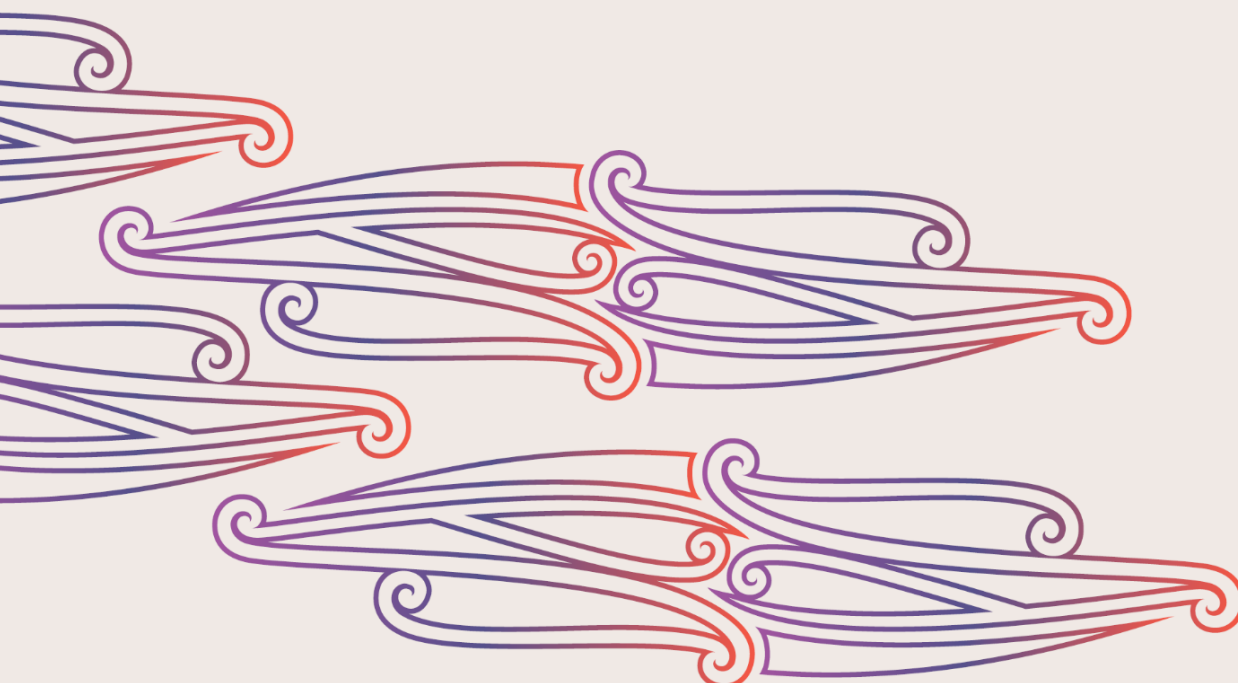




**COVID-19 care in the community
system learning opportunities |
KŌWHEORI-19 he whai wāhi hei
ako pūnaha manaaki i te hapori**

April 2023



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**Te Kāwanatanga
o Aotearoa**
New Zealand Government

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Health Quality & Safety
Commission



Acknowledgements | Ngā whakamihi

'I really appreciated the opportunity to all get together and have these discussions to not only discuss challenges we'd been experiencing but more so to feel heard and recognised.'

(Participant feedback)

On behalf of Te Tāhū Hauora Health Quality & Safety Commission, we would like to express our sincere appreciation to all contributors to this report for their work, dedication and contributions to our communities during the continued uncertain times of the COVID-19 pandemic.

To be able to tell their stories of what worked, what did not work and how they continued to provide services centred around their communities allows the health and disability sector to reflect on some important learnings.

This document has benefited greatly from the commitment, expertise and wealth of knowledge that these contributors so generously brought to this kaupapa. The time and guidance they have given to COVID Care in the Community is much appreciated.

Fittingly, the whakataukī (proverb) below encapsulates the combined efforts as it speaks of sharing resources and knowledge to ensure the wellbeing of all people.

Nāu te rourou, nāku te rourou, ka ora ai te iwi.
With your basket and my basket, the people will thrive.

Executive summary | He kupu whakarāpopoto matua

A project was initiated with Manatū Hauora | Ministry of Health (MoH), COVID Care in the Community (CCitC) health providers and Te Tāhū Hauora Health Quality & Safety Commission (Te Tāhū Hauora) to understand the processes that the CCitC hubs had adopted. The scope of the review includes four care coordination hubs identified by the MoH (three in Auckland and one in Southland) and may not reflect the approaches adopted by other hubs. Through a collaborative system learning review methodology¹ and the use of focus groups to hear the lived reality, we were able to learn about the important models of care delivery and how these have underpinned and informed improved care.

The project was to purposefully emphasise the localised lived experience of CCitC care providers, therefore the work that occurred before 2022 by the MoH in establishing and shaping the design of CCitC was not within scope. This review has identified system improvement opportunities, derived from common themes from the four hubs we engaged with, that can further inform and strengthen existing national and regional health care system enablers to support those providing care. Our aim now that CCitC has moved from the MOH to Te Whatu Ora, that Te Whatu Ora and Te Aka Whai Ora work together to act on the system learning opportunities to help strengthen the health care system and support all those providing health care in the future.

This report is focused on the CCitC response from January 2022 through to the end of July 2022 and there are several key salient points that are important to highlight:

- differing contexts meant that there was no 'one size fits all' approach. There was a need to work relationally to understand the contexts and find solutions that met these diverse needs
- decentralised responses were needed to respond rapidly to the changing needs of communities yet these were dependent on centralised resourcing and strategic direction. This local-central interdependence created challenges to coordination
- the historical system structures, priorities and funding models conditioned and constrained the way the response unfolded. Issues of power and voice were central to challenging these and finding new ways of working
- the formal safety systems captured certain kinds of harm but were blind to many significant risks being managed by staff
- the response relied on reprioritisation of care and redeployment of staff. The capability to respond effectively to future waves cannot be assumed.

¹ Pupilidy I, Vesel C. 2017. The learning review: adding to the accident investigation toolbox. In: Proceedings of the 53rd ESReDA seminar, Ispra, Italy. European Commission Joint Research Centre.(pp 255–61). URL: www.safetydifferently.com/wp-content/uploads/2018/08/171024TheLearningReview.pdf.

Understanding the system to inform improved care

The changing risks highlighted throughout this report, and the adaptations that were made to manage them, were generally invisible to our formal safety system in health care. Health care workers saw that responding to harm and adapting for and resolving issues was core to their daily work rather than identifying such harm and issues as risks to be reported. This is a common finding in complex adaptive systems, such as health care, where managing competing risks is a key task and is seen as an intrinsic part of professional identity.

Safety learning is dependent on making visible the changing risks within the health care system and highlighting 'system surprises'. It is notable that the issues reported by participants in the focus groups were not captured by the MoH CCitC framework or other formal safety structures. The concern is that this finding may be replicated in other parts of the health system, meaning other areas may also be potentially blind to how risks are changing.

Additionally, given the dynamic work and stretched systems, local quality and safety governance has predominantly focused on resolving operational issues, with limited use of hospital reporting systems or formal feedback channels.

System safety improvement opportunities:

- enable models of governance that meet the needs of diverse whānau and communities and inform the funding of health care services to meet the needs of end users
- widen the health care risk reporting system to encompass community, primary and public health care services and focus on making visible how risk is changing across the whole health system.

The CCitC response highlighted the different realities and needs that exist within Aotearoa New Zealand. Rather than a single response, multiple responses were required to deliver safe care that met the differentiated needs of people. These responses were built on the existing relationships that the CCitC hubs had with their communities.

However, the responses were constrained by historical structures that were often poorly matched to the need for a whole-of-system approach. These include the boundaries between primary and secondary health care or in traditional demarcations between 'health' and 'welfare'. It took extensive effort to bridge system boundaries and develop innovative new ways of working.

Information technology (IT) system improvement opportunities:

- provide a single IT health record across all health providers (for example, general practice, ambulance, hospital, maternity) that also supports whānau-based health care
- create governance tools (dashboards, reports, etc) to provide transparency of the overall health care system performance and to inform clinical governance decision making
- telehealth services to support rural emergency and primary health care response.

Understanding the impacts of how health care is commissioned and funded will be central to meeting the needs of differentiated communities. Pre-existing funding mechanisms had significant impacts on the provision of health care. While these mechanisms have worked well for funding general practice (GP) services, they were poorly suited to other primary and community health care providers, particularly Māori and Pacific providers.

Commissioning system improvement opportunities:

- ensure investment in 'by Māori, for Māori' and 'by Pacific, for Pacific' health services that will enable health services to be responsive to their communities
- fund for capacity rather than just activity, allowing health care providers the flexibility to meet the changing demands of health care in their communities
- provide ongoing funding for the CCitC hubs to support health care delivery across system boundaries and maintain the health capacity to respond to public health challenges.

Authentic and appropriate models of care are informed by those who best understand the cultural needs of their communities. This requires a workforce that shares the same cultural values as the communities they support.

Workforce system improvement opportunities:

- a long-term commitment to growing a diverse workforce that can meet differentiated needs, in particular, increasing the number of Māori and Pacific people in the health workforce
- develop the unregulated workforce, such as kaimanaaki and health navigators, to help deliver appropriate health care services. This would include a pathway of recognition for unregulated workers and mechanisms of oversight.

The success of the CCitC hubs was built on being able to work relationally with those needing CCitC, taking time to understand the experiences and specific needs of people engaging with the health services to guide service delivery appropriately.

Consumer- and whānau-centred system improvement opportunities:

- models of health care must not be built on assumptions but are culturally intelligent, valuing communities' 'soft intelligence' and focused on reducing inaccessibility.

Introduction | Kupu whakataki

This report was written following the He Awa Whiria model, like a braided river, which ‘allows for different cultural knowledge systems to function separately or together, just as the streams of a braided river flow apart or together in their journey to the sea’.² This approach has enabled partnership and for the uniquely different voices and world views to be heard with equal mana and to be woven apart and together in the discussion section.

The ‘rivers’ are the sections that contain the voices heard through the focus groups. The Māori and Pacific sections were each written in partnership with the COVID Care in the Community (CCitC) hubs to embrace tino rangatiratanga and kāwanatanga reflecting our commitment to principles of Te Tiriti o Waitangi. In line with Pacific world view and the Pacific methodology used, it is important to recognise that the quotes in the Pacific section have been attributed to the collective rather than individuals.

Background

The Ministry of Health (MoH), through the Office of the Clinical Chief Officers (OCCO), asked Te Tāhū Hauora to support the CCitC hubs with mortality reviews of people receiving care who died with COVID-19, with the aim of identifying any contributory factors that may have led to preventable deaths. After consideration, Te Tāhū Hauora presented to OCCO an alternative system learning approach. This is consistent with the Commission’s existing methodology around learning from harm and will assist in identifying risk and preventing future harm within the CCitC hubs.

Te Tāhū Hauora was to prioritise this piece of work with the intention of a timeframe that would result in improvement opportunities within the new health system for Aotearoa New Zealand 1 July 2022. The timeframe was extended to accommodate Southern Health systems and the distinctly different geographical and community settings they would bring.

The review was conducted as a collaborative process between the MoH (as of 1 July 2022, Te Whatu Ora and Te Aka Whai Ora), CCitC health providers and Te Tāhū Hauora, with a desire to improve health outcomes and health service processes and is not about attributing blame.

Te Tāhū Hauora acknowledges there have been, and currently are, a variety of reviews and reports regarding the wider COVID-19 health care response. There are some synergies between the Te Tāhū Hauora report and other reports, highlighting and validating consistent opportunities to improve³ and reduce harm.

² Superu. 2018. *Bridging Cultural Perspectives*. Social Policy Evaluation and Research Unit (Superu). Page 1. URL: <https://thehub.swa.govt.nz/assets/Uploads/Bridging-Cultural-Perspectives-FINAL-0.pdf> (accessed 6 October 2022).

³ For example, see Field A, Bateman A, Wehipeihana N, et al. 2022. *Delta Response Rapid Review*. Wellington: Ministry of Health. URL: health.govt.nz/publication/delta-response-rapid-review (accessed 6 October 2022); PaRCH. 28 April 2022. Response. *Pacific Regional Coordination Hub Response Post Implementation Review*. Pacific Regional Coordination Hub (PaRCH).

Purpose

The purpose of this report is to reveal the everyday reality of providing CCitC, with a specific focus on how Māori and Pacific communities and organisations provided care, given early predictions of these communities being at high risk from COVID-19.⁴

We focused on identifying issues, barriers and goal conflicts as well as adaptations that enabled safe health care. We aimed to understand the processes that the CCitC hubs adopted that enabled opportunities to learn about care delivery and how these processes have informed improvements. In line with the 'He toki ngao matariki Aotearoa, resilient health care' approach of Te Tāhū Hauora, we focused on establishing trusting relationships to enable participants to share their everyday experiences of COVID-19 health care. Our aim is that the MoH will act on the system learning opportunities to further strengthen the health care system and support those providing health care in the future. We did this through seeking to:

- understand how people navigated risk and created safe health care at various levels of the health care system
- explore what conditions made risk hard to manage
- make visible the system pressures at various levels of the health care system
- understand information flows within the health care system and how these inform improved care, particularly:
 - current processes to learn from harm
 - how they capture and understand the experience of people engaged with care and response to harm.

Engagement with CCitC governance

Te Tāhū Hauora representatives were invited to the Northern Region Health Coordination Centre (NRHCC) and the Southern Integrated COVID-19 Care Safety and Quality Group Health (SICCSQG) governance meetings to describe the purpose and proposed approach to our review, and both groups subsequently agreed to participate. The NRHCC and SICCSQG took responsibility for coordinating focus group invitations.

The team from Te Tāhū Hauora, the Māori Regional Coordination Hub (MRCH) and the Pacific Regional Coordination Hub (PaRCH) met separately, and through a wānanga process, agreed on an appropriate method for engagement.

⁴ Sharma S, Walton M, Manning S. 2021. Social determinants of health influencing the New Zealand COVID-19 response and recovery: a scoping review and causal loop diagram. *Systems* 9(3): 52. DOI: 10.3390/systems9030052.

Ethics

The engagement with focus group participants reflected bioethics principles and the Te Tāhū Hauora equity guide Te Ara Tika.⁵ The purpose of engagement was to identify quality system improvement opportunities and therefore ethics approval was not required. CCitC hubs were asked prior to commencing focus groups to consider local ethics approval in line with their policies. A copy of the information sheet that was provided to focus group participants is available in Appendix 1: Focus group information sheets.

Scope

The collaborative approach with the CCitC hubs involved multiple focus groups with health care workers. These provided an opportunity to capture a variety of perspectives on aspects of CCitC, for example, clinical governance and health IT, and from specific groups, such as Māori and Pacific health care providers, residential facilities teams, former refugee support teams, community providers and rural health workers.

The Te Tāhū Hauora team actively considered how best to engage with people receiving COVID-19 health care and, given the scope, chose to focus on understanding how the hubs captured people's experiences, including the experiences of harm. This decision was supported by the hubs, who appreciated the concern for potentially compounding harm through a review process.

⁵ For more information, see the webpage Ethics guide on the Te Tāhū Hauora Health Quality & Safety Commission website at hpsc.govt.nz/our-work/leadership-and-capability/building-leadership-and-capability/quality-improvement-project-bank/ethics-guide/

The 'rivers' | Ngā 'awa'

Context and provision of care

The need for CCitC arose from a recognition that the previous public health approach of 'elimination' and the use of managed isolation quarantine (MIQ) would not be able to meet the health care needs of the population if there was a widespread community outbreak of COVID-19.⁶ Work on new models of care began during the Delta outbreak and scaled up with the growing numbers of Omicron cases. As the MIQ approached capacity, positive cases could no longer be managed solely within its relatively controlled environments. There was an urgent need to provide health care to large numbers of people in the places where they live.

The scope of this report reflects care for the Omicron variant of COVID-19, which became prevalent in Aotearoa New Zealand in early 2022. However, we acknowledge the significant mahi that occurred before 2022 and the foundation this provided for the establishment of the hubs. The Māori and Pacific teams had been central in the response to the Delta outbreak in their communities, and the relationships formed during this time provided a scaffold for the response to Omicron.⁷

'Whānau HQ was able to stand on the shoulders of some really good relationship stuff ... ways of working together [founded on NRHCC].'
(Governance respondent)



⁶ Field A, Bateman A, Wehipeihana, N, et al. 2022. *Delta Response Rapid Review*. Wellington: Ministry of Health. URL: health.govt.nz/publication/delta-response-rapid-review (accessed 6 October 2022).

