve health outcomes for Māori at every opportunity. Comprehensive teams will grow Māori leadership, workforce, safety, and services. Refreshed and refocused teams with updated specifications detailing Te Tiriti obligations.

**Impact on Equity** - The collective understanding and focus of the reorientated services as part of comprehensive teams will be to deliver health services that give all new Zealanders the opportunity to achieve good health and wellbeing outcomes, regardless of who

they are or where they live. This will require a sustained priority focus on Māori, Pacific, Tāngata whaikaha and rural people and their communities. Refreshed and refocused teams with updated specifications detailing requirements.

**Population Health** - The refocused teams as part of comprehensive teams will support a population health approach, shifting the system focus, including their own, to prevent illness and improve the health and wellbeing of local communities. The teams will recognise that people's health can be achieved by collaboration with other providers, communities, working together to plan, design and deliver health services.

**Sustainability** - The refocused teams will achieve sustainability and affordability with an operating model that reduces bureaucracy and duplication. They will act to innovate and redesign how care is delivered, including digital technologies to ensure health service investments contribute the greatest value.

### 7.3 Phasing the reorientation of community nursing, allied health and NASC to join CPCT

Insights from the EAP has affirmed that a phased approach to changing the orientation of community nursing, allied health and NASC services will achieve the required outcomes and support the intent of Te Pae Tata.

The following staged phasing for Te Whatu Ora community nursing, allied health and NASC services and roles is as follows:

- District Nursing, and any associated service that supports hospital avoidance or early discharge.
- Social Workers, as a key enabler in equity and addressing the social determinants of health in primary and community care.

- Physiotherapists, as a key workforce to extend primary and community care and offer a workforce that can both diagnose and treat a range of health conditions. i.e., MSK packages of care
- Occupational Therapists, as a key hospital avoidance and early supported discharge workforce, addressing environmental needs that could precipitate hospitalisation.
- Dietitians have a strong role to play in early intervention for those at risk of long-term health conditions.
- Needs Assessment Service Coordination, to support access points for earlier services in the community and where relevant aged care.
- Other community nurses, whose roles are often specialists and bring the

ability to share knowledge, bring specialist knowledge to the generalist workforce. They have a strong opportunity to facilitate skill sharing across all roles, including non-regulated and kaiāwhina.

Having detailed a phasing approach to refocus these roles and services, it is acknowledged that the starting point for each district or locality would be different, based on their current state. Priority in the districts will be based on those roles that contribute to hospital avoidance, and early planned discharge. Individualised and planned phasing will also enable wider integration for those localities ready for further development if these roles are already integrated.

**Table 13: Attributes of a refocused community nursing, allied health and NASC**

1	Increased focus on Te Tiriti; equity; population health and sustainability.
2	Services operate with a shared primary and community locality vision, aligned to Pae Ora.
3	Whānau ora approaches with localised, equity focussed models of care evident.
4	Hospital avoidance, including early supported discharge is prioritised as an acute, same day response for the extended CPCT
5	Active support for other services such as ARC (Aged Residential Care) and HBSS (Home Based Support Services) with skill acquisition to support hospital avoidance and early supported discharge
6	Community nursing and allied health personnel work closely with the CPCT and as an equal partner within the IDT to support the mahi, including but not limited to skill sharing and task delegation.
7	The outcomes of NASC assessment are available to the extended CPCT with prioritised access to assessment and information to support hospital avoidance with information available to the extended CPCT
8	Equal participants in the IDT systems and processes with clear agreement between parties. Virtual access options are available where required and electronic tasking is in place.
9	Deliberate focus on skill sharing and the move to increased utilisation of the unregulated health workforce and kaiāwhina through delegation and inclusion into the IDT.
10	Refocused services participate in CPCT clinical governance, clinical leadership, and peer support activities.
11	Hospital avoidance and early supported discharge activities are enabled using IT enablers such as shared care plans; shared records; electronic tasking; telehealth; and remote clinical monitoring.
12	Where possible, co-location with primary care or operating out of bases within the community. If this is not possible, access for virtual IDT participation.
13	Simplified models for some communities and whānau / intensified for other high need communities and whānau
14	Services for community nursing and allied health are available seven days a week.

Table 14: Minimum Requirements for refocused community nursing, allied and NASC

Area	Requirement
Responsiveness	Hospital avoidance services remain top priority for refocused teams, alongside equity.
IDT	<p>Access to view electronic clinical documentation within both community and primary care settings. Preference to write into single electronic patient record, such as PMS.</p> <p>Refocused services can task and message within the wider CPCT and services.</p> <p>Participation in CPCT daily stand-up meetings and IDT meetings.</p>
Roles	<p>Specific attention focused on understanding the roles, scope, functions of the whole CPCT with refocused services with attention to:</p> <ul style="list-style-type: none"> <li>• Top of scope practice as a priority for all</li> <li>• Internal pathways, tasking, accountabilities, and messaging are clarified.</li> </ul>
Model of care	Is based on an IDT approach.
Clinical governance	CPCT clinical governance structures and processes included that for refocused community nursing, allied health and NASC.



## Section 8: Extended Care

Te Pae Tata 2022 requires a focus on hospital avoidance, as part of delivering the right care, to the right person, in the right setting, at the right time. The increased capability of CPCTs to provide acute care can be achieved by adequate resourcing, an ethos of high trust and low bureaucracy, phone and virtual support from specialist services, and gains in skill and knowledge from a comprehensive education programme.<sup>6</sup>

This Framework defines hospital avoidance as the provision of care in a person's permanent or temporary residence for health needs requiring clinical governance, monitoring and / or input that would otherwise require treatment in a 'traditional hospital.'

This focus on hospital avoidance includes the targeting of people that are acutely unwell, but who can safely be managed in the community, those at risk of hospitalisation or readmission, and those

people who are suitable for early supported discharge:

- The provision of safe, high quality hospital comparable care in the person's home including access to allied health and care for paediatric, elderly, and mental health patients supported by appropriate models of care.
- People on hospital avoidance programmes receive safe, high-quality care, delivered by a highly skilled workforce.
- That people and whānau develop greater autonomy and health literacy with their health care through partnering CPCT in deciding how and where their health care is to be delivered.
- Individuals and their whānau experiencing culturally and environmentally safe delivery of care.

Hospital avoidance programmes as part of extended care provided by CPCT and refocused community nursing, allied health and NASC services can support the health system to manage increased demand on acute services by matching resource needs of unwell persons with their clinical requirements, thus reserving highly resourced acute hospital beds for patients of appropriate complexity.

Service coordination and involvement of community, ambulatory and other health programs maximise access, reduces duplication and increases continuity of care for the patient. It is expected that there will be at times persons supported on hospital avoidance programmes that are already receiving care coordination and support by HBSS. In such cases the HBSS is expected to act as an integral part of the CPCT, taking the care coordination lead supported by CPCT personnel, unless agreed otherwise with the CPCT.

