

**Counties Manukau
District Health Board**

**Primary & Community
Health Services Plan**

February 2008

1.0 Introduction

The focus of this Primary & Community Health Services (PCHS) section of the Health Services Plan is an increased focus on prevention, early intervention, support for self-care, chronic disease management and integration.

Pivotal to the design of a new Model of Care for PCHS are two principles:

- Decentralisation of specialist services that are not facility dependent and which can be efficiently delivered outside hospital settings; and
- Aggregation, integration and co-location of primary and community health services – including general practice, CMDHB community services and NGO services.

The key elements for the future Model of Care are identified. These are consistent with international trends in primary health care and include:

- Services moving away from reactive, unplanned and episodic care to a systematic patient-centred approach.
- Services delivered sooner (early intervention) and closer to the patient: based in community settings ('the most intensive care in the least intensive settings').
- Services delivered by multi-professional teams, and teamwork with the delegation of 'traditional' clinical tasks to achieve more appropriate use of clinical skills.
- Service co-location with other community based services to improve integration and coordination.
- Visiting specialist services being 'part of the team' and supporting primary care to manage and support their patients.
- More integrated multi-disciplinary programmes for Chronic Care Management (CCM) across primary and specialist services and incorporating expanded nursing and allied health specialist roles.
- An increased focus on self-care knowledge and support (the 'expert patient') and empowering people to make healthier choices - diet, physical activity, and life-style
- A less fragmented (more 'joined-up') service delivery model by removing unnecessary funding and contracting 'silos'.
- Active case management for people with complex and multiple needs including out-reach and home based services where appropriate.
- Better use of clinical information and technology to identify patients with complex needs, to provide structured personalised care, and to incorporate best practice clinical decision-support.
- Access to patient information that is available to providers in primary, specialist, emergency and acute care settings.
- Use of 'collective' population information to analyse utilisation across primary and specialist settings, for planning services to a defined locality and for targeting services to people at risk.
- More co-ordinated discharge planning, rehabilitation and community-based care to reduce hospital length-of-stay, avoid unnecessary hospital re-admission, and manage a higher rate of chronic illness and disability in community settings.
- Inclusive, culturally appropriate care to target groups with poorer health status and to promote lifestyle changes appropriate to the individual's cultural and health needs.
- Ongoing development of evidence-based practice, clinical guidelines, audit and quality improvement programmes.

2.0 Environmental Characteristics – Primary Health Care

2.1 The Case for Change

The Primary Health Care Strategy (2001)

The introduction of the national Primary Health Care Strategy (PHCS) in 2001, and the associated establishment of Primary Health Organisations (PHOs), has seen a fundamental change in the way general practice is funded. Capitation funding for an enrolled population has replaced the fee-for-service General Medical Subsidy and Practice Nurse Subsidy, and provided increased and more equitable funding for high-need communities.

The PHCS has promoted a population health approach and introduced additional DHB funding for reduced fees, health promotion services, and to improve access for high-need populations (Maaori, Pacific and high deprivation). However, new programmes have also placed additional compliance requirements on busy general practice teams and there has been low uptake of some projects because general practices in high-need areas have continued to give priority to meeting the needs of patients with urgent health needs.

Responsibility for implementing the PHCS lies with District Health Boards.

Locality Planning

The primary care infrastructure in high-need areas of Counties Manukau faces a number of specific challenges. The presence of multiple PHOs in high needs suburbs has resulted in different services being delivered to enrolled populations with similar needs in the same localities. The public generally has a poor understanding of the services available through the PHOs in their area, and there is limited structured engagement with the community in locality health planning.

The Primary Health Care Workforce and Teamwork

General practice nationally faces critical workforce shortages, and Counties Manukau has one of the lowest numbers of GPs per capita of all New Zealand cities. A RNZCGP Workforce Survey (2005) identified that approximately 30% of the GP workforce was planning to leave general practice by 2010. The predominant independent business model is losing attraction to medical graduates considering general practice, with younger GPs preferring to work as associates on salary in larger practices where they can receive professional support and access to ongoing education and training. Younger GPs, with a predominance of female practitioners, also want a better work/life balance.