⁷ *Ibid.*



Saving Māori lives – CCitC by Māori for Māori (written in partnership)

Staff of two Māori CCitC hubs, the Auckland Metro MRCH and WellSouth Manaaki COVID-19 Hub, generously shared their time and stories to help form the account that follows. Ngāti Whātua Ōrākei, as mana whenua and an independent Māori health care provider were partners in the development and set up of the MRCH. They also shared their views on what it took to provide frontline care to whānau Māori within the Tāmaki Makaurau area. The two hubs are quite distinct, with diverse functions and capabilities, and each serves a distinct population. Strikingly, all three participating organisations share common values and experiences that govern the care they provide to whānau Māori contending with COVID-19 in their homes. This is their story of dedication, drive and passion to protect and save Māori lives.

The MRCH was predicated on saving Māori lives and keeping whānau safe during the initial Delta phase of the COVID-19 pandemic. It went live in December 2021 as demand on an already over-burdened public health service was rising significantly. What was apparent was the systemic failure of the health system response at that time, with COVID-19-positive people facing delays across the health system – in testing, contact tracing, results notification, receipt of assistance from the Auckland Regional Public Health Service (ARPHS), referral/transfer to MIQ/community isolation and quarantine – all severely delaying time taken to isolate a person and provide them with appropriate health care.

The complex and overloaded health care system involved handovers and transfers between multiple providers, with minimal safety checks and oversight. Furthermore, the policy shift to home isolation highlighted the fact that the ARPHS, as a public health provider only, was not designed to serve Māori well. Whānau Māori were left vulnerable and poorly set up to stay safe, even though, as a population group, they were considered high risk. These issues, in addition to concerns about cultural safety, such as the lack of Māori-appropriate personnel and work processes, prompted the establishment of the Pae Ora Mobile unit in September 2021. Pae Ora Mobile were able to address and better meet the needs of whānau Māori by taking contact tracing to the community and prioritising whakawhanaungatanga and manaaki needs before public health investigation and questioning.

The evolution to MRCH was the next iteration of the rapid service changes needed to respond to, and avoid further, service failings for Māori. The MRCH model of operation was planned, developed and implemented within weeks. Staff were recruited and trained to the model, and a team of up to 30 people, made up of clinical, coordination and various welfare staff, started their work from office facilities located in East Tāmaki in late December 2021. Its mandate was to risk assess all Māori COVID-19 cases and provide COVID-19 care and assistance to all high- to medium-risk whānau Māori across the three Auckland district health board (DHB) catchment areas – extending from Wellsford in the north to Franklin in the south. The intention was to provide a culturally safe triaging service at the same time as assessing clinical, public health and welfare needs and referring patients to appropriate providers while maintaining oversight and coordination so that Māori cases did not fall through the cracks. The main community providers were the Whānau Ora Community Clinic, Turuki Healthcare, Ngāti Whātua Ōrākei and Te Whānau o Waipareira.

As the omicron variant became more prevalent in Te Waipounamu, WellSouth Manaaki Welfare COVID-19 Hub started to mobilise, informed by the northern region's approach.



The MRCH model – a tino rangatiratanga approach

The MRCH model deliberately used a tino rangatiratanga approach to provide a unique ‘by Māori, for Māori’ service, with Māori governance, sovereign decision-making and Māori-led solutions. It supported use of holistic Māori models of health and wellbeing. The MRCH model represented a paradigm shift that transformed the established NRHCC’s Whānau HQ model (see Appendix 2: Overview of COVID-19 care connections for Auckland). The resulting model was premised on principles, values and mātauranga Māori – Māori values were privileged, including manaaki, whanaungatanga, aroha and responsibility to whānau and community. These values were central to and fundamental in the design and development of the MRCH model of care. This made MRCH influential at many levels and helped in the design and redesign of the Whānau HQ, WellSouth, Waikato and Northland hub models.

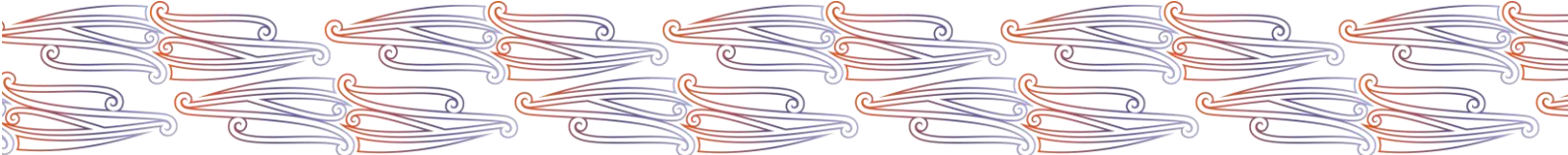
The MRCH model deliberately transformed the existing public health model, focusing first on whakawhanaungatanga, then the simultaneous assessment of welfare, clinical health and public health needs.

MRCH was specifically designed to combine all three domains because the mainstream systems were refusing to do that; the funding was refusing to do that. So we had to create a new paradigm. We had to basically sit down and say, if our priority is to save Māori lives, what would we do?
(MRCH governance respondent)

The MRCH model abolished traditional boundaries between the domains of public health, clinical and welfare needs by bridging across all three fields simultaneously. Risk had been created for Māori in the existing model when public health approaches to individuals identified as COVID-19-positive were found unacceptable or unwelcome. Many whānau had been approached first with privacy statements and in-depth public health-focused interviews and had refused, for various reasons. MRCH provided a holistic, household or whānau approach that started with the question ‘What do you need?’

The focus on whakawhanaungatanga, first via aroha and manaaki, allowed MRCH workers to access households that had resisted public health approaches or had found them unacceptable. Once the relationship and trust was established, or re-established, clinical and public health concerns could be addressed. Initial contact therefore focused on the lived reality of whānau Māori coping with COVID-19 in their homes and communities rather than identifying and managing epidemiological risk. This was a holistic approach based on the welfare of whānau and households not individuals or the need to manage COVID-19 from a public health perspective. MRCH thus reflects tino rangatiratanga, Māori self-determination to find Māori appropriate responses and solutions.

As organisational structures, the MRCH and WellSouth Māori hubs adopted flat, strengths-based hierarchies similar to the way a marae functions – one where ‘everybody digs in’, individual strengths are known and people are sent where their strengths can best be used. This model is based on shared collective values, collective responsibilities, trust and relationships. Hub staff were required to take on multiple roles.



‘That’s a really important message because it’s a bit like being on a marae. You have many, many hats. You’re applied to what’s your strengths, or not, or where you need to be.’

(MRCH respondent)

The Māori hubs are viewed as sovereign spaces where staff are trusted to work for the good and a set of shared values around protecting one’s own whānau. This allowed rapid evolution, dynamic flex and adaptation to changing conditions, in particular, in the shifts from Delta to Omicron and polymerase chain reaction (PCR) testing to rapid antigen testing (RAT) and in anticipation of exponentially rising new case numbers. Safety science experts refer to this as ‘course approximation with fine adjustments’.⁸

‘We were doing that just without the flash words.’ (MRCH respondent)

Tensions were created when formal governance structures were imposed externally on this way of working. Control over a Māori space and successful Māori model, even when seen from outside as risk management, was experienced as an act of colonisation and a violation of tino rangatiratanga.

‘It’s very confusing because Whānau HQ are confused themselves around who we belong to. They keep trying to – they have tried to colonise us and claim us as being under them. And I reject that.’

(MRCH governance respondent)

The tino rangatiratanga that, in itself, allowed the success and access of the model to whānau is the quality that felt under attack, resulting in active rejection of attempts to colonise their model of care.

In the context of rapidly rising case numbers and the need to respond dynamically and quickly, the MRCH structure removed bureaucratic barriers and hierarchical leadership, often using plain common sense when critical decision-making was needed on the fly. Mainstream policy approaches were experienced as cumbersome or too slow to react to information flowing up from MRCH, despite MRCH informing the MoH and the Ministry of Social Development (MSD) of its approach to Omicron and design of the triaging tool.

‘We designed the triaging tool, that came from us, that we then handed over to the Ministry to use nationally. So ... we use our different roles for whatever’s needed.’


(MRCH governance respondent)

Risk was created when events happening on the ground were changing fast and experienced as quite different to perceptions and decisions being made ‘from the top’.

Delays in contractual and funding processes were experienced as hindrances to attempts to create or understand and draw on functional relationships to make rapid decisions in a dynamic context.

MRCH’s successful ability to both reach out to and access people who had resisted contact and to identify ‘invisible’ cases or risk within households was enabled by this tino

⁸ C Horsley, personal communication, 23 August 2022.



rangatiratanga approach. The Māori hubs became safety nets for whānau Māori with COVID-19 who were excluded by the public health system.

Whānau based

A whole-of-household approach was used across the Māori hubs, and need was identified directly by whānau, extended whānau and community members. Risk arose when mainstream systems and services were unable to comprehend this whānau-based model. For example, risk level based solely on the positive individual limited the ability to reach low-risk cases who may have contact with high-risk household members.


Funding formulae are based on data for individuals only and cannot extend to whole or extended families who live multigenerationally. These formulae therefore systemically privilege non-Māori non-Pacific households. Similarly, access to welfare is based on fitting defined criteria for help and undefined measurements of deservedness for care that do not take into account challenging home and social circumstances. Further assumptions in system design hindered whānau access to care because they did not acknowledge the reality of some peoples' lives, such as the assumption of IT connectivity and lack of awareness of 'digital inequity'.

'So that was one of the other weaknesses of all the systems. We have multiple systems. But none of these multiple systems is collecting the data that is required to represent a whānau-centric model'.
(MRCH respondent)

The Māori response to CCitC was to be inherently inclusive, accepting of all ethnicities, unregistered families, hard-to-reach families, people sleeping rough and other marginalised or disenfranchised groups. Even in the face of political and community backlash, MRCH established an ongoing relationship with a national Mongrel Mob leader in order to ensure a level of buy-in and trust in order to secure resources for affiliate families. Assistance was deployed where the need or risk was found to be highest.

Relationships based

The Māori hubs drew heavily on existing trusted relationships and established partnerships with communities and providers that hold local knowledge and intelligence. These relationships are interdependent, relying on trust and constant information flow and feedback loops to keep each other updated and performing efficiently. The hubs needed visibility of community provider capacity on a day-to-day basis. Regular daily huddles to share and seek information from each other, their clinicians, and to be updated on issues arising for the hub and its many providers was a feature of the Māori hubs.



'The thing I wanted to say was the end-to-end connections that we had. So, as we saw the lab testing PCR stuff breaking down and we could see the RAT testing was coming, we still had to navigate a pretty complex system to be able to get RAT testing into our community providers. But because we had end-to-end good relationships across community providers and social and health providers and our team, and into Whānau HQ and into NRHCC, we were able to quickly get those RAT tests delivered through an informal distribution approach to service all of those providers until we got bigger supplies. And getting bigger supplies required a bit of a breakthrough from [A] and [K] as well. But, you know, the evidence that we had those good relationships was deployed time and time again to get good results.'

(MRCH governance respondent)

Relationship-building was also required with a multitude of external players – including the MoH, MSD and DHBs. This was particularly important for forward planning, anticipating impacts and responding to context – course approximation and adjustments, and the ability to impact both regionally and nationally. Even though the hubs often found national directives to be at odds with what was happening in the community.


In WellSouth, managing a large network of providers and stakeholders across vast geographical areas presented risk to providing care to whānau and to the hub workers themselves. This was overcome largely by calling on pre-existing relationships but also the recruitment of a Māori workforce directly into the DHB itself and throughout the provider network. This was a necessity given that the entities at that time held different contracts – for example, WellSouth managed the Manaaki Welfare and public health teams, and providers held the swabbing, MSD and vaccination contracts. It also meant a great deal of coordinating and matching whānau to the most appropriate provider, which at times was dependent on who had, or did not have, capacity.

Concurrently, WellSouth were dealing with inadequate levels of GP coverage and a significant population of people not enrolled in the DHB catchment area, such as tertiary students, seasonal workers and whānau who only rarely engage with health care services, or who live in remote locations. However, once contacted, these people were proactively directed and given koha to attend and enrol with a general practice. In this way, the Māori hubs acted as a gateway for unenrolled whānau to access health care now and in the future.

In some instances, rural hospitals were reappropriated to provide community COVID-19 care.

Strengths-based governance and leadership

The Māori hubs function as collective/multidisciplinary teams, drawing on peoples' different strengths, skills, experiences, knowledge, networks, relationships and on team knowledge of these strengths and the ability to quickly move people to where their strengths can best be used.



'I've got a kind of bunch of roles. So, on Saturday, I'm clinically for MRCH and, you know, actually figuring out some of the complex cases and sometimes during the week. And then also, I'm on the clinical governance stuff representing MRCH but also from Whānau HQ and occasionally going to meetings to advocate and support the kind of intentions and designs that the MRCH leadership group has.'

(MRCH governance respondent)

'I really believe in the [MRCH] model. From a personal journey, within this COVID[-19] response, I found my own identity within my Māori whakapapa. I've been brought up very privileged, very Pākehā, and I had the privilege of working in health care when you say, "I've got this great idea or great initiative" that things get handed to you. So you get, "What do you need? Do you need staff? Do you need resources? Do you need funding? Do you need ...?" And it gets put to you and you go, "Great! This is amazing!", and you get it off the ground.

'And then I stepped into a kaupapa Māori space where I still have all the same connections with people out there and I'm like, "Hey, this is what we need. We need to do this, this, this, and this." And they go, "No, you can't do that. You can't do that. You can't have that. You can't have that funding. No." Doors shut. ... And I'm standing here going, I'm still the same person as before and still working in health care, yet all the doors are shutting on me. And I had to go out to the wider whānau and go, "Is this just what it's like being Māori?" And they were like, "Yeah". Oh my gosh, it's like wading through mud to try and get what you need for your people.'

(MRCH governance respondent)

The Māori hubs needed strong leaders in order to establish themselves in their own right and to survive external pressures of institutional racism and bias that kaupapa Māori organisations are subjected to. Their governance groups constantly lobbied on behalf of their workers and the model of care that they wished to deliver to their whānau and communities. This required liaising with multiple stakeholders at national and local levels, even when that liaising was historically fraught by relationships that challenged their tino rangatiratanga. One leader who, by virtue of their Māori and Pākehā whakapapa, was able to negotiate both Māori and Pākehā spaces felt the differences in how innovation and resourcing worked depending on who was asking.

Māori health experts involved in the development of MRCH reported how hard it was to influence CCitC policy and funding decisions. To be heard required them to be overtly forthright, tenacious and resourceful. They found their voices were frequently ignored, contested and debated in direct contrast to current health policy rhetoric that affirms the importance of solutions and expertise led by Māori. Some were exposed to interpersonal racism or unconscious bias from their colleagues that speaks to the undervaluing of Māori knowledge and intelligence.

The WellSouth Māori governance experience was not so fraught, due to pre-existing strong Māori leadership that was already functioning within the DHB in a more partnership-based way.



Solutions focused

The Māori hubs are driven by passion and dedication to finding solutions to problems from a values-based position. For example, risk was identified where the various IT systems were unable to talk to each other. IT issues were worked on until a solution was found, with staff navigating and merging information from across multiple domains.

‘So each time there's a data problem, we just work [through] the problem until there's a solution.’

(MRCH respondent)


Further risk arose when frontline COVID-19 community workers were unable to or prohibited from accessing patient information due to role restrictions. This was resolved simply by sharing information informally while also protecting and respecting issues of patient privacy.

One of the most significant risks for whānau Māori in Tāmaki Makaurau occurred when MSD took over the welfare contracts. Historical negative experiences when engaging with MSD has resulted in a strong distrust of this organisation for many, to the extent that some whānau Māori reject all contact. Understanding this whakapapa of distrust, MRCH responded by finding alternative welfare providers. Often these providers gave their time, expertise, resources, money and support voluntarily or on the promise of payment. However, frustrations arose when contractual arrangements resulted in delayed payment for providers who were often left out of pocket for extended periods.