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<sup>6</sup> Hospital avoidance: an integrated community system to reduce acute hospital demand | Primary Health Care Research & Development | Cambridge Core

Table 15: Attributes of hospital avoidance within CPCT

1	Hospital avoidance programmes replace an admission to hospital in its entirety or a component of a hospitalisation.
2	Care provided in such programmes is comparable to that the person would have received as an inpatient and meets the person's needs, noting that there may be different service deliveries required within their home or aged care facility if relevant.
3	People on such programmes will require regular clinical intervention or assessment, with clear accountabilities and responsibilities within the extended CPCT. Support and interventions for persons on this programme receive priority focus from all team members.
4	Clinical governance is in place to provide transparent monitoring, reporting, leadership, advocacy, and clinical risk management, with representation from all clinical levels and professionals within the extended CPCT.
5	<p>Assessment and care are provided through an IDT approach:</p> <ul style="list-style-type: none"> <li>• Across a range of settings including the persons or whānau home, aged care facility, practice, or urgent care facility</li> <li>• Clinical teams are well-equipped and mobile, working in a responsive manner</li> <li>• Access to additional nursing assessments by appropriately trained nurses</li> <li>• With access to rapid diagnostics including radiology, ultrasound, ECG, and blood tests with results made available to clinical teams on same priority as if in the hospital, including point of care testing</li> </ul>
6	<p>Care is coordinated with:</p> <ul style="list-style-type: none"> <li>• Clear lines of responsibility for the clinical management of those on the programme is essential to ensure care is coordinated, and a clinical management and treatment plan established, implemented, and monitored. Clarity across team members regarding accountability at any point in time is essential.</li> <li>• Escalation plans that have been agreed with clinical teams are in place and visible to CPCT members.</li> <li>• Hospital and Specialist services taking responsibility for case finding for appropriate individuals and liaising with care coordination for the planning to support early discharge from hospital</li> </ul>
7	People are admitted into this service to provide clarity regarding the need level. Unless otherwise determined, the clinical accountability lies with the relevant personnel in the CPCT.
8	Specialist phone support is available for the clinical team and for individuals and their whānau is accessible 24/7.
9	<p>With the CPCT there is a centralised view on intake of people into the services to:</p> <ul style="list-style-type: none"> <li>• Deliver effective streaming.</li> <li>• Simplify decision making for referrers.</li> <li>• Risk assessment and prioritisation tools underpin need for more detailed assessments.</li> <li>• Documentation is standardised for clinicians working across multiple CPCT supporting hospital avoidance and to reduce duplication.</li> <li>• IDT and planning meetings are held and include where applicable the person and their whānau, or their hospital and specialist services team for transition planning.</li> </ul>

Table 16: Minimum Requirements for hospital avoidance within CPCT

Area	Requirement
Responsiveness	<p>Evidence of effective selection includes criteria such as:</p> <ul style="list-style-type: none"> <li>• clinical stability</li> <li>• provision of equivalent care</li> <li>• safe and appropriate environment</li> <li>• carer support</li> <li>• consent to service</li> <li>• location of care</li> </ul> <p>There is provision of medical review to occur in the home as necessary</p>
IDT	<p>Access to view electronic clinical documentation across community primary care and hospital settings. Preference to write into single electronic patient record, such as primary care PMS.</p> <p>IDT can task and message within the wider CPCT and services.</p> <p>Participation in CPCT daily stand-up meetings and IDT meetings.</p> <p>Selection of individuals and whānau is limited exclusively to those whose acute treatment and care needs will be safely met by the extended CPCT.</p> <p>People will not be disadvantaged by being on this service, resulting in unmet needs due to the limited range of service, or inadequate specialist medical oversight.</p> <p>Provision of nursing allied health, and medical review appropriate to the model of care is available.</p> <p>24-hour emergency telephone support and access to a face-to-face review is available.</p> <p>Ensure provision of pharmaceuticals to the home is available and there is access to rapid diagnostics including radiology and laboratories, portable diagnostics such as ultrasound and remote clinical monitoring of those persons with highest risk of admission.</p> <p>There is evidence of an interdisciplinary approach through collaborative goal setting and shared resources.</p> <p>Clarification where an ACP or EPOA (Enduring Power of Attorney) are present and activated.</p> <p>Evidence of avoidance of duplication of information collection for example use of information already collected and held elsewhere such as medication alerts and falls risk assessment from hospital.</p>

Workforce	Specific attention focused on understanding the roles, scope, functions of the whole CPCT about hospital avoidance with attention to: <ul style="list-style-type: none"> <li>• Top of scope practice as a priority for all</li> <li>• Internal pathways, tasking, accountabilities, and messaging are clarified.</li> </ul>
Model of care	There are policy and practice processes across the extended CPCT to promote effective patient selection for safe, high-quality acute care in the home setting, including enabling direct admission from ED (Emergency Department) or early discharge from hospital. Monitoring of health status will utilise where appropriate digital enablers with a view to manage risk and empower people and their whānau.
Clinical governance	Provides oversight on quality and risk of hospital avoidance programmes including risk mitigation, and occupational health and safety for staff.

## Section 9: Clinical Governance

For the purposes of this Operating Framework Clinical Governance refers to the governance clinical of clinical and quality matters. It is expected that existing structures will be built upon, or if absent, then guidance for the establishment of structures will be part of the change support process for implementing CPCT.

Clinical governance, including continuous quality improvement for CPCT is a priority, with greater intensity required during the period of change to address any issues and risks with transition.

CPCTs are required to have a governance group made up of key stakeholders, who participate in an ongoing review of

performance of the CPCT. The governance group is responsible for ensuring that quality care is provided and that the team are responsive to needs. It is expected that these groups will be able to monitor, review and report regularly, providing up to date information on issues which affect service delivery, preferably using integrated IT systems where common sets of outcome measures are captured and utilised by the CPCT for continuous quality improvement.

Clinicians and healthcare organisations working within the structure of CPCT must have robust clinical governance structures in place. Clinical governance structures must ensure that quality and safety are

monitored, significant events are reviewed and analysed, and opportunities for quality improvement are identified and implemented.

As with any change process, there can be associated risks where there are changes in roles, responsibilities and processes are not fully established, and information (IT) systems are not well integrated. Further challenges exist to ensure we meet our obligations to Māori, Pacific, and tāngata whaikaha as stated within the Pae Ora legislation. Clear, effective, and consistent governance for quality and safety is critical in this context. This section provides guidance on clinical governance for CPCT.

## 9.1 Approach

It is expected that while the articles of Te Tiriti o Waitangi provide the constitutional settings for Clinical Governance the new principles following the Wai 2575 claim provide some practical guidance for the establishment of local quality and safety governance groups. Further expectation is that Clinical Governance systems and structures are aligned with any current Health, Safety and Quality Commission guidance. These principles should be applied collectively and include:

Principle of Partnership	Partnering and shared decision making for quality and safety is informed by Māori experiences and Māori provider knowledge.
Principle of Options	Quality includes having available viable Kaupapa Māori services so that Māori are not disadvantaged by the lack of choice.
Principle of Tino Rangatiratanga	Ensuring that Māori have the “right to autonomy” and to manage the full range of their affairs in accordance with their own tikanga.
Principle of Active Protection	Actively protecting, supporting, and empowering Māori receiving services, and Māori organisations to provide services that support wellbeing.
Principle of Equity	Provision of culturally and clinically responsive mainstream services that are equitable in terms of access, process, and outcomes. Power and control are shared equitably by Māori and non-Māori

### Wai 2575 Te Tiriti o Waitangi Principles

The role of a quality and safety governance group must be grounded in the strategic direction for the CPCT. Part of the objective of this group is to ensure that processes and systems are in place to deliver high quality, coordinated, culturally safe, and responsive care that is continuously monitored and improved. The group with designated responsibility should meet regularly and adjust frequency of these meetings as systems are embedded and should be developing and monitoring a set of measures relevant to the CPCT.