Although capitation funding of general practice provides opportunities for more flexible use of nurses and other staff, the implementation pathway for nursing development is unclear. Nursing development is constrained by the funding and individual practice employment model. Employer GPs are generally unable to offer a career path for nurses wanting to undertake further specialist training in areas of primary care due to the size of practices. Advanced primary care nursing roles are limited to a relatively small number of PHO and DHB positions and it is difficult to incorporate other health professionals, such as pharmacists and midwives, into the primary health care team because contracting and service 'silos' continue to reflect historical delivery models. The opportunity to integrate and co-locate other services with primary care is also limited by small primary care facilities that are at capacity.

Primary Health Care Capacity

There has been some success in engaging general practice in proactive population programmes in Counties Manukau, such as Chronic Care Management (CCM) and Services to Increase Access (SIA) initiatives, but this has not reached its potential due to general practice capacity limitations and priority being given to patients who required urgent services. It is difficult for practices to undertake more proactive approaches to support patients who are high-users of secondary services due to a shortage of primary health care nurses.

Key points:

- CMDHB has significant concerns about the primary health care infrastructure and its capacity to meet the long term needs of a growing and ageing Counties Manukau population.
- A significant number of practices are small 1-3 GP practices, with a large enrolled population, which does not support advanced team working and sub-specialisation.
- Recent primary health care investment in facilities has been low – particularly in high-need localities.
- Counties Manukau already has a very low GP:patient ratio compared with all other New Zealand cities, and projections based on the current model care indicate that an additional 81 GPs will be required to meet the needs of the CMDHB population in 2026.
- Despite considerable population growth and ageing in the past 10 years, there has been no increase in the number of GPs practising in Counties Manukau.
- There is little evidence that an increased GP workforce will be available – hence the requirement for a new Model of Care.

3.0 Key Directions

3.1 Overview – a Locality Approach

PCHS will be delivered to locality populations from eight key health delivery ‘hubs’ called Primary & Community Health Centres (PCHC). PCHCs will serve catchment populations of between 50,000 to 120,000 and will be located in the suburbs shown below:

Suburb	Population in 2026
Mangere	65,000
Papatoetoe	45,000
Otara	41,000
Manukau/Manurewa	110,000
Howick/Pakuranga	105,000
Flatbush/Clevedon	82,000
Papakura	67,000
Pukekohe (Franklin)	75,000

PCHCs will provide local delivery of a wide range of services across the continuum from prevention, diagnosis and treatment, through to rehabilitation and continuing care for people with long term conditions. Some care previously provided through a day admission or overnight stay in hospital will to be provided as a day attendance at PCHCs or in the home through outreach services.

PCHCs will allow general practice services to move into settings that are ‘scaleable’, – that is, able to provide services for a larger population without a corresponding increase in practitioner numbers. A high proportion of routine care will be delivered through a ‘nurse-led team-based’ model allowing general practitioners to assess and treat more complex cases and develop skills in areas of GP specialisation. In the long term, it is envisaged that the majority of general practitioners in Counties Manukau will practise from a PCHC and/or its satellite clinics.

Services provided from PCHCs will vary slightly depending on the locality they serve, but will generally include:

- General practice
- Primary care nursing, including practice and district nursing
- General practitioners and nurses with special knowledge and skills (especially in the management of long term conditions)

- Dispensing and clinical pharmacy
- Primary midwifery
- Community mental health
- Medical and surgical specialist clinics (where these do not require specialised equipment)
- Dental
- Physiotherapy and other allied health therapies
- Radiology
- Laboratory specimen collection and some on-site processing
- Procedure rooms for minor procedures
- Extended hours Accident & Medical services (and, in some cases, overnight services)
- Observation facilities, with some centres having short-stay beds and others having a direct relationship with nearby residential care facilities.

PCHCs will provide a base for outreach workers, including community health workers, clinical and support services delivered in people's homes, public health nursing, community rehabilitation, and needs assessment and service co-ordination (NASC). In high-need localities, other government agencies will have customer service offices located within the centres.