A further example of Māori public health innovation associated with those leading the MRCH model included the development of the triage tool in response to the measurement of epidemiological risk being unable to score those truly most at risk. The triage tool involved electronic assessment to identify social and public health risks associated with Māori cases not enrolled with a GP, those living in high-deprivation areas and people not vaccinated against COVID-19 (all markers of health service disengagement, social risk and high clinical risk). The assignment of high, medium or low risk allowed the most urgent cases to be prioritised by Pae Ora Mobile and eventually MRCH. Once contacted, additional risk factors could be identified such as whānau who lack resources to be IT connected and IT literate and vulnerable whānau often with exceptional additional need due to ‘invisible’ risks, such as elderly household members with multiple co-morbidities or households with family members who were coping with mental illness, substance dependency, disabilities, pregnancy or food insecurity.

The ability to pivot

A prominent feature of the Māori hubs was their ability to pivot and improvise to make their services fit for rapidly evolving purpose. Traditional ways of working within a public health response inhibited responsiveness, so staff were actively encouraged to be permissive and generous, able to adjust or update protocols according to emerging risk, reinterpret massively emergent situations, tolerate push/pull factors and provide options that best suited whānau and community needs. On occasion, it also enabled staff to be innovative and creative and prepared to forsake completeness for efficiency in order to match peoples’ lived realities. The ethos was: ‘Do whatever it takes and provide whatever is needed’ (MRCH respondent).



Delivery of the model was dynamic enough to respond to the changing context of the pandemic. For example, with the advent of Omicron, the extensive telephone interview process was successfully streamlined in order to help the hubs cope as case numbers rapidly and predictably rose. The interview was reduced to a 15-minute screening assessment, which ‘got to the absolute guts of “what does this whānau need right now?”’ (MRCH respondent).

Flexibility from a values-based position meant the work of MRCH included providing nappies, baby formula, car battery jumper leads, wood or coal for home heating, care for those with acute mental health needs, finding alternative accommodation, correcting the assigned risk level of individuals to take into account the whole-of-household risk, tracking families using ‘finders’, navigators, mobile units and pānui (public notices) through schools and kura and using effective messaging that was clear and simple and tailored to those who needed to be reached. Grassroot community champions were used to communicate messages to their networks – sending out messages that resonated with Māori audiences and were delivered by trusted representatives.

Being agile and responsive allowed staff at the Māori hubs to undertake intuitive and opportunistic options, such as proactive welfare checks based on community soft intelligence of whānau circumstances and to use subtle cues that were largely automatic, non-conscious and rapid when Māori staff engaged directly with whānau Māori in their homes kano ki te kano.

The Māori hubs found they could draw on the community when they were unable to provide the care themselves. Community members with previous health care experience were asked to fill support roles and encouraged to expand their scope of practice – empowering those communities in participatory ownership for whānau health and wellbeing. This illustrates how transformative investing in and devolving resources to Māori providers and communities can be.

The CCitC model established by the WellSouth Māori hub gained the trust of whānau Māori and their communities. Consequently, WellSouth DHB wishes to secure and reinvest in this model – to adapt and pilot it toward making outpatient and hospital appointments more accessible and acceptable to Māori and Pacific patients who require tertiary health care but are often unable to attend.

‘One of the things that we absolutely acknowledge is that this team is really unique and we don’t want to lose them after this.’
(WellSouth governance respondent)

Conclusion

The tino rangatiratanga Māori models of providing CCitC demonstrate that Māori have the expertise, relationships, skills and capabilities to design and deliver culturally safe care to whānau Māori and to positively influence non-Māori models of health care and service provision. The models align Māori values and world views within a strong whānau-based response with solutions led by Māori that are inclusive, relational and meet the needs of diverse whānau and communities.



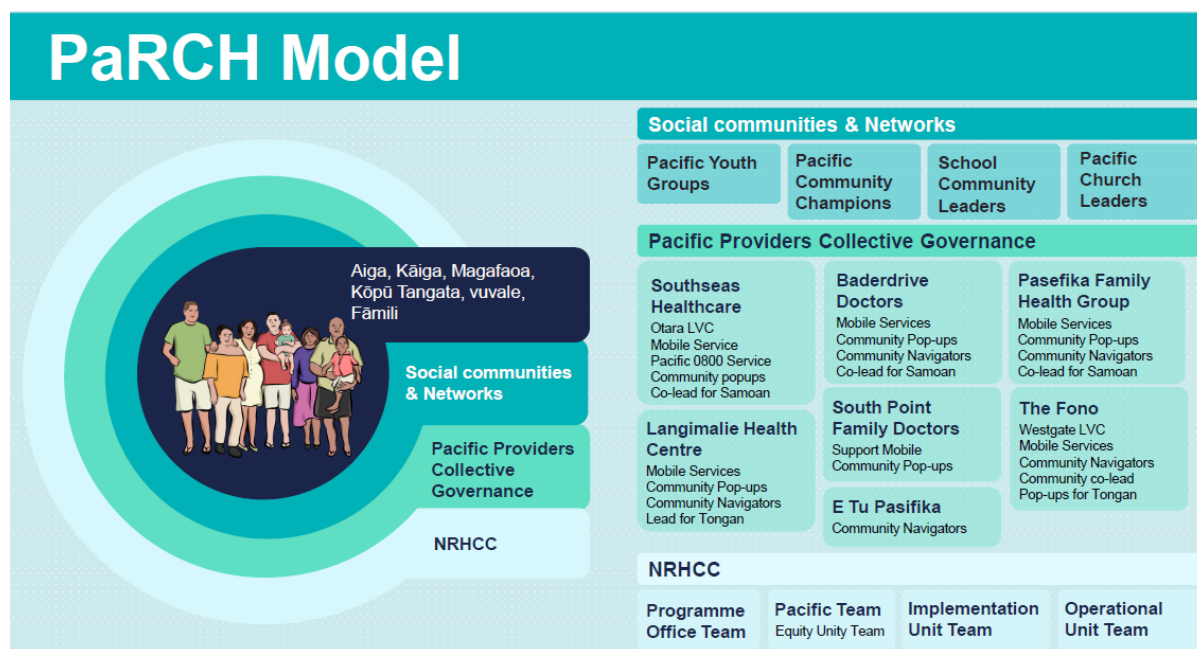
The largely self-determined nature of these pandemic responses not only gave expression to mana motuhake and community expertise but also enhanced the capacity of Māori communities to develop their own forms of resilience. The success of the Māori hubs provides a compelling argument to invest boldly in ‘by Māori, for Māori’ health services and providers – as knowledge holders and drivers of locally grounded solutions, central to health policy formulation and implementation.

A sea change is needed. At the heart of our current health reforms is the immediate objective of achieving Māori health equity. At the heart of this are the Wai 2575 principles of partnership, ōritetanga (equality), tino rangatiratanga, active protection and equity that were abundantly visible and tangible within the care delivered by the MRCH and WellSouth CCitC hubs.

Pacific Regional Coordination Hubs (written in partnership)

Auckland/Tāmaki Makaurau

The disruption caused by COVID-19 has been challenging and long lasting, particularly for Auckland, which has had many lockdowns. The Pacific Regional Co-ordination Hub (PaRCH) played a key role as the enabling touchpoint between Pacific communities in Tāmaki Makaurau and the health system. PaRCH leads the call to action for the health care system that fails to serve Pacific communities to 'level up'.



PaRCH resets health care towards equitable systematic approaches and a model of care that values wellness and relationships and a culture that kindled the fire of community leadership and cooperation during COVID-19. PaRCH played a critical role in enabling outreach and relationship with Pacific communities in Tāmaki Makaurau 'Auckilangi'. Their decolonising model of care focused on wrap-around services for community by devolution of power and a spirit of service to centre the needs of āiga, kāiga, magafaoa, kōpū tangata, vuvale, fāmili.

PaRCH's response to centre kāinga for holistic care is driven by the six Cs: culture, community, communication, commissioning and capacity, coconut wiring and care. This responsive model of holistic care for Pacific families in Auckland that emerged during COVID-19 will now be explored as an option to tackle longstanding non-COVID-19 inequities, such as diabetes (the coexistence of diabetes and obesity), child health, cancer prevention and screening, and mental health.

Culture

Culture is inherent, contextual, and dynamic but is considered the shelter for life as represented on the falealuga or roof of the Fonofale model. With culture as the roof of PaRCH COVID-19 care this directed pro-action to decolonise and transform a monocultural health system that fails to serve Pacific communities. As PaRCH collabor-acted with diverse Pacific health providers such as Langimalie Health Centre, the Fono, E Tu Pasifika this directed inclusion and reflection of diverse cultural values and behavioural nuances particular to ethno-Pacific communities. This enabled care to uphold the principle of options, or where health care was provided in culturally appropriate ways that recognised and supported the expression of the plurality of Pacific health models.

Culture in health directs that society be free of systems and structures that create and maintain inequities. PaRCH care valued the understanding of the fānau story that included their specific profiles considering context, mixed ethnicity and generational differences: 'What does growing up Tongan in Māngere look like for me?' 'What does my Kiribati family in Pukekohe need to flourish?'

As PaRCH care created the safe space for fānau to share their dynamics of their home and social lives, this led to fānau co-designing effective health care responses that reflected their different wider spiritual, socio-cultural and environmental needs. For example, the PaRCH care wide array included alternative housing for larger households' managed isolation, food supplies, community mental health and coordination of long-term conditions management. The PaRCH care plan went back to the basics that care would wrap around the fānau and their story to support their needs. The PaRCH care illustrated that health must seek to understand the contexts, recognising and embracing intersecting Pacific identities to be inclusive of the diversity throughout Pacific fānau. In this context, culture in COVID-19 care was not about the surface-level differences of languages, clothing, or skin tones but instead it was the deeper roots of cultural values and beliefs that influence the way fānau think, the way fānau do things, the way fānau live and relate, and the way fānau value things.

'That was just like the culture of what was started – a system and a process and practises that was started by Pacific, for Pacific embedded in the community.'

'Grow what we've got. Building capability – a workforce pool that can be drawn from PaRCH training ground for Pacific response for non-COVID[-19] health issues.'

'A Pacific model for Pacific families can be built on intuition and cultural knowledge, and clinical experience.'

'We need to move away from a Pākehā approach or one-size-fits-all service that does not address Pacific health. Pacific need to be in control. Pacific know best for Pacific.'

Community

For COVID-19 care enabled by PaRCH, there was a strong shift and emphasis on wellness of the whole family and community, including physical, mental, emotional and spiritual wellness. Interests of communities were at the centre and motivated the workforce to 'submit to commit' to a health care agenda defined by Pacific fānau and communities.

The best way to engage with Pacific communities is to talk with them rather than at them. This means coming together online or offline ke fofola e fala ke tau lava o talanoa: let our communities talk about the things they need to set in place to cater to the health of their fānau and communities. The health care system, workforce and services need to reset their relationships with communities as trusted and confident leaders of public health.

Care by PaRCH affirmed that the social, spiritual and relational contexts promoted and protected family and collective wellbeing by encompassing actions of reciprocity, balance, respect and trust. Wellness for Pacific communities is realised as the health care system mirrors and leverages Pacific communities' socio-relational understandings of health. Kāinga, churches, schools, sports teams and communities can bring to life their collective aspirations to innovate and progress their wellness. If community, in all its cultural, social and economic variety, is an authentic partner in leading the agenda and changing the environment for health, then the goal of healthy people in healthy communities can be realised.

Communication

Communication encompasses cultural views, languages and histories, which significantly influence the way in which Pacific peoples perceive, access and continue to use health services and health information, as well as the outcomes of interventions.

'Community was everything, relationships was everything. A community approach to households in the system.'

'Family in the middle with community leadership around.'

'Working with community leaders helps overcome any stigma, hesitancy.'

'Our Pacific team had local communications channels/church communities. The power of our local networks – through relationships to communicate or find people.'

'Each of the churches have their own functions already, so it was just plugging in our services to provide the clinical service.'

'The talanoa is based on community needs, rather than what our information needs: it's what is important to them.'

'With language, we could get them (community) accurate information that they wouldn't have known. We could pick up on people that may be missed as our services are Pacific specific, language specific and understand cultural and non-verbal communication cues. Through cultural channels, a risk can be identified before it becomes a risk.'

PaRCH was aware of cultural communication, which runs deeper, influencing the way communities think, the way communities do things, the way communities live and relate and the way communities value things. With trust, transparency and truth, PaRCH was able to inform communities and drive behaviours to serve the greater good. Best practices for PaRCH public health communication included clear, concise and consistent messaging, trusted messengers, ways to hear back from communities and cross-cultural communication. PaRCH demonstrated cultural competence and intelligence to improve communication, which kept kāinga and communities safe. Culturally competent communication was enabled by linguistically diverse materials, interpreters and diverse staff who had local knowledge of the communities they served. Culturally connected communication generated talanoa or active dialogue in which kāinga and communities could become trusted co-designers for the health of their people, ask questions, correct misunderstandings and build trust.

Commissioning and capacity

Commissioning for capacity is about responding to specific community needs by removing middlemen to close the gap between the health system and the communities. This equitable commissioning commits to supporting champions or organisations in the vaka (canoe) close to the school of fish. Flexible and agile commissioning that is responsive to changing needs during COVID-19 required engagement, the re-centring of vaka way finders and navigators who were close to communities and who could harness community energy and cultural intelligence for local solutions and action.

Commissioning for capacity ensures communities that need support get the support they need, which means commissioning for resource and the capacity to take on work and deliver for work.

Rethinking and reimagining commissioning for capacity should reflect Fa'afaletui, which guides the weaving and validation of different fale or knowledge holders on the community map. The commissioning of services was not effective by being 'sector blind' or neutral but by putting on 'Fa'afaletui frames' to reach out to all

'We engage in a cultural way. We need to talanoa with our people and offer different languages. Do you have enough people to cover language? We have enough Tongan and Samoan, Niuean, Fijian but don't have some of the other languages for smaller Pacific nations.'

'Feed forward to government. Feedback to community.'

'The relationship was built naturally from the start. By engaging with the community in their space, it was really giving them the power to tell us what they need, rather than just providing them what we think they need.'

'Providers provided services ahead of contracts as the contracts were not completed fast enough.'

'Work done through relationships – contracts to support that – not the other way around. And funding of service rather than a job.'

'Adaptive capacity was limited by certain resource constraints, such as staffing, and [we] could cope under certain conditions, but then [that] became trickier with staffing search, and the capacity is now going down due to a loss of staff and funding.'

sections of the community. PaRCH knew the change was already underway, and witnessed the transformation, where Pacific providers, communities and lay champions supported a stretched health system and workforce with their creativity and continuity of community care for Pacific wellbeing.

Pacific peoples not only give their time, but also their cultural knowledge, technical expertise, practical and logistical resources, money and social support as voluntary and unpaid work as the culture of contracting and funding was unconventional and prejudiced. Currently, funding is fuelled by data or outputs that can be seen. This is contradictory and misaligned with the PaRCH family approach, where outcomes or the focus of experiences of the end family users are central to guiding services. A strong focus should be on investing now and making it a priority to transfer power to Pacific communities in commissioning.

Coconut wiring

The coconut wire connects all Pacific peoples: health care, support services, community organisations, churches, sports teams, schools and localities across the motu. It is an innate way of working that has been established and successful for a long time amongst Pacific peoples. PaRCH leveraged the coconut wire to accelerate progress on COVID-19 care in the community.

The coconut wire demonstrated tauhi vā as Pacific peoples upheld the idea that they have civic responsibilities and moral obligations to serve all Pacific in the motu and across the moana, rather than just their local communities or countries. The coconut wire became an innate island homeland where Pacific could engage or rely on diverse Pacific villages to keep it fresh during COVID-19. All Pacific tuned into the intrinsic frequency or wiring were able to trust and call on relationships, share resources, boost morale, e-talanoa and keep up the energy to get work done. This coconut wiring or connection across Pacific cultures and Pacific localities fostered the bringing together and building of the Moana

Pacific collective culture and world community of compassionate care on a national and transnational scale. PaRCH, which utilises or stays true and authentic to the coconut wire, inspires the mainstream health care system to catch up with the trailblazing coconut wire of interconnectedness and interdependence of those who share common humanity.

‘Commissioning for capacity, because funding is really important because we need money and to continuously need to front for that and just imagine how much more we could have done. A lot of the work in the initial stages was done on the backs of so many hours, so many community people.’

‘Collective effort. This is the future.’

‘There's a lot of connection that's invisible that's always going to be a connection. And the coconut wire, I suppose, how we're wired, how we're going to deliver, how we're going to connect, how we're going to activate and work for our communities.’

‘You know when the coconut wiring is working well, when actually things are working well. And you know when the coconut wiring is not going well, if nobody's responding, people are dying, people are sick, people are not coming, people are not connected, that's because the coconut wiring is saying, the services sucks.’