## 9.2 Guiding values and principles

A set of values and principles are suggested the CPCT clinical governance groups. These include:

- whānau at the centre – people and their whānau receive safe, culturally tailored, high-quality care
- open and transparent culture – individuals/whānau and staff feel safe and are encouraged to express their views and speak up when care is not at expected standards
- accountability – all organisations and individuals are clear about their responsibilities for quality and safety
- privacy and trust are paramount – the health and welfare information of whānau should be treated with respect, following all protocols for ensuring data quality, governance, sovereignty, privacy, and confidentiality.

### Membership and chairperson

Providers working in collaborations to deliver CPCT should undertake a partnership approach to leadership of the group, and consideration for an iwi/Māori chairperson or co-chairperson be considered.

Membership should reflect both the range of local providers within the CPCT and professions within it. It is recommended that consideration is given to community representation (for example the locality may identify a whanau voice representative), reflective of the community served. Given the focus on WHARIKI, strong consideration must be given to a governance structure which provides a partnership approach from Māori and Pacific. In some groups this is likely to include iwi/Māori health or social service providers.

The CPCT clinical governance group may be a structure already in place, but will requires the following minimum requirements:

Table 14: Minimum Requirements for CPCT Clinical Governance

Area	Requirement
Focus & Priorities	Persons and their whānau at greatest risk of health inequities and people at greatest risk of hospitalisation are a focus of the CPCT.
Membership	Clinical representation from all organisations represented within the CPCT, including iwi, Māori and Pacific providers and any refocused services. Preference to include clinical representation from hospital and specialist services. Clinical representation from all professional groups, noting that allied health professional representation MAY be combined.

Process	<p>Documented clinical governance roles, responsibilities, and processes.</p> <p>Designated equity champion.</p>
Scope	<p>Focus on the four core elements of clinical governance:</p> <ul style="list-style-type: none"> <li>• Individual and whānau engagement and participation</li> <li>• clinical effectiveness</li> <li>• quality improvement/patient safety</li> <li>• an effective and engaged workforce.</li> </ul> <p>Including key change elements:</p> <ul style="list-style-type: none"> <li>• IDT enablers and functioning</li> <li>• Skill sharing and top of scope working</li> <li>• Direction and delegation frameworks</li> <li>• Standing Orders</li> </ul>
Quality Improvement	<p>Working towards a single documented quality improvement plan and implemented across the CPCT.</p> <p>All persons working across CPCT are informed of the continuous quality improvement system and participate in the ongoing monitoring and analysis in everyday practice.</p> <p>Working to ensure that there is analysis of the outcomes of patient care which is consistent over time to allow evaluation of specific indicators and improvement.</p> <p>Systems for incident, adverse event and complaint management are in place across the CPCT partners.</p> <p>Policies and procedures for risk management for activities that include transitions of care and shared care are consistent and available for whole CPCT.</p> <p>Evaluate the services including patient, staff, and stakeholder satisfaction/experience surveys.</p> <p>Evaluate the effectiveness of continuous improvement activities regularly and use clinical indicators to monitor and improve services</p>

## Domains of quality and safety

The following identifies critical components to support the establishment of CPCT clinical governance that incorporates the Wai 2575 principles for Te Tiriti o Waitangi, which provide practical guidance for how this can be achieved successfully.

### Individual and whānau engagement

Individual and whānau voices need to be central to the design and governance of the way care is delivered in their communities.

This can be achieved by:

- ensuring iwi/Māori and individual representation on all local quality and safety governance groups and in groups developing and adapting models of care/clinical pathways
- ensuring there is a mechanism for capturing and rapidly learning from the experiences of individuals/whānau. This may include seeking feedback when interacting face to face or utilising existing primary care feedback processes
- prioritising listening to iwi/whānau Māori, seek qualitative responses and use to adapt models of care as needed
- providing support for individuals/whānau to share decision-making and be involved in their own care planning. This includes having options for the provision of for Māori, by Māori care; shared goals of care and for end-of-life care in the community.

### Clinical effectiveness

Local application of the model of care should be regularly reviewed and updated to reflect evidence acquired locally and from national and international experience by:

- ensuring pathway and guideline development incorporates evidence-based practice and partnership with iwi/Māori and other individuals
- co-design measures relevant to local care in the community priorities, stratified by ethnicity, and deprivation level where appropriate
- supporting learning through inter-disciplinary morbidity and mortality meetings and clinical audit.



### Quality improvement and patient safety

Local governance groups must establish mechanisms to ensure care is being provided in a safe way and identify opportunities to constantly improve this. Central to this is that governance groups:

- have an agreed process for the reporting, rapid review, and learning from adverse events
- review local performance on Te Aka Whai Ora and Te Whatu Ora measures, and this Operating Framework
- commit to continuous quality improvement, ensure there is access to improvement science capability and Te Ao Māori approaches
- ensure clinical risk management processes are in place. This could be through a clinical risk register where the circumstances that put individuals/whānau at risk of harm are identified, and action is taken to prevent or control risks
- ensure coordination and clarity of the pathway of care and transitions, to ensure care is safe and risk reduced

### Engaged and effective workforce

The workforce is critical to ensuring care is delivered safely whilst identifying potential areas to continually improve its quality. Local governance should:

- aim for a workforce that reflects the population being provided with care where possible
- ensure cultural safety is practiced by all staff (including reception and administrative) and visible in all activities
- seek feedback from the range of service providers: iwi/Māori, Pacific, non-governmental organisations – use to adapt approach as needed
- ensure orientation and induction of new staff occurs, and education and training are provided to all staff. This is particularly important in the context of rapid change and new processes
- articulate roles and responsibilities of the various parts of the system and within models of care. Ensure staff have the appropriate knowledge, skills, and tools required to fulfil their role
- foster teamwork and make communication easy: allocate time to build relationships within and between teams, develop handover processes and collective problem solving
- ensure staff are working at top of scope and appropriate and safe skill sharing structures are in place
- consider how staff wellbeing is being monitored and maintained

## Section 10: Outcome accountabilities

This programme has identified measures from three levels within the system relating to the implementation of CPCT. Planning guides us to take a learning approach to the implementation, with reporting focusing on using new roles, by ethnicity, and some markers relating to IDT processes<sup>7</sup>. The interim Government Policy Statement on Health states access to services in the community is a priority. Through utilization data, changes to access for primary care can be elicited, noting that improving access to care for Māori, Pacific and rural persons is one of the key objectives.