Priority will be given to PCHC development in localities with the highest health needs in order to reduce avoidable hospitalisations and inequalities. These will generally be funded through public/private partnerships with private sector investment capital. Community governed 'locality PHOs' will develop to become the head lessee and facilitator of local integrated health services. They will be encouraged to look after the health of the whole community they serve and this will be monitored using health outcome and clinical indicators.

Integrating services in the PCHCs will also be achieved by integrating funding through a Locality Health Improvement Plan which will form part of the CMDHB District Annual Plan. The community and patient user groups will be actively involved in local health services delivered by the PCHC which will ensure that services are responsive to local needs.

Key points:

- PCHCs will be the key health delivery 'hubs' for delivering primary health care in defined localities.
- PCHCs will be the setting for delivery of a comprehensive range of services across the continuum from prevention, diagnosis and treatment, through to rehabilitation and continuing care for people with long term conditions.
- PCHCs will deliver a high proportion of routine care through a 'nurse-led team-based' model which can deliver services to a larger population without a corresponding increase in practitioner numbers.
- Priority will be given to the development of PCHCs in those localities with the highest health needs.
- PCHC will be operated by community governed 'locality PHOs' that will facilitate and integrate local health services.

3.2 Health Promotion and Illness Prevention

A Population Health Approach

The PCHC core teams will be responsible for the health of the locality population. Patients who enrol with the PCHC will be assigned to a core team and a 'link' primary health care nurse who will be responsible for managing and coordinating their health needs. New patients will be offered a health assessment which will include an identification of risk factors. Patients with moderate risk factors will be routinely assessed and monitored using evidence based guideline tools.

Where possible and appropriate, the same link nurse will be assigned to all members of a patient family/whanau so that the PCHC can be proactive in encouraging all members of the family to access services. This approach will assist with 'whole family' approaches to

nutrition, physical activity, lifestyle, mutual support and education where there is a family history of long term conditions.

The PHCC will have a health education resource centre, staffed by a health promoter, which will give people access to health resource materials, web-based information, and information on local classes and groups (e.g. walking groups, exercise classes, swimming groups and self-support groups). The PCHC will run regular health and lifestyle seminars which will be open to anyone in the community to attend and which will outreach into other community based services.

Key points:

- The PCHC core teams will increasingly take on responsibility for the health of a locality population.
- The PHCS will have a health education resource centre which will give people access to health resource materials and local information.
- The PCHC will run regular health and lifestyle seminars which will be open to anyone in the community to attend.

3.3 Early Detection

The PCHC will provide basic imaging and 'point of care' diagnostic services as these become available and affordable as a result of advances in technology. This will enable the PCHC teams to test to diagnose and treat, rather than having to refer to specialist outpatient services for a diagnosis - with resulting delays in treatment and the risk of patients falling between the gaps at the primary/secondary interface. Imaging and communication technology advances will enable tests to be remotely read by specialists located at CMDHB's Manukau campus.

Advances in medical diagnostic technology will eventually extend to more sophisticated home diagnostics which will support patients to take greater responsibility for monitoring and managing their health care as part of an 'expert patient' programme. Patients will be able to post their home testing results into their e-record at the PCHC using secure internet access and any unfavourable results will be reviewed and followed up by their core team. Patients will increasingly become partners in their health management.

Key points:

- The PCHC will provide imaging and 'point of care' diagnostic services as these become available with advances in technology.
- Home diagnostic technology will enable patients to take greater responsibility for monitoring and managing their health care (patients as partners).
- The PCHC will provide early detection through screening and health assessments.

3.4 Supported Self Care

A new way of working will require communication strategies to change the way that people think about their health. This will require public education on:

- The advantages of routinely accessing primary health services, rather than waiting until people become unwell.
- The benefits of self-management and the support offered through groups in the community.
- Accessing the most appropriate member of the PCHC team - not necessarily a doctor in a face-to-face consultation.