‘That relationary way of knowing who to talk to and knowing what connections you need and knowing where to pull people from, that requires that knowledge of who's around and what's going on.’

Care

Putting the 'care' back in health care necessitates improving family and community experiences and outcomes. During COVID-19, community organisations along with PaRCH took the lead in the shift away from a supply-driven health care system organised around what clinicians do toward a community-centred system organised around what communities need. The weaving of a net (work) of care for communities re-centred a values agenda that emphasised value-based care to transform family outcomes and experiences.

The big picture of personal-relationship-oriented villages and cultural alignment with families and communities ushered the focus on the human side of care. As true relational partners to communities, PaRCH, providers and other health professionals were prioritising resources and time available to implement a holistic approach to address all the needs of Pacific families. During the COVID-19 crisis, the opportunity to revolutionise health care was seized as the workforce and health system yielded to care, empathy and patient and family satisfaction; nothing new or innovative, but the 'care' part of health care, if prioritised and not forgotten, can disrupt the system to reach better, more satisfying and less expensive outcomes for communities.

'Was just putting the care back into health care, putting the care back into primary care, putting the care back into community care.'

'Manaaki can be inserted, a part of conversation or talanoa. We had to advocate to Ministry of Social Development for our people to get help for their welfare needs. Judgement on deservingness needs to be dropped for our people to be healthy.'

'Workers went above and beyond to cover during outbreaks – reaching out to church and community groups. Much of the work had to be done in evenings.'

'The main focus was on providing wrap-around services for community; capability building of providers and region could provide wrap-around services – clinical, public health/social support. Wasn't a breakaway from public health, more a pivot.'

How to build connected communities of care like Auckland

- **Culture:** What is the health care system's cultural standpoint? How will the health care system build on the strengths of Pacific cultures and weave Pacific world views?
- **Community:** Whose agenda are you working to – the needs and aspirations of the community or the needs of your organisation?
- **Communication:** What necessary methodologies, skills, attitudes and knowledges does health care need for the work it is required to do with Pacific communities?
- **Commissioning and capacity:** Can the health care system relinquish/devolve control in areas that Pacific communities are strong in?
- **Coconut wiring:** How will the health care system keep up to date and connect in with fresh community intelligence?
- **Care:** How will the health care system engage and centre Pacific communities as an active partner with compassion?

Oamaru

In Tonga, the term haua means a wanderer to whom being in motion is the ultimate purpose, and other aims are secondary to going to places. In Oamaru, our Pacific communities are not haua but exist with the intention of securing the Niu Sila vision of the land of milk and honey.

Since the 1970s, far away from the main hub of Auckland city, a vibrant Pacific community has found its own spirit in Te Wai Pounamu, with the migration pull factors of job availability and housing affordability. Oamaru churches' architecture and grandeur make you pause and marvel. A central structure such as the church, the village fale or local schools are the focus for communal activities amongst most Pacific communities. Such physical structures transcend to serve as a focal point for activities that are essential to Pacific communities' cultural expression and foster a sense of belonging, safety and identity.

The Oamaru Pacific Island Community Group Inc (OPICG) is a focal point in the Oamaru community. OPICG played a chief role as an ambassador for Pacific communities in Oamaru for the wider community and the health system. This regional town's fast-growing Pacific community, at 13,000 people, makes up 20 percent of Oamaru compared with Auckland's 15 percent. At the core of the OPICG are the 'O.G. (original) mamas and aunties' – people you know on a nickname basis. Their pioneering treks, sense of pride, vision and values have retained comm-UNITY at the heart of all they do.

The OPICG model of care was to provide care for the whole community (including non-Pacific peoples) – the Pacific way where values of alofa, tautua and faka'apa'apa are activated and woven for health and social care provision. OPICG worked closely with the Waitaki Multicultural Council, Tumai Ora Whānau Services, Te Rūnaka o Moeraki, Waitaki District Council, Waitaki District Health Services, Stronger Waitaki, WellSouth, Southern DHB and the Ministry of Health. Additionally, OPICG developed a Waitaki COVID-19 welfare care network that currently meets monthly with representatives and volunteers who span the district to help provide welfare care coverage across the whole district. OPICG demonstrated that health care should be collective, culturally grounded and contextualised to be led and owned by communities. This relational approach, centred by OPICG, resulted in care that was anti-racist and accessible, promoting a sense of belonging and storying and collabor-action.

Anti-racism and accessibility

OPICG COVID-19 care in the Oamaru community was open to all Pacific and non-Pacific peoples. Their accessible 'care to all' imitates the tolai fish-traps of Papua New Guinea or inaki fish traps of the Cook Islands – an elongated round-sectioned basket, where the wider end leads and tapers towards the other end. OPICG-wide catchment of the net gave

'To give them, non-Pasifika, a Pacific experience at the same time, I would hear conversations like "Oh you should've gone to the Pacific clinic, I got tea and a scone, and I hung out, listened to music and it was great". As a completely different experience from what they were getting when they were getting vaccinated anywhere else. And for many people, this is their first time to have a real interaction with a Pacific person. I thought it was quite a weighty responsibility for them to have a positive experience because this is a small town, and until Pacific showed up, it was a very white town. It was amazing that we were able to put that forward.'

them the opportunity to build their profile and standing in the general community and across diverse stakeholders, such as local government, regions and non-Pacific communities. OPICG engaged Pacific and non-Pacific to have a Pacific experience in a manner that was culturally responsive, family centred, holistic, collaborative, faith filled, innovative and compassionate.

OPICG's COVID-19 care to the whole Oamaru community challenged negative attitudes and notions about Pacific peoples in Oamaru. That is the goal of anti-racism: to challenge and actively change policies, behaviours and beliefs that perpetuate racist ideas and actions. OPICG's courage, compassion and dedication to COVID-19 care supported humanity, which meant rehumanising Pacific peoples. As the wide catchment built OPICG community reputation, it was funnelled to tapered and targeted engagement to convene deeper dialogue, mapping of and net(working) of care for diverse Pacific groups, such as the Fijian community at Mount Cook or the Pacific in Palmerston. The OPICG locally owned COVID-19 care was anti-racist and equity focused and, like the Pacific fish traps, enticed the whole community, including larger fish or seldom heard and seen Pacific communities.

Belonging and storying

OPICG's COVID-19 care in the community conveyed belonging as edifying vā or relational spaces to anchor and enrich life story construction. Tok stori, talanoa or storying was foundational to OPICG exploration, development, creation of their own identity, building connections, and making meaning to the world around them. OPICG 'akapapa is from pioneering 'mamas' as part of the first Pacific wave to Oamaru in the 1970s and 80s who wanted to serve and help families migrating and settling in Oamaru. Every place tells a story, but most importantly, every OPICG member has stories – their own, those of others and their community's story.

OPICG's inclusive process to successfully engage and listen to diverse voices formed a rich foundation for equitable design of COVID-19 care. The talanoa with churches, freezing

'We knew that the uptake for our Pacific people was going to be low because our people wait until they're very sick, and then they come in – it's just the psychology of our people ... so we were like "OK, let's try and vaccinate as many people as we can and that could help protect our people. And when our people are ready to come on board, then we'll be ready." So we did a whole blanket approach even though our focus was still on Pasifika.'

'It was an amazing opportunity for us to provide this service to the wider community and non-Pacific because we were the only community provider doing it. And we did some clinics up the Waitaki valley. People started to talk within the community about the clinics that were being run here. The atmosphere was different; people were friendly, we were feeding them, we had good music going, we were very caring.'

'We have people from all over the Pacific in OPICG that if we heard something or know something, it was easier to let our people in the community know. For myself (OPICG nurse), I connect well with the Tuvaluans, the Indo-Fijians and the Fijians (iTaukeis), so if I heard something, I would be on the phone to the Indo-Fijians that are dairy farmers out on the outskirts of Waitaki "Hey, there's these clinics that are coming up on these dates, are you free?" – "Oh, we can make it". So that's how we connected out.'

works, schools, youth, elderly, sport teams and ethnic-specific community groups was critical to the future of a healthier Oamaru community.

Importantly, this extended to inclusion of the diverse things that were whispered or left unsaid. OPICG was able to work with a group of church leaders who were anti-vaccinators. OPICG belonging and storying enabled their delivery of non-judgemental holistic health care for all.

The stories shared through the coco-net or interpersonal interactions have formed an infrastructural support for OPICG and continue to ignite their innovative care. For example, OPICG surveyed and talanoa how their Pacific families were impacted from the first COVID-19 lockdown. This community qualitative data informed OPICG on their Pacific communities' health priorities that needed to be addressed, such as digital divide, health care accessibility, housing, gender divide, financial hardship, and children and young peoples' education. As OPICG talanoa, it developed a sense of belonging, the being and becoming of equity for historically and medically underserved communities. Stories of belonging provide the outline for pro-actions, which are key to building equitable communities.

Collabor-action

A Pacific culturally based model of care demonstrated by OPICG enacted Pacific cultural values, concepts and practice. Collabor-action ends transactional services and elevates health care to transform it into a values-based net(work) of relational care for wellness. OPICG, like other regional Pacific communities, did not have monetary incentives for their community vaccination drives or health promotion efforts. Instead, OPICG drew from community talents and relationships to provide experiential rewards, such as haircuts or non-monetary perks like back-to-school stationary packs.

The OPICG collabor-action spirit extended as they invested in community members who had health care experience in support roles to be trained as authorised vaccinators working under supervision (CVWUS). Today, a key challenge of health systems in many countries is the need to develop and strengthen human resources to deliver essential interventions in a

'You'd just go and get vaccinated back in the day when the doctor tells you to get vaccinated. But now, it's something to do with your livelihood and your children and their futures. We know what's more of a drive for our community to be vaccinated, like, if you can't go to work, how are you going to support your family? Or if your kids can't go and play sports, what are they going to do?'

'We collected information and did qualitative work. Some of the needs that fell from it was that: during COVID[-19], landlords were increasing the rents, without additional notice, increased cost of living as well as mental hardship and distress for families and accessing health care services. So those priorities helped form what the next piece of work was going to be.'

'Our model of care is that we deliver for our community. We had a Christmas theme at our clinic one time, then we had a barber come in and do haircuts, so I think it was giving our community an in-depth experience of what it's like to be taken care of in a Pacific way. With our values/care in the community, you don't get that level of care and attention or alofa when you go to a GP or even a hospital. The community had tagged on to a different model of practice that we have and that they [the health system] should be looking at delivering those things as well.'

culturally responsive way. The CVWUS COVID-19 vaccinator workforce received comprehensive training and competency assessment. A bonus for training an Oamaru CVWUS workforce was that their community vaccinators delivered the COVID-19 vaccine programme confidently, competently, and safely because of their cultural intelligence and connectedness with the Pacific communities in Oamaru. Expanding this training for non-COVID-19 population health efforts, such as childhood immunisations or flu vaccines, should be a continuous process and not a one-off scenario to alleviate a stretched health system. The mindset change for the health care system will occur by the 'submit to commit' of the intersections and interconnections of communities' collaboration for wellbeing.

'We shoulder tapped some people in the community that we knew who were wanting to do something in health or were already in some health capacity, like carers at our local nursing homes. We had four women, three Tuvaluan and a Samoan. It was sort of an unintended consequence of creating a small community health workforce from scratch in a really short period of time. There was a need and a passion to be able to run it ourselves, and I think that's really where that drive came from is that we wanted to be able to do as much as possible on our own. We still had to rely on bringing in outside vaccinators if we knew we had a clinic, but we became increasingly independent, and it's been a nice opportunity to get to know some of the wider health workforce in Oamaru by using our local nurses in addition to our own CVAS to do the vaccinations and the cold chain.'

'To deliver for the whole Waitaki-wide, our COVID[-19] response network has been really good, so we're not having to do all the work ourselves and not working in isolation but leveraging on the support from all the other agencies, our multicultural council and team of volunteer deliverers as well.'

How to build connected communities of care like Oamaru

- **Anti-racism and accessibility:** How are Pacific peoples moving into leadership and decision-making roles?
- **Anti-racism and accessibility:** Do existing pathways operate with a framework of compliance or a framework that centres on anti-racism and equity?
- **Belonging and storying:** Which stories and voices need attention?
- **Belonging and storying:** How will health care embed seeking to listen to understand and act?
- **Collabor-action:** What resources are necessary to coordinate better, devolve and transform relationships enabling Pacific communities?
- **Collabor-action:** How will health care reflect on the quality of relationships?

Dunedin/Ōtepoti

Our Pacific communities in Dunedin illustrated that authentic presence and engagement with communities are key enablers for Pacific partnerships of health leadership and action. In Dunedin, there is the O.G. (original) wave of Pacific families, who have been calling 'Dunners' their home for at least three to four generations, there is the student wave, where most Pacific students at the university are from out of town, and there is the niu wave of Pacific families from priced-out city dwellers. Our burgeoning Pacific communities in Dunedin include the biggest group of Samoans with links to the Tokelauans, Cook Islanders since the 1940s, Tongans who are linked to the fastest-growing Aotearoa New Zealand Tongan group in Oamaru, as well as growing Kiribati, Wantok, Fijian, Niuean, and Tuvaluan communities. The diversity of Pacific peoples in Dunedin has enriched and contributed to a range of activities from academia, churches and local communities to industry.

Pacific Trust Otago (PTO) is an independent community provider of health, education and social services to Pacific peoples in Dunedin. PTO was formed in 1999, with its primary focus being to engage with and support multilevelled activities to realise the wellbeing aspirations of Pacific families and communities. PTO's conceptual framework is based on the concept of a vaka (canoe), as the model for governance and operational functions in the organisation. The framework is based on a Tongan proverb of a canoe with torn sails (la mahaehae) being ineffective in capturing (to ki he) fair winds (matangi lelei): 'Matangi lelei to ki he la mahaehae.' The deeper meaning infers that, to be effective, the vaka requires the combined skills and talents of many craftspeople to be maintained in top condition and to capture the winds (matangi lelei) to reach its destination.

Despite PTO having to compete with non-Pacific providers to serve the same communities, they have demonstrated, by their COVID-19 care, that a community approach to health requires compassionate care and culturally anchored service. Our Pacific village in Dunedin that has flourished over time justifies the call to action for specific equity and culturally connected health care by focusing on tā and talanoa, equity narratives and spirit of service for the people.



Tā, talanoa

Haukafa is the name of Tongan traditional binding methods, also known as lalava, traditionally made with sennit (kafa processed from coconut fibre). The kafa is interwoven into strong, robust lashings and used to bind all the parts of the popao, or Tonga outrigger canoe, together. If the kafa or dialogue with communities is weak, then it will lead to the popao or the whole structure being weak. Dialogue or talanoa are personal encounters where communities can story, ask questions or even show their realities and aspirations.

'I guess that's the difference that we make because we have the connection, we know our people and we, most of the time, try to work with actions that best suits their needs. So, that highlights to me of how the system doesn't work for our people.'

Talanoa enabled a connectivity, where PTO staff worked relationally, circularly and collectively to ensure Pacific families were at the centre of their care. At the heart of PTO talanoa, staff embodied time as spaces where they could authentically engage Pacific communities and find meaning in their work as they provided health care that aligned with their cultural expertise and intrinsic obligations. There was a situation where a Pacific family had two positive COVID-19 cases, as told by the family via phone, so the WellSouth testing team along with a PTO nurse took enough PCR test kits to test the remaining family members. When the WellSouth testing team arrived, the PTO nurse was able to talanoa with the family spokesperson, and new information emerged that there were three more families living at the house, so the testing team needed to come back with more PCR test kits to test the whole household. The PTO nurse also noticed a child from the family that had been tested was running back and forth to a house across the road. The PTO nurse through their cultural connectedness followed up on this and found out that the house across the road from the positive cases were the grandparents. Thus, altogether PTO were able to manage and keep safe the positive cases and their whole kāinga.

PTO exemplifies that tā and talanoa for the purpose of establishing dialogue and context informs compassionate care and humanitarian decision-making, ensuring accountability to our communities. Working by linear time seeks to dissect, analyse and measure. However, circular time, or tā for talanoa, embodies the power to connect and enact a movement of aligned action that supports the health of Pacific communities.

Equity narratives

Equity trend analysis predicts the future movement based on the current ongoing trend data. PTO were agile with changes in epidemiologic and demographic trends. By analysing an equity narrative of community

‘You know, in the south, we haven’t really developed our Pacific services very well, which Pacific Trust Otago is really looking at trying to set up. I remember one Zoom we had, and it just really hit me, when here I am trying to educate our people, that as soon as you get symptoms, get your test, this is what needs to be done, and then let your doctor know because we’ve got new anti-viral medication. And they’re like, I’m not comfortable, I’m not comfortable going to my doctor, I feel like a number. So, there were a lot of things that were coming up that have highlighted the health system in our southern region and where the deficit is that we need to be filling for an area that has just doubled its population over the last couple of years and what we need to do.’