Further there are three levels of measurement that will be monitored through usual channels:

- System measures
- Service measures
- Comprehensive team development

<b>Comprehensive Care Team Performance Metrics</b>		
<b>System measures</b>	<b>Service measures</b>	<b>Comprehensive team development</b>
ED Attendances	Alternatives to face-to-face consultation available	Skill sharing and scope development for CPCT
After hours consultations	Virtual (telephone / video) planned consults	Clinical governance
ASH (Ambulatory Sensitive Hospital) admissions	Population stratified for equity and complexity	IDT meetings in place
Acute admissions	Shared care record keeping	
Time to next appointment	Shared care planning	
Whānau-centered care planning for complex situations	Patient portal available	
Patient experience		

<sup>7</sup> [Interim Government Policy Statement on Health 2022-2024 | Ministry of Health NZ](#)

**Expected essential functions and outcomes of CPCTS are (based on international evidence):**

Function	Outcome evidence
<b>Access</b> (first contact care for new health needs)	Reduces unnecessary hospitalizations, improves health, reduces non-urgent ED and specialist visits, improves rates of immunization, preventive services, and counselling
<b>Continuity</b> (long-term person-focused care)	Improves chronic disease management and use of preventive services, reduces ED use and hospitalizations, improves quality of care, and reduces cost
<b>Comprehensiveness</b> (care for most health needs)	Reduces cost, subspecialty visits and hospitalizations, improves rates of immunizations, preventive screening, and counselling
<b>Coordination of care</b> (when required outside the practice)	Reduces costs and hospitalizations, improves specialty referrals

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## Appendix A: Glossary

Abbreviation	Full Name
ACP	Advanced Care Plan
APC	Annual Practising Certificate
CPCT	Comprehensive Primary and Community Teams
CPG	Clinical Procedures and Guidelines
CQI	Continuous Quality improvement
EAP	Early Actions Programme, Primary Community and Rural
ECP	Extended Care Paramedic
ED	Emergency Department
EPOA	Enduring Power of Attorney
GP	General Practitioner
HBSS	Home Based Support Services
HCA	Healthcare Assistant
HPCAA	Health Practitioner Competency Assurance Act
IDT	Interdisciplinary Team
MoH	Manatū Hauora Ministry of Health
MSD	Ministry of Social Development
NASC	Needs Assessment Service Coordination
NGO	Non-Government Organisation
NP	Nurse Practitioner
PHO	Primary Health Organisation
PMS	Practice Management System
UTI	Urinary Tract Infection

## Appendix B: Definitions

	Definitions used for this paper
Care Coordinator	Core activities of a care coordinator range from planning navigation support, (which can be undertaken by kaiāwhina or others in the community), to care coordination (identifying those with highest needs and greatest risk of inequities and coordinating the clinical care), through to case management (providing the most intensive support to specific whānau, with the highest needs).
Clinical Governance	This refers to the systems, processes, and structures to oversee the quality assurance, quality improvement and clinical governance for CPCT. This includes the systematic approach to maintaining and improving the quality of care, requiring relationships and responsibilities of different stakeholders. Clinical governance in this context is a cross-organisation approach to the continuous quality improvement and safety of services and is aligned with the work of the Health Quality and Safety Commission.
Core Primary Health Care Teams	Current predominant team structure. As defined by Manatū Hauora Ministry of Health this relates to “the professional health care provided in the community, usually from a general practitioner (GP), nurse practitioner, practice nurse, nurse practitioner, pharmacist, or other health professional working within a general practice.” For the purposes of this mahi, this is specific to the above teams and other health care workers that are employed to meet the primary health needs of the enrolled population for a contracted provider. This team serves to meet the requirements of the current PHO Services Agreement. Wider primary care does include other providers of services in the community such as community pharmacies and dentists.
Comprehensive Primary Health and Community Care Teams	In addition to the core team, comprehensive teams will have additional roles such as those relating to Te Tumu Waiora (Access and Choice), clinical pharmacy, physiotherapy, and care coordination as examples. These teams may have relationships with other providers or agencies to provide comprehensive primary health services for their population. Comprehensive team members may or may not be co-located on site and will include Māori and / or Pacific partners. CPCT will usually require the formation of collaborative ways of working with other health and wellbeing providers such as Māori or Pacific.
Extended Care Paramedic (in CPCT)	A paramedic with postgraduate qualifications in primary/urgent care, also known as Advanced Community Paramedic. The ECP role falls within the paramedic scope of practice and is not separately defined by Te Kaunihera Paramedic Council. ECPs perform comprehensive clinical assessment for people with urgent/unscheduled health needs, perform a range of procedures such as suturing and urinary catheterisation, and utilise an extensive set of Standing Orders to administer/supply medicines.
Extended CPCT	CPCT with refocused community nursing, allied health and NASC. This includes developing current workforces to deliver extended services within the primary and community setting.

Kaiāwhina	This role is not regulated and is described by the Kaiāwhina Workforce Action plan. Although the definition is broad, for the purposes of the mahi of the EAP, it is defined as the workforce that represents the community they work in, have strong cultural safety for that community, and work in a partnership with whānau, wider health and wellbeing holistic approach.
Interdisciplinary team (IDT)	<p>Comprises professionals (including non-regulated roles) from various disciplines who work collaboratively to optimise the health and wellbeing of a person or whānau with either multiple physical and psychological or complex needs. An interdisciplinary team is not just a group of experts implementing separate treatments, rather they complement one another's expertise and actively coordinate to work toward shared goals.</p> <p>Characteristics at a team level:</p> <ul style="list-style-type: none"> <li>• Be people and whānau focused</li> <li>• Demonstrate culturally safe, whānau ora, Pae Ora approaches</li> <li>• Work in collaboration to actively reduce inequities within the system, address bias and discrimination</li> <li>• Positive leadership and management attributes</li> <li>• Team communication strategies and structures including electronic enablers for virtual teamwork</li> <li>• Team training and development</li> <li>• Skill mix consideration to support top of scope</li> <li>• Supportive team environment</li> <li>• Clarity of vision, quality, and outcomes of care</li> <li>• Respecting and understanding the roles of all members within the team</li> </ul> <p>Characteristics at a service delivery level:</p> <ul style="list-style-type: none"> <li>• Regular, (at a minimum) weekly team meetings</li> <li>• Complex case meetings, care planning, evaluation, and review</li> <li>• Clinical record access by all members of the IDT</li> <li>• Single IDT plan of care</li> <li>• Use of tasking for requests for input from IDT members and electronic responses back</li> </ul> <p>Interdisciplinary teams differ from multidisciplinary teams in that the latter does not employ an integrated approach to care. They work in parallel rather than in integration, each within their respective disciplines to devise their own care plans. Though applied simultaneously, each plan works independently of the others. Each may have their own goals for the patient and apply interventions without consultation with the others.</p>
Paramedic	A registered health practitioner who has completed a 3-year Bachelor of Health Science (Paramedicine). Paramedics assess, treat, and refer people with urgent/unscheduled health needs in consultation with other health professionals (e.g., a nurse practitioner or GP) and usually have less clinical responsibility than an Extended Care Paramedic with postgraduate paramedicine qualifications.

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Pharmacist Prescriber	A Pharmacist Prescriber is a separate regulated scope of practice for a pharmacist, that includes defined specialised clinical, pharmacological, and pharmaceutical knowledge, skills and understanding relevant to their area of prescribing practice. This allows them to provide individualised medicines management services, including the prescribing of medicines to whānau across a range of healthcare settings and models.
Practice Pharmacist	Is a role within the pharmacist scope of practice, although it is not separately defined by the Pharmacy Council. The qualifications, experience, and attributes “deemed necessary” to work in a primary care team are described by the profession.
Tasking	Tasking is the ability to electronically receive requests for care interactions from others within the CPCT and respond electronically, with that interaction's outcomes.