The PCHC will provide a strong focus on supporting patient self-care. PCHC staff will be committed to providing educational opportunities to assist patients to adopt healthy lifestyles practices and successful self-care – particularly those patients with long term conditions. An

extensive range of educational courses and tools will be available to patients and their significant other support people/whanau.

The PCHC will provide or host a wide range of health education classes including subjects such as:

- Activity, lifestyle and weight management
- Coping with illness
- Death and dying
- First aid, safety and CPR
- General health and wellness
- Heart health
- Living with long term conditions (including diabetes management)
- Mental health and well being
- Parenting and children's health
- Pregnancy and the new baby
- Senior health
- Smoking and tobacco cessation
- Stroke recovery
- Support for caregivers
- Women's health and family planning
- Youth and teen health.

Classes will generally be led by 'lay' (or 'peer') leaders who have graduated from previous classes and volunteer their time to the PCHC for the benefit of other patients. Lay leaders will be given additional health education and training in adult education techniques. Courses will include information about community and PCHC resources to support self-care. Tools will be available for patients to self-assess their health and monitor their progress. Those who work best as part of a team will be able to join support groups, which will be fostered to extend well beyond the term of the course. CMDHB will facilitate the development of health education packages and programmes to support PCHC staff and self-care groups.

Key points:

- Public education will be required to change the way that people think about their health.
- The PCHC will provide a strong focus on supporting patient self-care.
- The PCHC will provide or host a wide range of health education classes led by lay leaders.

3.5 Acute and Chronic Care

Acute, accident and urgent care will be provided by PCHCs' specialist teams. This will include assessment, treatment and observation and will be integrated with specialist DHB services on the Manukau and Middlemore campuses.

The PCHC core teams will provide a structured approach for those who require active ongoing planned care and support. Internal referrals will be made to members of the specialist clinical team and CMDHB visiting specialist clinics as required. Core team services will include:

- Assessment and treatment of urgent (non-accident) health needs.
- Regular review and active support and case management of patients with known health conditions.
- Annual health assessment of all enrolled patients.
- Targeting and screening patients in risk groups.

Services that will be coordinated and arranged by the core team will include:

- Bookings for specialist services delivered by the PCHC specialist clinical team and CMDHB visiting specialists (outpatient clinics).
- Assessment and services following an inpatient episode.
- Specialist pre-operative assessments that cannot be undertaken by PCHC staff using agreed clinical guidelines.
- Home treatment and support, e.g. home help and meals on wheels.
- Cultural worker or community health worker assessment and support.
- Local NGOs for relevant services and support.
- Government agencies; Work & Income, Housing, Justice, etc.
- Patient education and support groups.
- Rehabilitation services – physiotherapy, occupational therapy, speech language therapy.
- Clinical pharmacy.
- Midwifery services.
- Nutrition (dietary) services.
- Podiatry
- Diabetes eye screening.
- Expert patient education and support.
- Volunteer programme.
- Translation services.

The core team staff will ensure that these services are accessed and coordinated as part of the patient's Health and Support plan.

Key points:

- PCHC staff will provide acute, accident and urgent care that is integrated with specialist DHB services.
- The PCHC core teams will provide a structured approach for those who require active ongoing planned care and support.
- Internal referrals will be made to GPs with a special interest and other primary care subspecialty practitioners.

3.6 Specialised Care

Visiting Specialist Staff

PCHC teams will be supported by visiting specialists from CMDHB with specialist outpatient clinics booked and delivered from the PCHC. These will include those clinics where there are advantages in the specialist seeing the patient with the PHC core team to provide continuity of case history and to reinforce an agreed treatment plan. It is expected that this will also improve attendance (reduce DNAs) and help to upskill the PCHC core team for ongoing management. Clinics that require specialist diagnostic services at the time of the visit, and low volume specialties, will not be delivered from a PCHC setting, but instead generally at the Manukau campus.

Where appropriate, all outpatient clinics following hospital admission or specialist first assessment will be seen by a GP or nurse specialist under the guidance of the visiting specialist. Virtual clinics, where the specialist does not need to see the patient but can advise the PCHC core team, will also be offered.