‘The good thing with such Pacific providers as PTO is having that relationship with our Pacific community. Our Pacific come straight to us from our connection in the community. We are building that bridge. We are making ourselves accessible and visible to the community, to provide for them.’

‘In the Southern region COVID[-19] care community meeting, they’re talking about mental health and were like, “Oh, we’re doing this, we’re really good on this, and this is really doing really well” and they’re talking all these good KPIs that are getting met. But I had just come out of a Pacific Church Community Leaders meeting the night before where mental health was a massive issue, and we were not addressing mental health in our Pacific space. And so, I’m saying, “What do you have about Pacific? How many of those patients were Pacific? Because, right now, in our community, it’s a massive issue, and we don’t have specific services.’

trends, PTO was able to overcome challenges of excessive fragmentation of health care, low community satisfaction and inefficient use of resources. The equity narrative approach for care by PTO directed the match-up of health care services available and adaptation to the needs and preferences of growing Pacific communities.

As an outcome, PTO offered services that addressed the main community health issues from health promotion, preventative and curative perspectives by multisectoral collaboration for community development. Importantly, the equity narrative of Pacific communities in Dunedin was instrumental in highlighting current structures requiring equitable action of brownification of leadership and governance to ensure Pacific communities' needs are listened to and responded to within the southern region. Equity narratives are timely, proactive, actionable and trustworthy reciprocal relations that recognise communities' lived realities and aspirations for health.

For the people

The outrigger in the vaka or popao, though relatively small, functions to balance the whole structure. The kahoki, or connectors, link the outrigger to the hull (or where people/communities sit and are kept during the voyage to health). The kahoki or connectors need to be strong and maintain the ideal distance or negotiation space of dialogue for maximum effectiveness when the popao criss-crosses the moana. The connectors within PTO are an authentic, culturally intelligent and connected workforce. Altogether, PTO nurses, social workers and corporate staff were able to recognise and work with the nuances of the diversity of their Pacific communities and work with Pacific church and community leaders. They were able to maintain workable partnerships with Pacific families and communities to reflect culturally appropriate ways of working. This enabled diverse Pacific cultures to feel seen, heard, understood, and valued in their health care.

'Resources wise, we are not resourced enough. But it doesn't stop us from responding and providing for the needs. And we are not only responding to Pasifika, but whoever comes we respond to them with the best we can.'

'If you decide to come, move further south, why should you not be eligible to get health care that you would get if you were living further up north, you know? Like it's cheaper to see a doctor up north than it is to see one down here. So, there's a lot of areas where our community is expanding, but it's very much a white population. But as Dunedin is "browning up", the services need to brown up. We're hoping that, over the next few years, things can change as we grow with the population.'

'This was a unique time because all over the world we see that COVID[-19] has ... come in stretching organisations. And that's what really happened with us, the Pacific Trust Otago. We were stretched to provide services that we've never provided before, like a vaccination clinic – but the need of us providing for our communities was first and foremost.'

'We cater, and we've seen so many Pacific Islanders accessing the service. I guess because we are different the way that we assess family, we just want to support our families no matter what, and we must support the family. We even reach out to the students which a lot of them accessed our PTO service. And we did help a lot of our Pacific Island families, especially new families that we never heard about around here or, that are not on our system.'

The PTO staff connectors for Pacific communities are cultural assessors/advisors who understand and advocate for their diverse Pacific communities' profiles of context, cultural, ethnicity and generational differences. A PTO Tongan nurse was able to advocate to make changes at a system level for a Tongan family they cared for who were going to enter MIQ during dinner time but would not be provided dinner by MIQ. The nurse, as kahoki, understood that this decision by MIQ would not support feveitokai'aki (reciprocal respect) and 'ofa (care). The nurse communicated with the non-Tongan system to feed the family dinner, which was a decision that reflected and promoted positive family care.

How to build connected communities of care like Dunedin

- **Tā, dialogue:** What disaggregated data or soft intelligence do we need to understand our ethnic groups' aspirations and needs in the community?
- **Tā, dialogue:** How does the community like to be approached and engaged with and what is the appropriate gateway?
- **Equity narrative:** What community KPIs are locally relevant and actionable for community empowerment?
- **Equity narrative:** What are current community narratives that will advance policy and structural changes to help in efforts to support healthy and equitable communities?
- **For the people:** Are the community's values resonating in their health care?
- **For the people:** Does health care account for the cultural and historical context of the community?

Invercargill/Waihōpai

Invercargill, the most southerly city in Aotearoa New Zealand, and where you will experience southern hospitality too. The locals are always warm in their welcome, and this includes our Pacific people who live there and have been firmly woven into the fabric of this Southland region. Most people will call Invercargill cold, but our Pacific locals there call it 'fresh air'. So, with a chilly morning, Pacific locals are grateful for the extra fresh air. The depth of Pacific contribution in Invercargill resounds in the workplace, local government, business, religion, education, the arts and community wellbeing. When we think about our Pacific cities the default is Auckland. However, Invercargill or our regional Pacific and rural Pacific communities matter too.

Invercargill Pacific people perform several essential functions, from market nodes for food producers and processors to providers of services, goods and non-farm employment to local community leadership. Our Pacific regions matter, too. Our Pacific communities from Oamaru, Dunedin and Invercargill are part of a diverse range of places that form the regional heart of our Pacific nation.

The Pacific Island Advisory and Culture Trust (PIACT) in Invercargill has created a strong, permanent Pacific community response to focus on community-led solutions that harness the transformative power of Pacific cultural values and families. PIACT draws from a rich history of cooperation and local Pacific champions to build on local competencies and knowledge to improve the Pacific quality of life. Those who have become a part of the PIACT family have found there their Southland niche, which offers hope for a future. PIACT keeps it

fresh as it retains the Pacific cultural integrity for wellness to support Invercargill Pacific families to be resilient and to thrive.

PIACT has shown that community knowledge co-creation, circulation and engagement practices are effective for Pacific peoples' health and wellbeing. The PIACT model of COVID care in the community targeted Pacific by an inclusive, participatory approach that wove community solutions, invested in data community building and centred community leadership and governance. The PIACT interconnected approach to health engaged the diverse Pacific groups in Invercargill and strengthened their local ownership for health.

Weaving community solutions

PIACT's COVID-19 care was based on first-hand leadership by the PIACT's board through the Chair, Deputy Chair, Chair of the Community Advisory Group and resolute staff who were able to engage appropriately and effectively with the local Pacific community. PIACT demonstrated integrity and initiative that centred their Pacific communities as authentic leaders and respected creators for a local Pacific health care system to realise their aspirations and meet their needs. Indigenous voices embody indigenous knowledges, which poet and literature professor Audre Lorde alludes to in their declaration 'The master's tools will never dismantle the master's house'.⁹

Pacific knowledge and ways of being and doing are the tools that will empower and enable Pacific communities' health gains as illustrated by PIACT. Community gardens are a viable strategy for Pacific public health and reclaim Pacific agricultural knowledge and skills. Uniquely, PIACT's acquired land utilises green space for the matua to grow nutritious food in a common and collective way. These community gardens were a key sustainable resource for COVID-19 care kai packages to support Pacific families during lockdown and isolation. Additionally, PIACT were able to weave community through their Pacific Market, which was an economic opportunity for Pacific families in Invercargill to sell ethnic arts and crafts, such as carvings or kai. This market served as a main cultural nexus, social gathering place and income-generating activity for Pacific families and communities as vendors.

To meet ongoing community health needs for preventing morbidity and mortality, PIACT has implemented community-based delivery of essential health care services that includes placement of a nurse, pharmacist and Work and Income worker from the PIACT hall.

'A big connector was the organisation programmes. We had big days here where we used PIACT facilities where people felt comfortable coming and that connected them.'

'We have a lot of people with their health issues, and we know that they have medications, so we have a pharmacist here that can be able to culturally spend time with our people. The pharmacist explains to our people about their medications, spend time having anyone to translate, and so it's going well for our people coming in.'

'We concentrated on supporting the community, and I'm glad my gardening skills so that we can give back to our families.'

'The Pacific Market is to support our families. They have a stall to provide for themselves. It's all their own profit. We get nothing out of it. And it's a way of connecting people as well.'

⁹ Audre Lorde made this declaration in 1984, speaking of their experiences as a Black, lesbian feminist. In their declaration, they discussed the need to embrace difference.

Additionally, despite not having staff to conduct a vaccination programme, PIACT focused on health promotion and education and partnered with a Māori provider to run COVID-19 vaccination drives for Pacific in PIACT's 'built for purpose' facility. The delivery of these essential health care services from a place of familiarity and community for Pacific promotes the role of the community health workforce as trusted actors in protecting the Pacific community.

The variety of vehicles used for community collabor-action, including community gardens, Pacific Market and community-based health care services has involved complex social and relational dynamics, as well as efforts to produce change, that require significant investments of overtime, volunteer work and resources. Nevertheless, success, as PIACT has shown, is also more likely with strong community engagement, re-centring local knowledge, an awareness of the community's social dynamics and actions that reflect the ethnic diversity of the community.

Data community building

One of the most important aspects of data community building is the kumi fonua, or exploratory navigating and searching for new challenges, opportunities and relationships to evolve community goals and action for health. PIACT was able to understand and adapt to meet their existing and new Pacific communities' needs through soft intelligence, Zoom fono, social media pages, community events and forming their own community database. It's important to note that, through PIACT's database, they were able to conceptualise community wellbeing, not just as an objective to be desired but also as an analysis of elements that were driving their community's choices, behaviours and what makes them thrive. PIACT took the first step of collating and actioning their learnings to support their Pacific community objectives. For example, PIACT learned (and were able to respond) quickly through their community database that, after the first lockdown, there were Pacific seasonal workers who were 'trapped'. These Pacific seasonal workers could not return home, which added pressure to their Invercargill families who hosted them.

This first step of collating and actioning on community learnings and intelligence was a critical component for PIACT's data community building, because connection, collabor-action and learning became the bedrock foundations for their responsive Pacific health care

'It's 24/7 work, talking to the community, and there are Pacific families that are willing to just come forward to be known, but there are still those that are kind of remote, and they just wait and see what's gonna happen. But yes, we did get new families, build up our data and, as we come through the last lockdown, it just keeps building and the connection of the people came across not just because of COVID[-19] but for the other services that we provide here, too.'

'At the time, our priority was to get to know where our various communities were so that we could connect with them through the coconut wires or the white man's texts and phones.'

'We built a database of intelligence of where our people were collected and kept that which came useful later so we can chase up people, find out how they were in the second lockdown.'

practice. Leveraging current local knowledge systems and data community building can provide dynamic solutions tailored to specific communities.

Community leadership and governance

Leadership that influenced in a bottom-up way played a vital role in COVID-19 care for the Invercargill Pacific community. Several years ago, PIACT changed from being an incorporated society to a charitable trust. The resulting loss of community 'membership' and decision-making was addressed by the formation of a community advisory group, ensuring that each Pacific Island nation present in Invercargill was represented. The establishment of this village leadership encompassed Invercargill representation of the Samoa, Tonga, Cook Island, Kiribati, Tuvalu and Fiji communities. The inclusive and diverse governance enabled collective and collabor-active participation to ensure all Pacific communities were not left out in decision-making processes for their health and wellbeing.

This structured interaction of PIACT's advisory group led to effective engagement and quick reach of Invercargill's diverse Pacific communities to altogether be 'singing off the same song sheet' for community health.

Governance is dominated by Eurocentric thinking that you need to have a 'seat at the table' for your community. However, PIACT's Pacific Island Advisory Group re-centres the alternative that governance for Pacific health will require moving the table out to roll out the mats so that Pacific trusted leaders and all their connections and relations can dialogue and define the agenda for their health and wellness. Leadership and governance for community health requires community ownership, equity and responsiveness.

'With the advisory group and our own database and our information to the community, we sort of kind of did a competition. We used these as tools not so much a tease but in a constructive way, through the advisory group, we got onto the Samoan church ministers, not so much shamed them, but through banter would update which Pacific community was leading. Then the advisory group members were visiting families and bringing them in for vaccinations. The Samoan community response that was lagging was quickly addressed by significant input from the church leaders.'

'The representation from PIACT advisory group is different cause a lot of other regions will just take the willing rather than a representative from Tonga, Fiji, Cook Islands, to allow that information to go out kind of thing.'

'The community advisory group played a big role in getting the message out to the respective communities. Like, I can just think of one member, if we were having a public meeting or a vaccination programme, he had about 50 families on his phone. The messages just went out like that, so each Island representative on that advisory group played a big part in communicating back to their respective communities.'

'We have ongoing meetings with the advisory group so that, with COVID[-19] information coming in, we would be there talking with them. Also, we invited church ministers to come to those meetings. A lot of information came through every day, so with advisory group, we would meet consistently so that our people would be able to understand and relay information out.'

How to build connected communities of care like Invercargill

- **Weaving community solutions:** What structures/mechanisms could ensure that health care staff and health care professionals are 'on tap' as resources versus 'on top' as deciders?
- **Weaving community solutions:** Whose agenda are you working to, and who will benefit?
- **Community data building:** What strategies are proving successful in building a learning community for health?
- **Community data building:** What regular intelligence will it take for the community to thrive?
- **Community leadership and governance:** How do you create opportunities for communities to say what they think and experience and not what they think you want to hear?
- **Community leadership and governance:** How does governance reflect and contribute to the progression of the community's vision and purpose?

Northern Region COVID Care in the Community

See also the model diagram in Appendix 2: Overview of COVID-19 care connections for Auckland.

Governance

The NRHCC set up a governance group to support the move to CCitC. This brought together a diverse group of stakeholders across primary and secondary health care services, including doctors and nurses with strong Māori and Pacific representation and a Māori co-chair and co-clinical director. The governance group was established to enable collective and agile decision-making.

A Whānau HQ management team group included oversight of the enabling structures, including oversight of clinical operations, planning and intelligence, residential housing and the digital team. The initial priority was to 'not let anyone fall through the cracks', ensuring that all those with positive COVID-19 tests were connected to care. This meant having oversight of each person in the healthcare system as case numbers increased, as well as visibility of the capacity of primary health care and community care services to meet these demands.

'[The] tipping point I think for us was to say we don't feel we have visibility over the whole system and what do we need to have in place to have that'
(Governance respondent)

They also recognised that an early element of establishing a hub was changing community expectations from one of being 'reached out to' and having all their needs met in MIQ to one of increasing self-management and focused support for those most at risk.

Flipping and adjusting the model


The earlier work on forming CCitC involved a move from a predominantly public health response focused on the prevention of spread to providing clinical care and support to keep people safe in the places they lived. The community health needs of preventing spread could therefore only be achieved by first understanding the lived realities and non-health needs of those with COVID.

This meant 'flipping the model' from an initial contact focused on epidemiological risk to one that put meeting welfare needs first, followed by an assessment of clinical risk and only then gathering public health information.

'It was absolutely the right thing [CCitC] but definitely a lot more complex than we had anticipated.'
(Governance respondent)

The focus on keeping people in their homes also created significant operational demands. Traditional 'efficient' approaches, such as providing money cards for food, were mismatched to the realities of the situation and did not address the practicalities of getting support to people who were isolating at home.

The Whānau HQ team focused on identifying structural issues that prevented collaboration and compromised the model of care. To address these issues, they called on a range of relationships both within the governance structure and across the wider health community.



The NRHCC governance group provided the agility to make rapid clinical system decisions. However, these roles were not funded by NRHCC, and those involved gave their time from their usual day jobs because they saw it as important.

Dynamic work

The team were living with the reality of a dynamic ever-changing pandemic and made decisions ahead of national directives to meet the needs of their population. The national change to MSD taking over the welfare model came with tensions stemming from a model based on eligibility and means testing. The traditional approaches of MSD were reported at times to be misaligned with the complex needs of the people required to isolate, for example, sourcing and delivering medications. Therefore, the governance group provided a clinical sounding board to discuss immediate clinical safety considerations and to endorse clinical protocols.

Operationalising national directives was challenging as they were often experienced as out of sync with the reality of the surge and the needs of the Auckland population. For example, the introduction of RATs due to the backlog of PCR testing was welcomed, although implementing it within 24 hours of notification through a media release was challenging.