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## Appendix C: Vignettes

When we successfully complete this, the below vignettes are examples of what the future may look like:

### Kaiawhina working for a Māori Health Provider

*The local Māori Health Provider is supporting Anahena during her pregnancy and offer a kaiāwhina to visit the whānau to see how they may assist. Pania is a 24-year-old wahine that is working as a kaiāwhina at the Māori Health Provider in Te Tai Tokerau. She visits Anahena in her whare, bringing some kai to go with a cup of tea.*

*They discuss what concerns Anahena have regarding her whānau and together develop a plan on how to get the supports the whānau require. Together they decide that the pressing concerns is that the whare is cold and draughty, and with a new pēpi on the way, they ask for an assessment of home heating and insulation as part of the Healthy Homes programme.*

*Pania contacts the programme office and offers to be with Anahena when the Healthy Home Team visit next week. Anahena is also concerned about her elderly parents. Her mother has had two falls in the last three months and Anahena is worried she might break her hip. Pania asks Anahena and her mother if it is all right to mention this at the CPCT meeting later in the week to see the best approach to these falls. Anahena and her mother agree to this.*

*At the next team meeting, which Pania attends weekly, Pania presents the concerns and what her observations are. The team decide to ask Anahena's mother to come to the practice for a health check by the doctor, and a physiotherapy assessment of her balance. Pania proudly can tell the team what the mothers blood pressure was as she has been trained to take this within her course she has just completed. Pania messages this information into the practice system, so this information is available when they see the mother.*

*Anahena has also heard that there is Whooping Cough going around in the district. She agrees for Pania to take the names of all the whānau to check their immunisations are up to date. Back at the office Pania works with the team to identify what vaccinations are needed and arranges for someone to visit the whānau to bring them all up to date.*

*While visiting the whānau, Kaia, Anahena's eight-year-old son says he has had a sore throat for the past week. Pania has some guidance in her kete that recommends she swabs his throat and sends the swab to the laboratory. Pania messages the practice to let them know she has done this. When the results are back, the GP asks to see Kaia, so Pania works with the whānau and practice to arrange a telehealth consultation. Pania supports the whānau with the technology.*



## Tāngata whaikaha and kaiāwhina

*Meet Talia. Talia is a 4-year-old girl with tagata sa'ilimalo (disabilities) who lives with her faatima (mother) - Lupesina and aiga in a kaianga ora home. Her fa'atamā (father) Akamu, his elderly parents, and her five older siblings, aged from 7 years to 16 years, all live in the three bedroomed home. Akamu works in a factory where he works long hours to support the aiga.*

*Talia struggles with her walking as she was born with congenital dislocated hips and despite surgeries, she still requires crutches for walking, and at home prefers to 'scoot' around on her bottom. Talia is about to turn five soon, and Lupesina was looking forwards to her attending school, so she could find some part time work to help "ends meet".*

*The aiga look forward to attending the local Samoan Congregational Church every Sunday. Last week, the Parish Priest overheard Lupesina talking to her friend that she was concerned about how Talia will manage when she turns five next month and goes to school. The Parish Priest talked to Lupesina then introduces her to Asoese, who works as a Navigator, working for the local Pacific Health services. They arrange to meet next week, once the older children are at school.*

*On Tuesday, Asoese comes to Lupesina's home, and they talk about their common interests, finding out that their families originated from villages only a few miles apart in Samoa. Lupesina feels confident with Asoese, so confides that she is very worried that Talia may get bullied at school or miss having friends as she cannot keep up with them. Currently, Lupesina goes quiet... Asoese sits quietly with her for a moment, then asks 'what else is a worry for you?' Lupesina shares that she is worried the older children are eating so much, and that Akamu's job might disappear when the place he works gets new owners next month. They are behind in their rent, and she thinks she might need the oldest son to leave school to earn some money. Lupesina also is concerned that she thinks she might be ma'itiaga (pregnant) again and Akamu will be angry.*

*Asoese sits with Lupesina, and they work together to decide what to do the aiga. Asoese works with the IDT at the health centre and asks permission from Lupesina to talk to her colleagues, which Lupesina agrees. Asoese talks to the IDT and creates a plan for the aiga, including the school that Talia will be going to, Kainga Ora, Work and Income, and makes a time for Lupesina to see the Nurse Practitioner at the health centre. At the same time, the team check and find that Akamu's father is overdue for his bowel screening, so Asoese also talks to him and supports him through this process.*

## Care Coordinator

*Irihapeti is employed by a large CPCT. She recently worked with the team to identify 'at risk' people enrolled in the practice, with a focus on people with poorly controlled diabetes. Atawhai a 68-year-old infrequently attended the practice was identified as someone who may benefit from coordinated care.*

*Irihapeti met with Atawhai. He was living alone in a rented flat with limited heating and poor insulation. He struggled to walk any distance and limited understanding of medication use. He also has a small ulcer on his foot that was not healing. Atawhai was anxious and lonely. He was struggling to walk to see his friends regularly and relied on the neighbour to get his groceries. He wanted to feel well, have more contact with friends and avoid ending up in hospital*

*Irihapeti discussed the situation at the IDT team, and Atawhai's goals. Following this an electronic plan of what was agreed as captured which included:*

- Bob, the practice pharmacist reviewed Atawhai's medications and worked with the GP to adjust these. Bob also talked through their use and arranged to have these delivered from the local pharmacists.*
- The community nurse attended three times / week to dress Atawhai's ulcer. While visiting he would check on Atawhai's medication use.*
- Irihapeti suggested Atawhai attend the activity class at the Kaupapa Māori provider, Atawhai was initially hesitant thinking it may be too hard but agreed to give it a go. The Kaiāwhina employed by the provider would help with transportation and provided kai after the exercises and a chance to connect with others.*

*Initially Irihapeti contacted Atawhai twice a week and provided the IDT with regular updates; this reduced as his health improved.*

*Atawhai felt more trusting of Irihapeti and the CPCT. Irihapeti arranged for regular appointments at the practice which he would attend to enable a review of his diabetes.*

*With his ulcer healed, the practice arranged for regular foot checks with the podiatrist.*

### Hospital avoidance, care coordination and ECP

*Sharon is a registered nurse working in the community-based hub in a small rural town, where the community nurses and allied health teams are co-located. She is connected to the CPCT and attends the IDT daily stand-up meetings and case meetings.*

*It is 3.30pm on the Friday before the long Matariki weekend when she receives a call from the rural hospital ED, stating that 81-year-old Gwenda, who lives in her own home, was brought in by ambulance as she was not feeling well and had pressed her alarm. Gwenda was dehydrated, unsteady on her feet, and had a UTI (urinary tract infection). She did not require admission but needed rapid response of input to support her at home. Her closest family is in Wellington and are unable to get through to Thames. Until now Gwenda has managed independently without support.*

*As Sharon is working within the CPCT, she organises a team to support Gwenda to get home, have access to food and be monitored over the weekend by daily visits from the community team. The allied health team also visited her at home to assess her environment for safety from falls and give her a walking frame to help her confidence over the weekend. Gwenda will receive daily district nursing visits, but on Sunday there will be staffing shortages.*

*After liaison with the CPCT, it is agreed that the Extended Care Paramedic on duty for the day will call in and reassess Gwenda. The plan is written up on the new electronic system called Dynamite, so that both district nursing, allied health, and the rest of the CPCT can see the plan.*

*Sharon messages the practice team also to inform them that Gwenda has come into the Rapid Response hospital avoidance service and will receive intensive support over the long weekend, prior to a comprehensive review and case meeting next Tuesday.*