Key points:

- PCHC teams will be supported by visiting specialists in specialties where there are synergies with primary care, and where this benefits patients.
- The majority of outpatient follow-ups will be seen by PCHC GP or nurse specialists under the guidance of the visiting specialists.
- Virtual clinics with specialists will be offered to support the PHC core team.

5.0 The PCHC Workforce

The Core Multi-disciplinary Team

Due to workforce shortages and training lead-in time, new models of care and teamwork will be developed to meet the population growth and ageing. This will require a different way of working including delegation of many traditional GP tasks to other health professionals – in particular, nurses ('nurse substitution').

The PCHC will be staffed by multi-disciplinary clinical teams ('core teams') that each will be responsible for coordinating and delivering health services to an enrolled population of approximately 20,000. Each core team will comprise of:

- General practitioners
- Nurses – including nurse practitioners, nurse specialists and primary health care nurses (at different levels)
- Health assistants
- Social worker
- Community health workers..

The majority of core team staff will be employees of the locality PHO, with some practitioners being independent contractors. The core team will also provide outreach staffing to PCHC satellite clinics.

The Specialist Clinical Team

The PCHC core teams will be supported by a specialist clinical team comprising:

- Specialist geriatrician
- Specialist paediatrician
- Specialist psychiatrist
- Clinical psychologist
- Specialist mental health nurses
- NASC assessor covering all age groups
- District nurses
- Public health nurses
- Youth nurse specialists and youth health workers
- Vision and hearing tester (working with public health and school nurses)
- Physiotherapist
- Occupational therapist
- Clinical pharmacist
- Community midwives ('the midwifery team')
- Dietician
- Podiatrist
- Diabetes eye screening technician.

The specialist clinical team will be a mix of full-time and part-time salaried PCHC staff, CMDHB outreach/visiting staff assigned to the centre, and contracted providers who work on a sessional basis. This mix will change subject to availability of staff and the needs of the locality population.

The Non-clinical Support Team

The three core teams will also be supported by a non-clinical support team including:

- Centre manager
- Administration/booking/clerical staff
- Expert patient educators (who will work with the volunteer 'lay leaders')
- Centre assistants (who will also provide a security function)
- Volunteer programme coordinator
- Up to 50 volunteers from the local community (not on staff).

All non-clinical support team members, excluding the volunteers, will be employed by the locality PHO. Health volunteers will be part of a formal programme and contribute between 2-8 volunteer hours per week for a minimum term of 3 months. They will be required to undergo a volunteer training course prior to providing services.

Cultural Support Teams

The PCHC will recruit clinical and non-clinical staff who reflect the cultural mix of the locality it serves. The centre's clinical and non-clinical teams will be supported by a Maaori health team, Pacific health team and/or Asian health team (as appropriate). These teams will have a mix of cultural, clinical and life skills and experiences, and support the delivery of both clinic and outreach services. They will also have a focus on developing the existing 'social capital' through community development in their localities.

Co-located Social Services and NGOs

The PCHC will be a 'magnet' for social services and NGOs operating in the locality. The co-location of support agencies within the PCHC will assist in developing strong working relationships between Health and other sectors. The range of agencies and NGOs will include: Housing, Work & Income, local government, sports & recreation, family planning, well child, mental health, home help, whanau support, Family Start, alcohol & drug services, home-based and carer support services, and Maaori and Pacific networks.

Clinical Teaching and Education

The PCHC will be an important venue for clinical teaching for all health professionals and as such will develop strong links with the clinical training institutions. The PCHC team will be large enough to accommodate students at various levels of training and some services will be delivered by 'student practitioners' (senior students in their final year of training) under supervision.

Students in training will have the opportunity to experience first hand multi-disciplinary teamwork in primary health care with a focus on population health approaches including health promotion and risk reduction. Exposure to the PCHC way of working will have a positive impact on clinical students which in turn will promote primary health care as a popular career choice for graduating health professionals.