During the surge, primary health care services were providing CCitC, COVID-19 testing and vaccinations. The governance group asked primary health care services to prioritise their CCitC efforts on people with higher risk of more severe disease.

Enablers to improve

The governance group was aware of the importance of learning following previous reports during Delta. There were some desk-top reviews of patient deaths, particularly those thought to be at low risk of hospitalisation, and these informed calibration of the COVID-19 triage tool. However, there was no structured system of morbidity and mortality review.

Other improvement work focused on immediate operational issues, for example, when a patient was flagged to receive a pulse oximeter but didn't receive one.

While it was possible to give feedback via the website, there was minimal feedback received and no formal process to routinely seek consumer feedback on their experience of COVID-19 health care.

As Auckland was effectively always ahead of the rest of the country in their experience of COVID-19, there

'The Ministry was not quick enough to do what we needed, to tell us things that we needed to know. So, we just had to do it ourselves.'

(Governance respondent)

'Primary care have no RATS, there are no funding frameworks, there are no decision-support tools or anything like that.'


(Governance respondent)

'We don't know how most of the people low risk with COVID[-19] are because we don't call them ... we make massive assumptions around low risk.'

(Governance respondent)

'It made us feel like we were trying to say, Auckland was special ... and I do understand the rest of the country's perception, but it was because we were living and breathing it, and we actually had been for months.'

(Governance respondent)



was an opportunity to share what had been learnt there to inform national directives. The NRHCC CCitC clinical and operational staff believe that their input into national decisions could have been helpful in developing the CCitC response.

Along with the wider NRHCC team, the CCitC team reviewed all the COVID-19 communications received to help improve the coherence of information and to then share it widely, including through health pathways.

Health digital

The NRHCC has an IT team, with part of their function being to support CCitC. The team was constantly adapting the IT system to meet the changing needs of the CCitC model. This work has resulted in iterative changes that improved functionality across the various IT systems.

With the move in late 2021 to planning the community management of people positive with COVID-19, there was a need to design IT solutions that:

- enabled the team to make use of what they already knew about people who were COVID-19 cases
- provided an adequate tracking system to ensure that all required clinical care was being delivered to COVID-19 cases
- automated workflows to reduce the need for manual entry.


The IT response was built using existing tools and repurposing them. For example, the border care management system (BCMS) was intended for use in the MIQ facilities to detect rather than manage symptoms. This was repurposed to become the COVID-19 Clinical Care Module (CCCM or 3CM) for use in CCitC.

There were ongoing challenges and risks with using a variety of IT systems with no, or minimal, connecting interfaces and where recorded clinical notes across systems are not always visible. One specific outcome was the development of a long-desired 'shared record' across the secondary, primary and community health care sector. However, technical problems with the CCCM meant that primary health care did not engage in shared care as much as was initially hoped. Another challenge was how models of care and IT tool utilisation varied across the country. For example, a set of 'flags' within CCCM were used in different ways across the CCitC hubs nationally, with the potential for confusion for staff moving between hubs. The hubs were also required to engage with multiple separate IT systems, and the NRHCC IT team developed new tools to help support care provision.

While it was possible within CCCM to highlight a household or whānau association, the wider IT system was designed around individual care management, constraining the ability to manage whānau or households as 'one'.

'It's been brilliant. COVID[-19] has been a gift. We have never had such good trust and connectivity to primary care – between secondary and primary care – as we have over COVID[-19] ... So, hopefully, that will be a foundation we can build on.'
(NRHCC digital respondent)

'So, these are the systems that were there, designed for completely different things, and they've been forced to merge and automate work.'
(NRHCC digital respondent)



During the Delta outbreak in Auckland, a model was developed to predict those most at risk of hospitalisation or death from COVID-19, using information available in DHB systems. The triage tool was developed through a combined effort by the clinical leads from MRCH and Whānau HQ working with the i3 innovation team at Waitemata DHB. The tool used data pulled from various health databases and was used to identify cases at highest risk by generating a 'risk of hospitalisation' (ROH) score. This became critical to the hubs during the peak of the surge, when there were over 16,000 cases each day. Globally, Denmark is the only other country that achieved a real-time COVID-19 ROH scoring system.

While the system worked well in general, potential problems arose for people who did not meet the assumptions contained within the ROH algorithm. This included those with a small digital footprint (unenrolled, not engaged with health care, subject to 'digital inequity'¹⁰), and those from whom it was difficult to source data, such as pregnant people or those with disabilities, who were potentially scored incorrectly. These blind spots were recognised over time, with a variety of work arounds found, such as flagging those who are unenrolled.

One of the key requirements in dealing with large numbers of the population in a community outbreak was the ability to automate what had previously been manual processes. The purpose was to enable visibility of every positive case to try and ensure that no one 'fell through the cracks'.

Connecting the dots (or addressing the invisible)

The BCMS was adapted to meet the needs of the hubs. However, it initially had poor integration within the primary health care patient management system and not all general practices engaged with it. Initially, its main focus was around clinical care rather than the coordination of social and welfare care.


'CCCM had such a lot of issues for primary care usage that they found it really clunky and difficult to use, that a lot of them haven't engaged with that system.'
(NRHCC digital respondent)

The CCitC health care worker's ability to access various IT systems for relevant information was dependent on their role, and they often relied on others to access the systems for them. Providers in the community were not connected into the systems and relied on Excel spreadsheets that were unable to be integrated into the wider IT systems and required manual reconciliation. This reduced two-way sharing of information and opened the system to gaps in recording the clinical and welfare care provided to whānau.

A regional data visualisation tool was iteratively developed to bring the various data sources together in one view. The team were continually reviewing ways to draw data from a variety of sources, such as lab results, into one place in as near real time as possible. This involved numerous privacy impact assessments to access the data. Positive cases also provided information themselves, which also fed into these sources.

'Making it a right for frontline services to have access to data I think would be a real win ... rather than making it something they have to go begging for step by step.'
(NRHCC digital respondent)

¹⁰ Radio New Zealand NZ. 18 April 2021. Digital divide could lead to 'entrenched inequity', economist warns. URL: [rnz.co.nz/news/national/440711/digital-divide-could-lead-to-entrenched-inequity-economist-warns](https://www.rnz.co.nz/news/national/440711/digital-divide-could-lead-to-entrenched-inequity-economist-warns) (accessed 25 August 2022).



The self-serve survey was available only in English and left population groups at risk of becoming invisible. Examples included questions around current disability and the ability to self-isolate or where people had a positive RAT in an aged residential care (ARC) facility or hospital. The ambiguity of aspects of the self-serve survey added to the work burden and potentially 'hid' people who may have had risk factors not clearly identified and were subsequently rated as at low risk of hospitalisation, such as pregnant people.

Whānau HQ COVID-19 care hub

The Whānau HQ COVID-19 care hub had teams that included nurses, wellbeing coordinators, health care assistants and administration support personnel working together. The initial notification to the hub came from the registration of a positive case (the service user). The self-survey information was used in conjunction with a variety of different databases to generate an initial desktop risk assessment to determine if the positive case was at high, medium or low risk of hospitalisation and to set up safety nets for those who were not already enrolled with a primary health care service. The medium- and high-risk cases were then allocated to a phone contact. The health care assistants used a flow chart to guide their initial phone assessments to allocate an acuity score and used their personal judgement to seek nurse input when they had concerns about a case.

COVID-19 cases discharged home from the emergency department or hospital were identified to enable ongoing follow-up by the hubs. There were also processes in place to follow up uncontactable positive cases within 24 hours. The hub was keen to learn from these cases and reviewed those classed as 'no clinical care' to better understand how to engage with such people in the future.

'MRCH and PaRCH have done a really good job at managing the household bubble ... it was all about whānau, which I think is really good ... it just wasn't something that we were able to implement ... in Whānau HQ we cannot do everything.'

(Whānau HQ clinical team respondent)

Through a variety of workarounds and improvement initiatives, the hub managed to improve the contact rate from 40 percent to 70 percent. They were very aware they were providing care for an individual within a household and not the wrap-around services for the whole whānau that other hubs did. When they identified others within the household who were under different providers, such as a GP, whilst it could result in double handling, they would 'do a bit of a health check, even though we won't go through the whole process. We will make sure they are OK, they are safe, and give them some advice' (nurse).

To manage demand during the surges, there was a blended model that involved both primary health care services and the hubs. The primary health care services received twice-daily updates of new cases along with the ROH score (and later the case's eligibility for antivirals). The hubs prioritised all high- and medium-risk cases as well as those not enrolled with a primary health care service. The hubs also provided weekend clinical care for cases under primary health care that were flagged for follow-up through the CCCM.

During the surge, Whānau HQ could only focus on their assigned positive cases, despite an awareness that there were other household members needing clinical follow-up. It 'was complicated to navigate those conversations' (nurse). Households were split across hubs, for example, a person who identified as Māori was allocated to MRCH, and the rest of the



household remained under Whānau HQ. Merging households to a single hub was not easy within the IT system.

The Whānau HQ COVID-19 Care coordination hub team shared concerns about people who were not identified with risk factors, and thus often invisible, posing a risk in the health care system. For example, people with various disabilities, those who were pregnant, elderly living independently within an ARC facility or children under the age of 16 years with underlying medical conditions. Tensions occurred between the hub and organisations when the hub made contact that was perceived as not being needed, such as trying to contact a resident within an ARC facility.

The team were concerned about the significant focus on COVID-19 clinical needs to the detriment of psychosocial and underlying mental health needs. This included longer-term welfare needs as one team member explained ‘what are we doing to contribute to their wellness actually ... using the full breadth of Te Whare Tapa Wha’. There were many assumptions made in the model of care (for example, that parents can look after children) that could leave households vulnerable.

Residential facilities


The residential facilities team was established in the Delta phase of the COVID-19 pandemic as a welfare team to maximise the elimination of spread of COVID-19 within residential housing facilities, such as hostels and backpackers’ accommodation. As a member of the team described, ‘we don’t do the clinical part of the case, we would expect MRCH, PaRCH or Whānau HQ to provide that’, with the residential team focusing on the logistics of the facility rather than individual positive cases.

There had been concerted efforts to identify residential housing locations in the IT system. However, the residential team found that there was an issue in that this did not always occur, and the team had to develop their own workaround triage process.

Tension developed when the team required clinical input after becoming concerned about a positive case that wasn’t under MRCH or PaRCH. People in residential housing may have limited engagement with health care services and be inappropriately flagged as being at low risk in the acuity scoring system and therefore not be contacted. Therefore, work had to be carried out to identify residential housing locations in the risk report to better identify the need for clinical input.

The residential facilities often accommodated rough sleepers in emergency and transitional housing (especially at COVID-19 level 4). The hub was aware of the often-complex welfare needs of this group of vulnerable people and how those needs could be exacerbated in self-isolation periods, including leading to family harm or enhanced mental health and addiction issues. The hub had a close relationship with a variety of community and government agencies and shared information to better support this group. As a team member commented ‘It’s all how can we help to empower people and put more support in as that’s not always there, and so we are quite proud of that function in our team’.

The team coordinated COVID-19 screening of residents within facilities, vaccinations and welfare needs, including coordinating the supply of hot meals when shared kitchen facilities compromised the ability to isolate effectively with risk of COVID-19 spread. At times, they also supported moving people to managed isolation facilities when self-isolation was not



possible, with current projects investigating how to reduce crowded housing, using motels and campervans.

This team experience the first-hand reality of how people are living in Aotearoa New Zealand and how the other life pressures can be a bigger focus than COVID-19 for some. The team engaged closely with residential facilities managers in deciphering the often-conflicting information from MoH, resulting in difficult conversations at times.

The team recognised that the success of their work relied on building strong relationships with the residential housing providers, allowing easier sharing of information. Recently, the team surveyed their stakeholders to identify improvement opportunities and where to implement recommendations. The team valued learning and improving, with a clear escalation process if a death occurred within a residential facility. Temporary contracts and insecurity around the future resulted in instability within the team and the loss of knowledge when team members moved on.

‘As the team member described
“For us, we want to always learn to be relevant to public needs, what the community needs because that's who we serve, first and foremost.”
(Residential care team respondent)

Southern Health systems

See also the model diagram in Appendix 3: Southern COVID-19 quality and safety, overview of connections.

Background to the hub

In response to the COVID-19 pandemic, Southern Public Health employed a workforce to meet the demands of testing and vaccinating and was increasingly drawn into the provision of clinical care. There was a need for a service that could meet both primary and public health demands, especially with the projections of the escalating community spread due to the Omicron variant. This was enabled through the development of the WellSouth hub, based on the NRHCC model.

The focus of Southern Public Health returned to proactive and preventative work, with COVID-19-focused work in ARC and other recognised high-risk groups.

'It was an idea on paper, and it took a long time to turn that into an actual functioning care in the community hub, and it was not clear who had ownership of turning that idea in a document from the Ministry into reality, and when we had issues, the reply was, talk to the hub. It was like 'talk to the hand', but it was like, well, there is no hub. It was an idea on paper in your document, that doesn't help us solve our problems.'

(Public health respondent)

WellSouth clinical hub


WellSouth operated as a singular primary health organisation (PHO) for Southern Health and was well placed to lead the CCitC work. They employed a team comprising clinical, coordination and social work expertise. Members of the team covered a variety of languages, which was helpful in translating information for the community. The way the team had to respond to the changing demands was, 'entirely breaking down what we were already doing to rebuild it again for the new [COVID-19] numbers' (team member).

The hub clinical team had fluctuating workloads, providing care during the week to unenrolled patients (excluding Māori and Pacific peoples) and supporting GPs with staff shortages. Over the weekend, capacity concerns arose as the team endeavoured to cover their cohort of people and care for people flagged by their GP as requiring COVID-19 follow-up. The clinical team prioritised calling high-risk and unenrolled people, no matter their risk score. They found novel ways to deal with surge demand, such as taking on voluntary weekend assistance provided from a practice in Central Otago. When demand exceeded all capacity over the weekend, the team transferred people to Whakarongorau Aotearoa, New Zealand Telehealth Service, which caused tension with the GP teams who wanted to take their patients back on the Monday.

'A lot of the time, it's people have deteriorated over the weekend that the GPs thought, oh they're low risk, during the week.'

(WellSouth hub respondent)

The inconsistent use of CCCM by GPs also created issues around identifying the at-risk people requiring weekend follow-up as well as handing back the people, whose risk status may have changed.



WellSouth initially developed their own risk assessment tool, rather than following the MoH guidelines, to better reflect their population. This acknowledged that risk factors are different across the region, with urban Dunedin quite different to rural Central Otago or Southland. Overall, the clinical team felt comfortable that their updated ROH tool was more reliable in identifying high-risk people.

Meeting differentiated need

The region had many unenrolled people (approximately 6,000) due to insufficient GP practices, groups of transient people (such as seasonal workers) and a high population of students. When working with unenrolled people, the team endeavoured to enrol them in a GP practice. This was helped significantly by the work of a Māori GP and a Pacific GP who welcomed unenrolled Māori and Pacific people into their practices.

The recent addition of a social worker to the hub resulted from the high unmet needs that arose from the surge of socially complex patients and the ongoing impacts of long COVID-19. Social work input was invaluable for people who had accommodation as part of their employment agreement yet were being evicted once they tested positive for COVID-19. People in vulnerable situations, such as living in vehicles or with histories of trauma and no trust in the health system, had more positive experiences through the care received from CCitC.

‘COVID [-19] ... has actually been an entry point for some people to accept help that they may not have had previously. So, I would see that as a success in terms of gaining some trust and buy-in and that sense of feeling cared for ... The challenge is ... what does that look like in the future?’
(WellSouth hub respondent)

Self-managed isolation quarantine

The self-managed isolation quarantine (SIQ) team were advised to localise the MoH criteria to better reflect their population’s needs. The team did their best with goal conflicts to follow the criteria as well as provide solutions for the people in need, balancing needs with the direction from the MoH. The SIQ purpose was to assist in cases where there was clinical or exceptional need, with the process to define if a person qualified being lengthy. There were multiple challenges to navigate in this process, including family harm, justice systems requirements and keeping other people safe. There was unmet need, mostly due to existing issues being exacerbated by COVID-19, and the team did their best with limited options.

Unique workarounds

Ambulance service – an escalation pathway for CCitC

The ambulance service became a de facto escalation pathway for CCitC. There was confusion at times when the service was not sure whether a GP request was for an assessment or transport.