### Practice Pharmacist, working in a CPCT

*Rawiri is a 63-year-old Māori man living in Invercargill. Having smoked all his life, he now has CORD and hypertension. He often forgets his medication as he likes to go fishing and forgets to take this with him when he goes away for days at a time. Rawiri has recently been in hospital following an exacerbation, where his medications have changed.*

*Bob works as a Practice Pharmacist at the practice that Rawiri attends and during the IDT meeting, his recent admission to hospital was raised. Bob was allocated the task of connecting with Rawiri to talk about his medication treatment and how he might support Rawiri to get the best use and understanding of them. During the conversation Rawiri tells Bob about some rongoā his whānau have given him, which Bob said should not be a problem taking with his medications but offered to speak together with him and a rongoā provider or kaumātua if he had any concerns about how 'everything works together.'*

*Bob offers to work with Rawiri and his community pharmacist to return un-used and outdated medicines after the recent treatment changes in hospital, and about what the community pharmacy can offer to help him carry and take some medicines while out fishing. Any recommended changes to prescribing for Rawiri, Bob will talk to the Nurse Practitioner looking after his care.*

*Bob documents the medicines reconciliation including description of the rongoa as part of Rawiri's treatment in the practice management and shared care systems and makes an appointment for blood pressure checks in six weeks. Maria, the Kaiāwhina within the team makes note to follow up with Rawiri closer to the time and ensure he can make the appointment.*

### **Prescribing Pharmacist within CPCT**

*Rawiri is a 63-year-old Māori man living in Invercargill. Having smoked all his life, he now has CORD and hypertension. He often forgets his medication as he like to go fishing and forgets to take this with him when he goes away for days at a time. Rawiri has recently been in hospital following an exacerbation, where his medications have changed.*

*Rebecca works as a Prescribing Pharmacist at the practice that Rawiri attends and during the IDT meeting, his recent admission to hospital was raised. Rebecca was allocated the task of connecting with Rawiri to talk about his medication treatment and how he might support Rawiri to get the best use and understanding of them. During the conversation Rawiri tells Rebecca that he feels dizzy on standing. Rebecca assesses and reviews his blood pressure and prescribes a lower dose of hypertensives. Rebecca also discusses with Rawiri that she can prescribe a different sort of inhaler that he only needs to use once a day – making it easier for him to remember. Rawiri is grateful for the support.*

*Rawiri raises concerns about the local Covid outbreak, so Rebecca checks on the register and sees that he is overdue his booster, so administers that as she has recently completed her vaccinator training.*

*Rebecca documents the medicine changes in the practice management and shared care systems and makes an appointment for blood pressure checks in six weeks. Maria, the Kaiāwhina within the team makes note to follow up with Rawiri closer to the time and ensure he can make the appointment.*

### Extended Care Paramedic – Remote and Rural

*Sina is a 37-year-old Tongan mother of four who lives in Jacksons Bay, Westland. Her husband works on the fishing boats and is often away for a day at a time. Sina is concerned about her eight-year-old son (Manu), who does not have the energy to play with his older siblings, which Sina thinks might relate to his coughing at night. He is keeping his two older brothers awake with his coughing as they share a room. Sina does not drive, and the closest doctor is either in Wanaka 186 km away (2 hour 51-minute drive) or Hokitika 303 km or 3 hours 45 min drive.*

*Through the local newsletter, Sina found that Mark Bailey (an Extended Care Paramedic) visits weekly and sets up at the local DOC Centre. Her friends encouraged her to take her son to see Mark. Mark assesses Manu and performs some tests. Fortunately, Mark can supply some medications. He refers to Standing Orders that he and his colleagues use to provide urgent/unscheduled care and provide some inhalers for Manu. Mark asks to see Manu next week to see if the coughing and sleep has improved.*

*Mark also finds out that neither Sina nor her family are enrolled in primary care practice. He provides the choices of practice and Sina elects to travel to Hokitika as there is a weekly bus service. Mark then provides an update to the CPCT at the next IDT meeting he attends using an electronic platform. Following the next IDT, Mark discusses with Sina the benefits of calling into the practice to meet the team next time she is in Hokitika.*

### Refocusing Community Nursing

*Iosefa is a 48-year-old Samoan man, working on a RSE (Recognised Seasonal Employee) visa on a dairy farm in the Manawatu. The rest of his aiga is back in Samoa, and he sends money back home frequently. Last week, Iosefa sustained a deep laceration to his calf muscle when his chainsaw slipped requiring 20 sutures. He is now at his accommodation 25 km from the local town of Fielding but has been told to keep his leg elevated until the swelling reduces.*

*Laura is a district nurse that works closely with the practice in Fielding, attends their daily meetings and weekly IDT meetings. Today when she visits Iosefa, she notices that the pain has increased, and he is feeling unwell. Laura takes a swab of the wound and delivers it to the laboratory pick-up at the medical centre. Laura also messages the GP to provide an update and antibiotics are prescribed. Laura picks up that something is wrong with Iosefa, so she chats, and he confides that if he cannot work, he will lose his job and be sent home. His family depends upon this money. Laura is concerned that Iosefa will continue to work, endangering his leg. Laura talks to Anaru, the social worker in the team she works with, who agreed to contact Iosefa later today and support him liaising with his employer and Immigration New Zealand. Anaru and Laura mention the plan that is in place for Iosefa at the next morning's huddle. Both Laura and Anaru write into the practice's clinical record system, so everyone can see what is happening.*

*The team agree that close support will be needed for Iosefa, so the Navigator from the Pacific Health Service, who is also part of the IDT meetings agrees to remain connected with him.*

### **Refocusing Community Nursing and Hospital Avoidance**

*Bronagh works as a District Nurse in Nelson. She is employed by Te Whatu Ora, and recently the service has worked with the local operations manager Cathy, in re-focusing community nursing and allied health services towards CPCTs. Although Bronagh was worried about this as a start as their offices moved away from the hospital into the CitC (Care in the Community) hub premises in Richmond, which are in the same rooms as three GP Practices. Some of her other colleagues are now based in Motueka, and others in Nelson City. It feels different not having all the district nurses in one office.*

*Today is Friday 13th and Bronagh is working over the weekend. George, a retired 70-year-old schoolteacher has been in hospital for the last three days with Pneumonia, following an exacerbation of his Asthma. The hospital physicians have agreed he can transfer to the Hospital in the Home programme. Bronagh gets notified that George is ready for discharge later in the day, but is still requiring IV antibiotics, close monitoring of his oxygen saturation and blood pressure and is having difficulty with his self-care as he is weak.*

*Bronagh pops into the GP practice to let them know. The GP now says he is happy to take over the care but is concerned, as George is the primary caregiver for his wife who has early dementia. Bronagh works with the RN (registered nurses) on medical ward who is George's nurse and determines the plan required to admit George into the Hospital in the Home service.*

*Bronagh uses the new messaging application the CPCT has access to and documents the plan of care within the Shared Care Plan that can be seen by all personnel in this care.*