Key points:

- New Models of Care and teamwork will be developed to meet the growing population needs.
- The PCHC will be staffed by core teams responsible for coordinating and delivering care to a locality.
- Core teams will be supported by a specialist clinical team, a non-clinical support team and a cultural support team.
- PCHC teams will have access to co-located social services and locality NGOs.
- Clinical teaching and education will be an important part of PCHC services – to attract and retain the future workforce.

6.0 PCHC Teamwork

The Role of Nurses

Services to the enrolled population will be coordinated, and mainly delivered, by the core multi-disciplinary teams ('core teams') with the majority of front-line services delivered by the core team nursing staff.

The new Model of Care will require an investment in the PCHC nursing workforce. All nurses will be required to have core competencies in primary health care and provide a continuum of patient care that incorporates the roles and responsibilities previously undertaken by separate

nursing services. A structured and supported PCHC nursing career path will be available to nurses wanting to undertake further specialist training in a range of areas such as:

- Long term conditions and specific disease management (COPD/respiratory, diabetes, CVD/health failure, etc)
- Mental health
- Adolescent and youth health
- Child health
- Wound care
- Palliative and end of life care
- Older people care
- Pre- and post-operative care
- Post-hospitalisation follow-up
- Accident and acute care
- Alcohol and drug services.

The majority of PCHC nurses will be generalist primary health care nurses with a strong focus on population health. A significant number of PCHC nurses will be nurse specialists in one of the above areas and a smaller number will be nurse practitioners. Primary health will be an attractive career option for nurses wanting to practise as advanced practitioners within a large, supportive primary health care team.

The Role of General Practitioners

With the development of nursing able to provide most first level primary care services, GPs will see patients with more complex clinical needs. They will also provide medical support for nurses and other members of the team. This will make better use of the GP resource within the PCHC and support nurses to extend their scopes of practice. The majority of PCHC GPs will have an area of special interest within their core team, with some providing clinical leadership across the PCHC. Many GPs will also have a clinical or liaison attachment to CMDHB services and will be actively involved in service improvement processes across primary/secondary services. This level of clinical involvement will foster a more integrated delivery system through a better understanding of the issues across the whole sector continuum. It will also assist the development and introduction of clinical guidelines and audit to support nursing practice.

Healthcare Assistants

The healthcare assistant will be an important new role that will allow nurses to delegate basic tasks such as preparing patients for clinic, including recording basic patient data. Healthcare assistants will recall patients for routine appointments and provide other patient administrative support to the core team.

Community Health Workers

Community health workers (CHWs) will be deployed as part of the PCHC team to work with high need populations to improve patient/whanau access to all PCHC services. CHWs will provide support for high need patients who must attend a clinic, support case management by helping patients with transport, provide health promotion advice, and work with families where required to support care in the home.

Key points:

- PCHC service will be coordinated and delivered by multi-disciplinary teams with the majority of front-line services delivered by nurses.
- General practitioners will see patients with more complex needs and also offer expertise in areas of sub-specialisation.
- Health assistants and community health workers will also be key members of the core teams.

7.0 Accessing PCHC Services

Hours of Access

PCHCs will provide an extended hours clinic service Monday to Friday to allow patients to access their core team outside of normal working hours. The PCHC will provide accident and urgent medical services from 5-10 pm 7 days per week, including observation beds that can be utilised until 8 pm. Patients who require observation after 8 pm will be transferred to specialist inpatient services (either at Middlemore, or at a local residential care facility). Accident and urgent medical services after 10 pm will be directed via a 24/7 nurse triage help line to the nearest designated 24-hour clinic if the patient requires urgent care/treatment. Emergencies will be directed to Middlemore Hospital.

Low Cost Service

Maintaining a low cost service will assist patient access to primary health services. The PCHC will offer a subscription payment scheme - covering diagnosis, treatment and pharmaceuticals – as an option in addition to fee-for-service copayments,. A subscription payment option will also be available through Work & Income for people receiving benefits.