The ambulance service considered notifying positive COVID-19 cases, where the person had called them directly, to close the loop with WellSouth. However, there is no system to achieve this and instead the ambulance service would ask the person to inform their GP that they had been seen/assessed by the ambulance and identified as having COVID-19. This risked leaving the person invisible to the CCitC system and unconnected to welfare support and ongoing clinical care.

Aged residential care – an example surge capacity

The comprehensive ARC management team was a model funded from Southern DHB. It operated seven days a week, providing clinical care, infection control and public health input to 65 ARC facilities across the southern region. ARC facilities notified the team of staff or residents who had tested positive, thus enabling proactive involvement with the facility.

The ARC management team was a small team of health care workers, funded by the DHB to provide emergency COVID-19 staffing shifts, covering 500 shifts in the first six months of 2022. This enabled all ARC facilities in the region to remain open. The emergency staffing team was used less once the Omicron outbreak had eased and is now at risk of being disbanded.

‘Having that support and knowing that support is there to calm them and to give them the confidence and the tools they need, I think, has been absolutely critical to them being able to continue to care for their residents in place.’
(Public health respondent)

Unique challenges of rural care

Southern Health serves the largest geographic region of all Aotearoa New Zealand's health services; these distances resulted in unique challenges not experienced in urban centres.

Transport

The provision of CCitC was reliant on being able to transfer people who had deteriorated and needed hospital-level care. This was particularly challenging in rural areas, with long transport times leaving the rural community vulnerable. No additional resources were given to the ambulance service, although the ambulance service was mostly able to meet increasing demands through ‘COVID[-19] surge casuals’ and staff being willing to come back from days off. However, this critical service was highly vulnerable to staff sickness and had limited ability to increase capacity as demand increased.

‘People are there to help their communities, so there’s that sense that, you know, they want to keep the service running.’
(Rural respondent)

This limited capacity often went unrecognised by those in planning, demonstrated in the initial plans for all COVID-19-positive patients to be transported to Dunedin Hospital, bypassing rural hospitals. Those involved in the transport recognised this plan as being unfeasible, and it was never implemented.

Logistics

Coordinating care for a population across a vast geographical area required significant logistical planning. Provision of welfare and clinical needs in rural and remote areas was often reliant on community connections and relationships. For example, pulse oximeters for at-risk people in rural communities often required a ‘pass-the-baton’ approach. The team were constantly navigating delivery and retrieval of oximeters, which was time consuming and costly. The demand for oximeters was exacerbated by individual practices requesting oximeters for people ‘just in case’.

An audit revealed a big gap between provision of oximeters and clinical follow-up.

Rural hospitals filling the breach

The pandemic highlighted the importance of rural hospitals, particularly as case numbers increased, in avoiding transfers to the urban hospitals and overwhelming the transport system. Rural hospitals provided initial COVID-19 care by default for people such as tourists and seasonal workers, who were often unaware of how to access CCitC.

'They've had COVID[-19] ... no record of it 'cos they've either not bothered to register or they've tried and it's been too difficult.'
(Rural respondent)

One important outcome of the pandemic was the creation of a forum that enabled connection between all aspects of the southern health care sector, allowing rural hospitals to share the unique challenges they faced and be actively involved in coordination and planning.

Former refugee population – an example of differentiated needs


The cross-cultural navigators (the Navigators) support quota refugees in their resettling in Dunedin and Invercargill. The Navigators speak the same language as the refugee families and enabled the families to understand the nuances of the health system – they 'try to bridge the cultural gap and the health gap' (former refugee team member). Usually, they supported the families to become independent, however, it became clear early in the COVID-19 pandemic that their role needed to change.

'It's very easy to show a coping kind of front. But what we learnt quickly in March/April is that that falls away very quickly when the pressure's on. So, you know, you can put your lipstick on or put your brave front on for a little time, but when everything starts to go really difficult, then you're not coping, and it comes to be very hard, very quickly, and that's what we saw.'
(Former refugee team respondent)

A sense of community

In Aotearoa New Zealand we have a different sense of community to the former refugee population. Their past experiences inform their present and future; this influences their 'being' in the community. Those coming from a dictatorship, for example, have a different sense of community, and establishing a community is not a priority. As a result, the community is very fragmented, with limited support networks and increased dependence on the Navigators.

The Navigators became the 'crutch' for the differentiated needs of the refugee community during the COVID-19 pandemic. 'They (refugee families) were really lost' (former refugee team member), and they relied heavily on the relationships they had formed with the Navigators to seek advice and aid during the Omicron outbreak. Omicron 'hit really early and really hard' (former refugee team member) in the Dunedin community. However, for some of the population, COVID-19 was not the main concern; they had other resettlement issues or concerns that had higher priority.



The Navigators provided COVID-19 support in addition to their routine care for this community, working seven days a week, managing text messages from the community 24 hours a day. In the surge, the Navigators, with help from the DHB interpreter services, ensured there was always support for the CCitC team, with a ‘cross-cultural navigator bridge right beside them’ to ensure that the needs of the COVID-19-positive person and their families were being met. Strong relationships between the Navigators and the Red Cross also enabled regular problem solving within these communities.

A response built on assumptions

It quickly became evident that the information on how to seek help and on what to do with positive RATs didn’t meet the needs of this community. While some cases of COVID-19 were identified through the normal processes, many cases in the refugee community only became visible when families contacted the Navigators directly.

‘There was an underlying assumption that there is a cultural competency existing in the workforce, and in actual fact, what happened was, when we started to get, you know, numbers of people within the refugee community testing positive, it actually wasn’t possible for them to ring the Ministry of Health phone number. They didn’t have the language skills.’

(Former refugee team respondent)

It became apparent that contact from the hub with the one English-speaking member did not always reflect what was being experienced by others in the household. There were also cultural communication issues arising as families had no idea what ‘very euphemistic’ questions such as ‘Are you OK?’ or ‘Do you need help?’ meant, and consequently ‘people would slip under the radar’ and not receive the welfare required. Navigators encouraged the communities to be receptive to help, ‘speak openly, don’t [be] shy, this is your right ... this is your priority to live healthy now’. They also worked with CCitC to address support that failed to meet their community’s needs, such as culturally inappropriate food or credit to purchase food when they were in isolation and unable to access online shopping. Manaaki included other needs, such as firewood and hygiene needs.


The Navigators, supported by WellSouth, also established an 0800 number specifically for the Arabic-speaking community to replace the national 0800 number and found other solutions for smaller language groups. These workarounds were required to address the assumptions that were built into the national health system that didn’t match specific population needs.

The team shared learning and their workarounds with other national Refugees as Survivors centres.

Varying levels of trust

For this community, their employment is a vital component of settling into the community, and they were not prepared to compromise that. However, there was ‘mistrust by employers around the actual COVID-19 experience’, and the Navigators were required to intervene at the employer level, for example, sending proof of the employee’s state, such as their COVID-19 test results.

The community was fearful and reluctant to respond to communications that were not from known sources. The community’s distrust of communication channels such as



text/phone/emails meant they missed many contact attempts, including those from WellSouth. The Navigators established a successful communication channel that the community trusted.

During the pandemic, a wave of racism against the community became apparent. There were incidents where other people in the area were abusive to the refugee community. This resulted in the refugee community experiencing increased stress, anxiety and mental health issues.

Taking a toll

Relying on individuals or small groups of essential workers placed the health system at risk of delivering unintentional harm. The Navigators 'worked really hard to be the people that are trusted ... it took a toll on their own wellbeing' (former refugee team member). The refugee community expected the Navigators to be there continually, and it took education from the Navigators to reduce this reliance on them, which was also a fraught process as it often involved receiving emotional responses from the families.

Fractured future

There is unmet need for this collective group, many of whom enter Aotearoa New Zealand with histories of trauma and various health and mental health issues. The beginning years of resettling are the 'honeymoon years', with times becoming tougher once the former refugees face the reality of living in a different country. It is at these times that other health issues can arise, such as the need for mental health support. During the CCitC, these aspects needed to be considered.

Navigators needed to have special regard for families with new babies that had COVID-19 and their varying wellbeing needs. They also had to consider the elderly, who are often isolated, regardless of COVID-19, having come with family who have integrated into society and become the new generation, while the elderly, often illiterate in English, are left to place all their trust in others. This new construction of the family leaves many fractured and fragmented.

'I worry that we will continue to design services for those that find services the most easy to use. And I would hate to see us go forward not having learnt that we need to think of our most vulnerable when we design services ... we need to consider our former refugee community as part of that design.'

(Former refugee respondent)

'What I have liked about the system [the WellSouth hub] is it has been incredibly nimble and flexible, so not completely rigid and a slave to whatever the contract says that they were hired under. So, people have been really willing and flexible about deploying where the need is, and being flexible in their space and role, so I think that has been really useful to the system working.'

(WellSouth hub respondent)



Quality and safety governance

The Southern Integrated COVID-19 Care Safety and Quality Group (SICCSQG) met regularly, with representation from across the health care system and associated agencies. 'We're kind of the people that has leadership ... to make sure we are connected closer to the ground' (SICCSQG respondent). This enabled the group to raise and address system-wide issues/gaps, including sharing examples when the health system was working well. A network of relationships was built, forming the conduit to collectively finding solutions. Feedback from consumers came via the Community Health Council, which included a diverse range of community voices.

There appeared to be no formal pathway for reviewing data to make visible how risk is changing or where the health system is performing differently to what was expected for various population groups. A feedback loop to identify people receiving CCitC who were admitted to hospital was considered but didn't eventuate due to the demands of the surge.

Participants of this forum hoped that this opportunity to evolve and learn would remain after the pandemic, especially as rural hospitals are feeling more involved and connected as a result of their involvement during the pandemic.

'Community representation [Pacific peoples, Māori, rural and urban] ... to keep us grounded on how we're providing services and meeting the needs of our community.'
(SICCSQG respondent)

'A lot of what we did was really anecdotal rather than systematised, simply because of the speed at which things were moving.'
(SICCSQG respondent)

Discussion – Bringing the ‘rivers’ together | Matapaki – kia pūrua mai ngā ‘awa’

The COVID-19 response highlights that health care is a complex adaptive system that cannot be easily deconstructed to understand risk. A complex system needs to constantly adapt to competing demands and pressures whilst continuing to provide safe, efficient and effective care; this was obvious in the CCitC response.

One of the aims of the CCitC review was to get multiple perspectives on the response and use these to understand ‘what made it work’, while also highlighting the challenges and risks that had to be managed. This section therefore reflects on some of the common themes from the various responses, with a focus on the implications these ideas have for the wider health care system.

It’s all about context and relationships

The CCitC response highlighted the different realities and needs that exist within Aotearoa New Zealand. Rather than a singular response, it is clear there were multiple responses, each different and designed to meet the unique needs and challenges of its particular context.

Conditioned and constrained by the past

While this report is focused on the CCitC response from January 2022, the response was shaped by the historical relationships, structures and material resources that existed prior to COVID-19. The way the responses evolved and the challenges encountered can therefore tell us much about our existing health care system and provide insights to inform future improvements.

The CCitC response was built on the previous relationships that the hubs had with their communities and across the health care system. These historical connections influenced the way the response developed and were central to delivering health care that met the needs of those with COVID-19. For example, while Whānau HQ and WellSouth hubs generally made use of existing primary health care networks, Māori hubs also made use of iwi providers, while Pacific hubs connected with community providers and church organisations. This ability to tap into wider pre-existing networks was a key enabler of the overall response.

This link to historic connections was also seen in those who tested positive for COVID-19, where existing trusting relationships formed the basis for providing effective and safe health care. Without these existing relationships, greater efforts were needed to form new relationships, such as for those unenrolled with a primary health care service (that is, a general practice) or in residential housing.

A further example of how prior relationships impacted care was visible in the interactions of the hubs with MSD. PaRCH had a strong working relationship with MSD and had one of the MSD staff in the hub. By contrast, MRCH found that many of those receiving CCitC had strongly negative past relationships with MSD, to the extent that they did not want the hubs sharing any information with MSD.

These contrasting examples highlight that ‘everything has a whakapapa’, an evolving story of relationships that informs and shapes the present. This understanding was at the heart of the successful responses to the COVID-19 pandemic, as well as explaining many of the problems that were faced.

Enabling structures

The response was also constrained by historical structures that were often poorly matched to the need for a whole-of-system response. Such structures included the boundaries between primary and secondary health care, as seen in the lack of a shared health record or common IT platform across the health system. Likewise, traditional demarcations between ‘health’ and ‘welfare’ were a poor fit with the intertwined needs of those receiving CCitC. Extensive efforts were required to bridge these system boundaries and develop new ways of working.

The influence of existing structures was also seen in the way pre-existing funding mechanisms for primary health care enabled rapid financial payments for providing COVID-19 care. By contrast, community providers relied on a contractual system that created major delays, requiring them to take out bridging loans to fund expanded services. Pre-existing structural arrangements therefore have the potential to act as both enablers and barriers to the provision of equitable and suitable health care.

‘We’ve got to stop designing systems for those who find them easiest to use’
(Former refugee respondent)

Differentiated cultural meaning

The interviews also highlighted how long-standing differences in cultural meaning created tensions within the response. This was especially evident in the way the health system took an individualistic approach, tracking the care of individuals within the system. This was a poor fit with Māori and Pacific conceptions of care being focused on whānau or family (āiga, kāiga, magafaoa, kōpū, tangata, vuvale, fāmili).

Shared cultural assumptions inform certain ‘ways of being’ and create connections with those seeking care. Conversely, when the connections are misaligned, they can be a source of frustration and disengagement. Cultural approaches and definitions need to be defined by the cultures that the initiatives and care are aimed at. This then allows for meaningful, authentic and appropriate models of care and delivery of care to populations who, historically, have not benefited from a Pākehā-led health system – who have their own notions and ideas of cultural meaning.

Adapting within limits

The health system was already under strain before the arrival of COVID-19, with both hospital and primary health care services operating near capacity and experiencing widespread workforce shortages. As such, there were minimal strategic reserves or ‘slack’ to meet the increased demands of COVID-19.¹¹ The subsequent response to support MIQ and vaccinations further stretched the system, requiring staff to be redeployed from other areas.

¹¹ Saurin TA, Werle N. 2017. A framework for the analysis of slack in socio-technical systems. *Reliability Engineering and System Safety* 167(C): 12.

This became increasingly problematic as non-COVID-19 demands returned, creating a need for staff to go back to their previous roles.

We can see here that the capacity to adapt to change is 'bounded' by prior resources. Even if more financial support becomes available, there are limits to the rate at which resources such as workforce or hospital capacity can be created. A lack of adaptive capacity in the face of increasing demands is a well-recognised pattern of how systems fail¹² and is more likely in systems that are already running near their limits.

Context matters, there is no 'one size fits all'

The interviews with the hubs highlighted how this was not a singular CCitC response. The different histories, contexts and relationships of communities meant that one-size-fits-all approaches were inadequate. Care was most effective when it was aligned to the differentiated needs of the community, delivered by people who understood the realities of those they were talking to.

What was clear from the CCitC work is that assumptions and values are always present in system design. These often remain invisible to those designing the system yet are clearly visible to those whose realities are misaligned to those of the designers. The risk is we place the blame on users of a system for not fitting in with the system design rather than challenging the underpinning assumptions and values of the system itself.

This supports the calls for responses to be designed by those who are best placed to know the needs of their communities and for them to be supported and given the power to decide how best to meet the unique challenges they face.

Working relationally

All the groups interviewed for this report talked about the collaborative work that was required to create CCitC. Central to this was the ability to bring together groups with diverse perspectives and use these to find solutions that meet the needs of all those involved.

These forums for discussion enabled participants to share the realities of their situation and understand how their work related to others' work. This appeared to be what enabled the hubs to respond rapidly and learn, consistent with the wider literature on high-performing teams.¹³

Likewise, the success of the hubs was built on being able to work relationally with those needing CCitC, taking time to understand their specific needs. However, this way of working came under significant pressure with the surge, when time pressures increased significantly. This reflects an efficiency–thoroughness trade-off¹⁴ that may explain why health care systems operating at capacity may struggle to deliver care that meets the needs of those seeking care.

¹² Woods DD, Branlat M. 2011. Basic patterns in how adaptive systems fail. In: Hollnagel E, (ed). *Resilience Engineering in Practice: a guidebook*. Ashgate: Farnham, Surrey, England; Burlington, VT.

¹³ Edmondson A. 1999. Psychological safety and learning behavior in work teams. *Administrative Science Quarterly* 44(2): 350–83.

¹⁴ Hollnagel E. 2009. *The ETTO Principle: Efficiency-thoroughness trade-off: why things that go right sometimes go wrong*. Burlington, VT: Ashgate.