*Life is easier when care can be shared and coordinated with General Practice!*

### **Refocusing NASC Services into CPCT**

*Matthew works for NASC services in Balclutha. He is employed by Te Whatu Ora, and recently the service has worked with the local operations manager Astuti, to refocus the mahi of NASC to being part of the CPCT. Although Matthew lives in Balclutha, he travelled to Dunedin to be part of the NASC team based at Dunedin Hospital. In re-focusing the community allied health and nursing team, Astuti, when co-designing the best way for the services to operate in the Balclutha area, found that the community and health service providers wanted the NASC based locally. Matthew*

*was involved in these discussions and was worried as he knew that pay rates are not as high within the practice and he values the time with his other NASC colleagues as they peer review assessments frequently, although the burden of travel to Dunedin for work daily is a chore.*

*After the re-focusing, Matthew continues to be employed by Te Whatu Ora, but he is based at the small rural hospital in Balclutha, where there is a large medical centre. Matthew attends the NASC meetings weekly by Microsoft Teams and uses this for the case review with his colleagues. As NASC assessments are not integrated with the primary care record yet, Matthew cuts and pastes the summary page from the assessment into the primary care health record.*

*He also attends the daily huddles and weekly IDT meetings within the practice. He finds that this means that he may be called on earlier for assessment, and that some people he is asked to see are of higher priority than they would be if he received a paper referral.*

*The biggest difference for Matthew is that he never assessed many Māori or Pacific people. They often did not run up for appointments or return phone calls. This is despite there being a reasonable population size of Māori and Pacific due to those previously working in the freezing works, remaining in the area. Now that Matthew is in the practice, Julia the Nurse Practitioner will often bring the person down to his office to introduce them.*

*Matthew still feels he is part of the NASC team, but his new main team is that of the primary care practice staff.*

#### **Future State: Extended Community Care**

*A rural Te Tai Tokerau wahine, Anahena who is hapu, has three tamariki, Wiremu 2, Kaia 7 and Tane, 10. Anahena has elderly parents living with her, her partner is away at work, and she is isolated from her natural whānau supports. The whānau have a low household income and unreliable transport options.*

*During a Saturday afternoon, Tane has an accident whilst playing in the nearby park. Anahena is concerned that Tane has broken his ankle as he is quite uncomfortable and is having difficulty weight-bearing. She would like him to be checked and his pain reduced as soon as possible.*

*There will be an 0800 primary care helpline which will connect this whānau to 24/7 telehealth services. An initial telehealth medical assessment will advise which first aid actions and medication Anahena could give Tane to ease some of his pain.*

*After further consultation, the telehealth GP will advise Anahena that Tane needs an x-ray at the nearest radiology unit an hour away, and books local transport for them.*

*While the local transport team are planning, the telehealth GP will also ask Anahera if she would like the local whānau ora service provider to make contact to assist her whānau with other health issues. If Anahera agrees, the on-call whānau ora team will contact her. They will arrange a kaiāwhina to visit the house the following week.*

*Wiremu (2) travels with Anahera and Tane (10) to the radiology facility, after-hours care, and pharmacy. While they are travelling, the telehealth GP orders the x-ray and in anticipation of ongoing pain, emails a medication prescription to the "after hours" pharmacy next to the radiology unit so it is ready for Anahera to pick up.*

*The x-ray was carried out at the nearest facility and is reviewed by the telehealth team. Required treatment is provided, health information given, and follow-up appointments made. Home transport is provided and Tane's pain is controlled.*

*The aim of the kaiāwhina visit the following week would be to link the whānau to the health and social services that will provide additional support for them. Wiremu suffers from asthma, Anahena's parents have several long-term conditions including gout and COPD (Chronic Obstructive Pulmonary Disease), and Anahena's partner has diabetes. The overall health of this whānau can be improved with increased holistic and pro equity support of primary and community healthcare services.*

*With the provision of pro equity extended community care (acute and planned), and culturally appropriate Health Pathways encompassing a whānau ora approach, there will be increased opportunities to provide earlier interventions, and therefore, better ability to improve health outcomes for Māori. Alongside newly developed communication systems that improve co-ordination between partners such as Māori health services, telehealth, and primary healthcare teams, this will support timely and improved whānau-centered care.*

### **Improved access to Services**

*Atarangi is a 17-year-old rangatahi high school student, who lives in rural Tairāwhiti, with a large whānau which includes her parents, four brothers, two sisters and her grandparents.*



*Atarangi recently had protected sex, using her and her partners preferred contraception - condoms, that unfortunately broke this time. With the challenges of living rurally, Atarangi accesses a borrowed car, travelled 1.5 hours to her nearest pharmacy for the Emergency Contraceptive Pill in anticipation of reducing the risk of an undesired pregnancy. However, Atarangi discovers she is two weeks late for her expected menstrual period.*

*Atarangi has had little interaction with her nearest primary care services and secondary care requires several hours travel to access their services. She is also worried that presenting to the GP will be a problem due to current fees owed by her whānau.*

*Current state: Early medical abortion (<10 weeks' gestation) is accessed less by Māori women, potentially due to cultural, socio-economic, and geographical barriers delaying their ability to access suitable health services. Most abortion services are provided by hospitals, with very few Māori, Primary or Community Providers available.*

*Future state: 0800 DECIDE will be a national abortion telehealth service that Atarangi can get all the information she might need about abortion services or continuing her pregnancy. From November 2022, this telehealth service will itself be able to support/provide a holistic service to enable an Early Medical Abortion (EMA) including assessment; counselling/psychological support; medication administration and future family planning/long-term reversible contraception.*

*Updated Health Pathways will ensure that Atarangi does not have unnecessary scans and blood tests, with associated costs to her. The pathways will also describe the appropriate approach to support a wahine Māori.*

*Multiple providers including Māori health services, youth health services, school nurses, and primary care will be able to provide the culturally safe complete care package from the early medical abortion service, which ensures Atarangi will have more choice and access to local providers that may suit her needs better.*

*Multiple professionals within service providers can provide all or specific aspects of abortion services. Professional training, service provider policy and informed clinical guidance will ensure tikanga is understood and practiced. The requirement for a pro equity and whānau ora approach to an EMA package of care will also be supported.*

## Supporting Pacific Providers

*Fiafia is a 40-year-old New Zealand Samoan mother who lives with her five children, two grandchildren, her partner, and his elderly parents in a Kāinga Ora home. They live in a five-bedroomed home which has some challenges due to poor insulation and inefficient heating. Three of her children are adults and working, and she has two younger children at school. The household income is below the National average for the family despite five working adults. Fiafia's mother died from uterine cancer five years previously aged 55 and her father ten years before after experiencing a severe stroke.*

*Fiafia has experienced abnormal and heavy uterine bleeding for the past two years but has not sought a health review. Recently the bleeding has become worse, limiting her daily activities, and causing her great anxiety. Fiafia is becoming increasingly tired with some breathless when she does any mild exercise. As a result, Fiafia has visited her primary healthcare team despite being worried about the cost and having difficulty in taking time off her full-time work.*

*After an assessment, Fiafia was prescribed iron because she was anaemic. Fiafia is now waiting for an ultrasound and pipelle biopsy to assist in diagnosing the cause of her abnormal bleeding. She is very worried that she may have uterine cancer like her mother had, however, she is having difficulty in attending the planned appointments. Both the venues for the two procedures are a distance from her home or work, which will cost her. Neither provider offers appointments out of routine weekday hours.*