Primary Triage Services

All 'in-hours' patient calls will be directed to a core team nurse. The nurse will be able to access the patients' electronic notes and discuss their health needs/concerns. Where the patient has a long term condition, the individual care and support plan can be accessed, discussed and modified as necessary. Many health enquiries will be addressed by the nurse through this initial telephone assessment and in consultation with other members of the core team.

Patients who need to be seen will be booked for an appointment with their core team nurse. The nurse may refer to a core team GP at the time of the visit where clinically required, for advice or for a second opinion.

A 'walk-in' (non-booked) service will also be available for patients who prefer to discuss any health concerns face-to-face on the understanding that they may not be seen by their designated core team. Patients with long-term conditions will be encouraged to access services through their core team and only use walk-in services when essential.

Patients will also be able to access health advice from their core team using e-mail. Email consultations will be subject to access guidelines, e.g. limited size and attachments.

Key points:

- PCHC services will be available at times that suit patients.
- Emergency and urgent services will be integrated with specialist hospital services.
- Maintaining a low cost service will assist patient access to primary health services.
- A primary triage service will be put in place to ensure that patients can access appropriate services.
- Walk-in and e-mail consultations will be available to improve patient access.

8.0 Integration Enablers

Information and Information Systems

Information is an important enabler for integration. The PCHC will have a single integrated patient management and information system which can be accessed remotely. Full clinical notes will be available to the core team the patient is registered with and specialist services that the core team refers to – that is, the PCHC specialist clinical team, visiting specialist services, and specialist and diagnostic services at DHB campuses.

A summary clinical record, to an appropriate level of detail, will be accessible:

- At the PCHC when a patient presents for urgent care after-hours,
- By CMDHB Emergency Care at the Middlemore campus when a patient presents for urgent care,
- By PCHC non-clinical support team (on referral by the core team), and
- By NGO service providers (also on referral).

Patients will be able to access their full clinical records electronically or view these at the PCHC. They will also be able to assign electronic access to a third party provider through a secure national network – for example, when accessing urgent care when they are away from their PCHC. Patients will also be able to delegate access to next of kin for emergency access.

The core team will be able to make direct 'e-bookings' for some specialist services delivered within the PCHC or in any CMDHB facility subject to certain criteria being met. Booking of CMDHB outpatient services will be through agreed clinical protocols and can be discussed with the visiting specialists.

Technology will play an important part in supporting self-care. It will be used to give patients access a wide range of general health information as well as information specific to their illness or disease. Patients will be able to check on bookings and results, and gain access to clinical tools and support (e.g. BMI calculator and weight management tools). Mobile phone technology will be used extensively to support self-care, record and transmit results, and for health reminders and recalls. Decision-support tools (e.g. for CVD risk assessment) will be available for patients to use in conjunction with home diagnostic testing.

Patients will be able to update their records and results on-line and these will be monitored by their core team link nurse. PCHC staff will use technology to give feedback, support and encouragement. Patients will be able to make on-line appointments with their core team and use validated access to order repeat prescriptions.

The public will also be able to access information on PCHC locality services including clinic opening hours, and practitioner biographies when enrolling with a core team (e.g. qualifications, special interest areas, and languages).

The PCHC Facility

The facility is an important enabler for integration. PCHCs will be modern purpose-built facilities that will accommodate the core teams, accident and urgent care services, diagnostic services, minor procedure rooms, clinical support and outreach services, dental, NGO support services, and associated health retail. Clinic rooms will generally be multi-purpose (not allocated to individual practitioners) to maximise flexible use. PCHCs will be designed to be a community resource with a 'Health Education Resource Centre' and meeting rooms which can be accessed by patient groups and support classes in the evenings and on weekends.

Key points:

- Information and information technology will be a key enabler for integration.
- Summary patient information will be available to providers in different settings and when patients access acute and emergency care.
- The PCHC core team will be able to make e-referrals and bookings for specialist services.
- Technology will play an important part in supporting self-care.
- Patients will be able to access and update their clinical records and access information on PCHC and community services.
- PCHC facilities are an important enabler for integration to support co-location and visiting specialist services.