*Current state: For Fiafia, the initial assessment for abnormal uterine bleeding was available but associated costs were expensive and inconvenient for her in the Primary healthcare setting. However, her ability to access subsequent investigations is even more challenging due to work and living some distance from specialists. In addition, Fiafia has difficulty affording the transport costs with no access to independent transport.*

*Future state: Fiafia will be able to opt for her initial health assessment from a Pacific health provider. The Pacific provider will utilise a family centric model of care that suits Fiafia and puts her at ease with the health system and health assessment processes.*

*The Pacific health provider can either follow up procedures or refer to other community providers. The Health Pathway will provide clinical and care package information to support a standardised approach to assessing and managing her intrauterine bleeding. The approach will include information to support access to transport, facilitate access to psychological support and other healthcare costs such as medicines that Fiafia encounters.*

*The holistic assessment carried out by the Pacific health provider will enable follow-up health and other support for other family members and the household. For example, Fiafia's partner had diabetes and struggled to manage his condition. This caused Fiafia great worry. One of the grandchildren had not been vaccinated and one of the grand parents had an untreated chronic leg wound. These health issues will be managed by Pacific or other primary and community team members.*

*Referrals to other support services for house insulation and heating improvements will also be made. Fiafia will be supported to deal with her primary health issue and further encounters with the Pacific health team will help her and her family progress to better health and wellbeing.*

Draft for comment

## Appendix D: Te Tiriti o Waitangi and Equity Guidance for CPCT

The following is based on the COVID-19 response. With minor modifications only, this is applicable to the CPCT development, new roles into CPCT and refocusing of the community nursing, allied and NASC workforces.

Ethical principle	Application of ethical principle to address equity within CPCT
All people are equally deserving of care	<ol style="list-style-type: none"> <li>1. Each person and their whānau in New Zealand deserve equal respect and consideration.</li> <li>2. Each person’s interest should count equally, unless there are good reasons that justify the differential prioritisation of resources. Differential treatment is consistent with the right to equality and non-discrimination; in fact, differential treatment is sometimes required, if it can be justified on objective and rational grounds.</li> <li>3. Biases should be checked. Resources should not be distributed arbitrarily or withheld based on individual or group characteristics that are irrelevant to a clinical prognosis; for example, including: ‘race, colour, gender or gender identity, sexual orientation, language, religion, political allegiance or other opinion, national or social origin, property, birth or other status such as disability, age, marital and family status, health status, place of residence, economic and social situation.’ <sup>[1]</sup></li> <li>4. Sick people should all be given the care they need with the aim of achieving the best and equitable outcomes. ‘Care’ in this instance includes all aspects of health care, including hospitalisation.</li> <li>5. This principle is often used to justify a system of ‘first come, first served.’ While this is often applied when allocating resources in health care settings, it is likely to favour certain groups, such as those with access to better information, or those with better resources and more social or other types of capital.</li> </ol>
Getting the most from the resources	<ol style="list-style-type: none"> <li>6. Resources within health must be managed responsibly and based on need and outcomes expected. In the context of CPCT, we should aim to allocate resources efficiently and maximise the social and health benefits.</li> <li>7. There are several competing interpretations of how best to gain the most benefit; for example: to maximise lives saved, to maximise quality and/or life years saved (for example, by prioritising the young to maximise length of lives saved), to maximise the cost-effective use of resources for whānau and communities, and to prioritise essential workers (such as health care staff) so they can continue to serve and protect the public. These competing interests often conflict with equity goals. Careful assessment should occur to ensure decisions are not solely focused on efficiency and should take a broad assessment of processes and outcomes when making trade-offs on resource.</li> </ol>

	8. This principle involves acknowledging the skills, expertise and knowledge of people working in a broad range of relevant fields as a crucial resource and the critical connections to achieve best outcomes. For instance, the value of culturally responsive and safe whānau-led contexts as an essential component of best practice decision-making.
Achieving equity	<p>9. 'In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with various levels of advantage require different approaches and resources to get equitable health outcomes' (Ministry of Health 2019). In working towards equitable outcomes, one option is to give priority to individuals or groups in greatest need.<sup>[2]</sup></p> <p>10. There are competing interpretations of how to determine those with the most need – we may define this as the sickest, the most disadvantaged or marginalised, those at greatest risk of harm or those subjected to previous injustices. Prioritising those in need will sometimes align with and sometimes conflict with prioritising those who can most benefit from health resources.</p> <p>11. It is likely to be difficult to ameliorate all existing inequity; however, all efforts must be made to ensure equity is at the forefront of decision-making. An equity approach would consider how resources can be allocated to mitigate adverse consequences and avoid or minimise growth in inequity deriving from those measures.</p> <p>12. An equity approach also involves identifying why the inequitable scenarios are created and making changes to address the sources of those inequities to avoid the same scenario arising in future. The Crown has specific obligations to achieving equitable outcomes for Māori, given its Te Tiriti o Waitangi obligations.</p>

<sup>[1]</sup> This guidance has been adapted from National Ethics Advisory Committee *Ethics and Equity: Resource Allocation and COVID-19 – An Ethics Framework to Support Decision-Makers* 2021 by the Māori Health Directorate January 2022

Note that under right 2 of the Code of Health and Disability Services Consumers' Rights, every health consumer has the right to be free from discrimination.

<sup>[3]</sup> The WHO (World Health Organization) stated in the *Rio Political Declaration on Social Determinants of Health* (WHO 2011) that people have the right to 'the highest attainable standard of health'. The highest attainable standard of health reflects the standard of health enjoyed in the most socially advantaged group within a society. This indicates a level of health that is biologically attainable and the minimum standard for what should be possible for everyone in that society. See *Achieving Equity in Health Outcomes* (Ministry of Health 2018) for more information

## Appendix E: Appendix Three: Links to Resources

Resource	Rationale	Web Link
Case Management	Standards and self-assessment frameworks	<a href="#">Case Management Society of Australia and New Zealand - Case Management Society of Australia &amp; New Zealand &amp; Affiliates (CMSA)</a>
Collaborative Aotearoa	Healthcare Homes Resources and information	<a href="#">Home - Collaborative Aotearoa</a>
Hospital in the Home Guidelines	Relates to Extended Care CPCT	<a href="#">Hospital in the Home guideline   Queensland Health</a>
Kaiāwhina Workforce Plan	Guiding document for the role of kaiāwhina	<a href="#">Kaiāwhina Workforce Plan 2020-2025 (kaiawhinaplan.org.nz)</a>
Physiotherapy code of ethics	Professional standards	<a href="#">Code of Ethics and Professional Conduct – Physiotherapy Board (physioboard.org.nz)</a>
Physiotherapy Thresholds	Guidance on Physiotherapy	<a href="#">Physiotherapy Thresholds – Physiotherapy Board (physioboard.org.nz)</a>
Competence standards for the pharmacy profession	Professional standards	<a href="https://pharmacycouncil.org.nz/wp-content/uploads/2021/04/CompStds2015Web.pdf">https://pharmacycouncil.org.nz/wp-content/uploads/2021/04/CompStds2015Web.pdf</a>
Standards and guidance for pharmacist prescribers	Professional standards	<a href="https://pharmacycouncil.org.nz/wp-content/uploads/2021/04/Pharmacist_Prescriber_Standards_July20138dd8.pdf">https://pharmacycouncil.org.nz/wp-content/uploads/2021/04/Pharmacist_Prescriber_Standards_July20138dd8.pdf</a>