Coping with complexity – muddling through

While systems may be optimised for efficiency during normal times, this may create brittleness when conditions change.¹⁵ There is now a growing understanding of how resilient health care systems cope with challenges such as pandemics.¹⁶ It is about how effectively the system as a whole is able to adapt to the dynamic and often complex conditions and still deliver high-quality care.¹⁷ COVID-19 represents an extreme example of a dynamic challenge and offers a chance to identify what enabled the health care system to adapt.

Issues with fragmentation and duplication

The COVID-19 response highlighted how fragmented the health care system is. Rather than a singular system, there are multiple boundaries that create separation, such as those seen between public health and clinical care or between primary and secondary health care. The difficulties of coordinating across these boundaries often led to duplication of efforts, as seen with whānau overwhelmed by the multiple daily calls they received early in the response.

One of the central roles of the CCitC hubs was therefore to act as a coordinating centre, to understand whānau needs and match resources to those specific needs. The hubs also become a bridge across system boundaries, using the digital platform to make visible the delays or duplicated care that led to frustration. This function as a 'system bridge' also explains the success of the health navigator or kaimanaaki role within health care.

These issues of fragmentation and duplication are common in health care and can be seen in areas such as diabetes care, which involves the coordination of multiple specialities, as well as primary health care and community supports. This highlights the future role that coordinating hubs might have beyond COVID-19.

Success required constant adaptation to dynamic conditions

The CCitC response was notable for several significant 'mode shifts', such as the change from MIQ-based care to community management and then to coping with a surging outbreak. Each of these different states required different approaches and upended the assumptions built into the previous stage of the response.

In the midst of this change, the CCitC staff were constantly adjusting their work to meet the needs of those they were caring for. This often meant that roles and activities became fluid, focused on responding to the demands at that time. As one MRCH responder put it, 'It's like a marae, we just do what needs to be done'. This also created risk as the constant need to adapt created significant distress for staff, especially as health system demands increased and the capacity to adapt was strained.

¹⁵ Woods 2011, *op. cit.*

¹⁶ Thomas S, Sagan A, Larkin J, et al. 2020. *Strengthening Health Systems Resilience: Key concepts and strategies*. European Observatory Policy Briefs. European Observatory on Health Systems and Policies, Copenhagen (Denmark).

¹⁷ Wiig S, Aase K, Billett S, et al. 2020. Defining the boundaries and operational concepts of resilience in the resilience in healthcare research program. *BMC Health Services Research* 20(1): 330. DOI: [10.1186/s12913-020-05224-3](https://doi.org/10.1186/s12913-020-05224-3).

This need for constant adaptation may be a poor fit for commissioning models focused on prescribed activities or roles. What may be needed is support for capacity rather than just activity, allowing providers the flexibility to better meet the changing demands of health care.

Decentralised approaches were needed to deal with rapid change

In the face of such dynamic change, overly bureaucratic approaches became unwieldy. The flow of information was too slow, and the responses from central government were often out of sync with the realities being faced on the ground, particularly in Auckland. Conversely, central decisions were sometimes announced without necessarily understanding the operational implications that the changes resulting from such decisions involved.

This reveals a common tension, whereby the rapidly changing realities require a highly adaptive local response, yet this response is dependent on the resourcing and support from centralised agencies.¹⁸ This system can only work when there is high trust in the local response and where there is free-flowing information between the local and central responses.

This local–central tension is likely to be an ongoing feature of the current reforms, trying to balance the need for central strategic oversight and support against the need for granular understanding of the realities faced by local responses.¹⁹

System learning

Case reviews are a major part of our current approaches to safety, yet they often focus on the specific details of cases with poor outcomes. This project provided an opportunity to step back and explore wider issues in the health care system that might otherwise remain unexamined.

The invisibility of risk

The changing risks highlighted in this report were generally invisible to the formal safety system. Staff described many episodes where the health care system's assumptions of risk were found to be mismatched. These included cases where the registered individual had a low clinical risk yet unregistered whānau member were high risk, as well as several unwell cases that were only identified through community contacts.

However, the staff saw that resolving these issues was the core of their work, rather than identifying them as system risks to be reported. This is a common finding in health care, where managing competing risks is seen as an intrinsic part of the professional identity.

¹⁸ Amalberti R, Vincent C. 2020. Managing risk in hazardous conditions: improvisation is not enough. *BMJ Quality & Safety* 29(1): 60–63.

¹⁹ Leveson N, Dulac N, Marais K, et al. 2009. Moving beyond normal accidents and high reliability organizations: a systems approach to safety in complex systems. *Organization Studies* 30(2-3): 227–49. DOI: [10.1177/0170840608101478](https://doi.org/10.1177/0170840608101478).

Additionally, given the dynamic work and stretched systems, quality and safety governance was predominantly focused on resolving operational issues, with limited use of reporting systems (or use of the Adverse Event Review Guide²⁰) or formal feedback channels.

However, in the interviews, staff were easily able to identify sources of frustration or potential risk, as well as what kept people safe. Their discussions highlighted that the most significant future risk would be for those who were either socially isolated and/or mismatched to the assumptions built into the current system design.

‘Usually, people on the ground know the next point of failure, not just the past one.’
(Southern Public Health respondent)

Safety learning is dependent on making visible the changing risks within the health system and highlighting ‘system surprises’. The concern is that the issues seen here are likely to be replicated in the formal safety activities across health care. The tools we currently use may highlight certain risks, such as individual adverse events, like falls, while at the same time leaving others invisible, for example, the system-wide impact of workforce shortages. This may mean that we may be unknowingly blind to how risks are changing until they become uncontrollable.

Issues of power and voice

Hearing different views and experiences on the same response provided insights into the way issues of power and voice play out in our health system. These include issues such as those listed below.

- Who has power over the decisions about the resources and system design? How are conflicts over these decisions negotiated?
- Who gets to be part of the decision-making processes, recognising that the interests of those with a seat at the table are likely to be given preferential treatment, while the concerns of absentees are more likely to remain invisible.
- Who gets to decide on issues such as ‘what is good care’? The meaning we give to ‘good care’ will shape what is valued and measured by the system.²¹

While relevant to many of the groups interviewed, issues of power and voice are particularly important in understanding the impacts of colonisation in Aotearoa New Zealand.

Colonisation stripped Māori of their rights, property, infrastructures and sovereign voice. Over generations, colonial health policies and practices have sustained a deep-seated population health trajectory of inequities for Māori. The ‘tyranny of the majority’²² determines who is at the table, whose voices are being heard and whose objectives, goals and solutions are privileged.

The CCitC response highlighted that these issues remain prominent in health care policy and practices. Gains negotiated by ‘for Māori, by Māori’ health experts and leaders were

²⁰ Ministry of Health. *COVID-19 Care in the Community Adverse Event Review Guide*. URL: <https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-information-health-professionals/caring-people-covid-19-community>.

²¹ Antonsen S. 2009. Safety culture and the issue of power. *Safety Science* 47(2): 183–91.

²² Came H. 2014. Sites of institutional racism in public health policy making in New Zealand. *Soc Sci Med* 106: 214–20. DOI: [10.1016/j.socscimed.2014.01.055](https://doi.org/10.1016/j.socscimed.2014.01.055).

frequently undermined and debated as tensions in trying to work in partnership and navigate ongoing power imbalances transpired.

These issues are central to the current health reforms and the attempts to deliver equitable health outcomes. Meeting the differentiated needs of communities will require new ways of working in partnership, navigating the conflicts that often arise from issues of power and building relationships of mutual learning.

Brittle success

The interviews highlighted that, despite the success of CCitC to date, this cannot be taken for granted for future waves. The hubs had initially been set up to deal with a crisis, and there was uncertainty about their future role. This was highlighted by staff concerns over short-term contracts, a lack of professional development and the possibility of other more secure job opportunities across the health sector. The high turnover of staff during the response also led to a loss of institutional knowledge that may undermine the success of future responses.

Additionally, there was little formal recognition of the vocational skills of kaimanaaki and the community workforce. These roles have been at the heart of the CCitC response and may be a solution to issues such as inequitable care and the shortages in the regulated workforce. However, without ongoing support and resolving issues such as clinical oversight, this valuable workforce is unlikely to remain.

The hub model has shown its value during the CCitC response, yet the workforce upon which its success was built remains under threat. Urgent action is required to ensure the long-term sustainability of the hub model.

System improvement opportunities | Kia whakapai ake i ngā pūnaha

System safety improvement opportunities

- Enable models of governance that meet the needs of diverse whānau and communities and inform the funding of health care services that meet the needs of end users.
- Widen the health care risk reporting system to encompass community, primary and public health care services and focus on making visible how risk is changing across the whole health system.

IT system improvement opportunities

- Provide a single IT health record across all health providers (for example, general practice, ambulance, hospital, maternity) that also supports whānau-based care.
- Create governance tools (dashboards, reports, etc) to provide transparency of the overall health care system performance and to inform clinical governance decision-making.
- Telehealth services to support rural emergency and primary health care response.

Commissioning system improvement opportunities

- Ensure investment in ‘by Māori, for Māori’ and ‘by Pacific, for Pacific’ health services that will enable health services to be responsive to their communities.
- Fund for capacity rather than just activity, allowing providers the flexibility to meet the changing demands of health care in their communities.
- Provide ongoing funding for the hubs to support health care delivery across system boundaries and maintain the capacity to respond to public health challenges.

Workforce system improvement opportunities

- A long-term commitment to growing a diverse workforce that can meet differentiated needs, in particular, increasing the number of Māori and Pacific people in the health care workforce.
- Develop the unregulated workforce, such as kaimanaaki and health navigators, to help deliver appropriate health care services. This would include a pathway of recognition for unregulated workers and mechanisms of oversight.

Consumer- and whānau-centred system improvement opportunities

- Models of health care must not be built on assumptions but are culturally intelligent, valuing communities’ ‘soft intelligence’ and focused on reducing inaccessibility.

‘In terms of our future and where the health system needs to be heading, we really need to be thinking about how we can manage care for our whānau and how all the different things, including funding and IT, can support that, rather than make it a barrier.’
(NRHCC digital respondent)

Participant feedback regarding process | Whakahoki kōrero mō te tukanga

We asked for participants' feedback on how they found the experience of being involved in the focus group. We wanted to find out what worked well and what could have been improved. This was to inform and improve the approach and practice of our Systems Safety team (a team within Te Tāhū Hauora).

We received nine responses to our very brief survey. Quotes in this section are not attributed to protect anonymity. In addition to the survey, we also received some unprompted feedback from participants via emails.

Overall, the feedback was positive. The main themes included the openness and empathy of the delivery team, appreciation for the opportunity to reflect on learnings and valuing being recognised.

In terms of what could be improved, one participant fed back that the purpose of the review and the involvement of Te Tāhū Hauora was a bit vague to begin with. It suggested the pre-focus group information that we shared beforehand may not have reached every participant. Another participant felt the questioning could have been more focused on how your organisation learns about itself rather than understanding what people did in their workday. They also felt that some of the key participants were unfamiliar with the challenges faced by different regions.

'There is a Samoan proverb that says "E pala le ma'a, ae le pala le upu" – stone and rock decay, but words do not. Your genuine empathy for the road we took to get to where we are for our people was truly felt. You felt our concern for our aiga and fānau that we serve and the battles we faced and continue to face for CHANGE in attitude, in behaviour, in response, in delivery of care. E le sili the ta'i nai lo le tapua'i – The people supporting are just as important as those who are working. I see your piece of work as a pillar of support for this galuega, so thank you for your time.'

'Useful as a way of prompting us ... to reflect on our processes and learning over the past six months and about how the organisation evolved and what has worked well and what hasn't and needs improvement.'

Conclusion | Kupu whakakapi

The CCitC is an excellent example of a resilient system, one that is 'able to adapt to challenge and change to maintain high quality care'.²³ Adaptation was central to meeting the differentiated needs of those with COVID-19, but it was also important to be able to reconfigure the health care response to meet the changing system demands.

The final aspect of a resilient system is the ability to learn and transform.²⁴ Without taking the time to learn, the long-term issues that contributed to the original crisis remain unseen, and this may inadvertently leave the system vulnerable to the next disaster.²⁵ There is no going back to the past, both the health care system and the environment in which it exists have fundamentally changed. The CCitC response contains many lessons, if only we can learn from them.

'One of the things that I think is very problematic is this want to return to a level of normality, so not having learnt from what we've been through and some of the important gains that we made that need to be maintained and developed. Because what we're seeing, even now, is we're reverting to old models and care paradigms that have existed before. So, the worst thing will be that we learnt so much, we achieved so much, but then it's just easier to revert back to what people did before.'
(MRCH PaRCH Leadership)

²³ Wiig S, Aase K, Billett S, et al. 2020. Defining the boundaries and operational concepts of resilience in the resilience in healthcare research program. *BMC Health Services Research* 20(1): 330. DOI: [10.1186/s12913-020-05224-3](https://doi.org/10.1186/s12913-020-05224-3).

²⁴ Woods D. 2015. Four concepts for resilience and the implications for the future of resilience engineering. *Reliability Engineering & System Safety* 141, 5–9. DOI: 10.1016/j.ress.2015.03.018

²⁵ Dalziell EP, McManus ST. 2004. Resilience, vulnerability, and adaptive capacity: implications for system performance. In: *International Forum for Engineering Decision Making (IFED)*. University of Canterbury, Christchurch: Stoos, Switzerland.

Appendix 1: Focus group information sheets: the COVID-19 Care in the Community Quality Improvement Information Sheet | Āpitihanga 1: Puka mōhiohio mā ngā rōpū tautoko: Te puka mōhiohio hei whakapai kounga mō te manaaki KŌWHEORI-19 i te hāpori



COVID-19 Care in the Community Quality Improvement Information Sheet

Invitation

We invite you to take part in a focus group to share your everyday experience of providing COVID-19 care in the community (CCitC). Participation is voluntary, and if you do not wish to take part, it will have no effect on your current or future employment.

Background

Te Tāhū Hauora increasingly recognises the health care system as a complex system that constantly adapts to change; this is seen in the adaptations that have occurred from the COVID-19 care in MIQ to COVID-19 care in the community.

As a systems safety team (a team within Te Tāhū Hauora), we work alongside health care services to help them consider how they are becoming learning organisations, meaning how they are open to learn from the everyday experience of their health care providers and consumers. We recognise that high-quality health care is provided every day at different levels within the system through anticipating, adapting, learning and modifying. We value the people within the system, their interactions and interconnections and how these relationships inform everyday care.

Spending time with the different levels in the system will enable us to identify how they interconnect and interact and how this influences quality care. The opportunity gives voice to the people and how they have navigated risk to create safe care, to explore when conditions become hard to manage, to make visible the pressures in the varying levels of the system and to understand the information flows and how that informs care.

Purpose of the focus group

The aim is to understand the processes CCitC hubs have adopted so we can identify opportunities to learn about care delivery and how these processes have informed improvements. In this way, we hope to use these learnings to strengthen the system to support those providing care.

We acknowledge that CCitC was established in the face of rapidly increasing demand with frequent changes to the model of community care. As CCitC becomes more embedded in the health system, it is necessary to check that the process is both fit for purpose and working as intended. A variety of focus groups will provide insight into the experiences of health care providers to increase our understanding of the context rather than individual

decisions. This will help us identify areas for improvement from the perspective of those most closely involved in care.

The focus group process will reflect good bioethics principles and Te Ara Tika, a set of Māori ethical principles that draws on a foundation of tikanga (Māori protocols and practices).

What you will need to do as a participant

If you would like to participate in a semi-structured focus group that will take about 60 to 90 minutes, register by phoning or emailing us (hubs to complete). We will phone you to confirm the time and place.

Light refreshments will be provided during the focus group. You are not required to respond to all questions asked in the discussion and will be free to leave without explanation at any time. The information shared will be recorded by a scribe at the time. As the focus group outputs will be anonymised, it will not be possible to remove individual contributions from the notes. The group can share where they see opportunities to improve the model. At the conclusion of the session, the facilitator(s) will summarise the points of view.

After the focus group

After we have conducted the focus groups, we will sort the findings into themes and share the opportunities for improvement both locally and nationally with the Ministry of Health. The Ministry of Health will be responsible for managing the findings for national system improvements.

Your rights

- Participation in the focus group is voluntary.
- Your attendance demonstrates your agreement to participate.
- Any questions regarding the focus group can be asked at any time.
- You can choose which questions you want to answer during the discussion.
- You have the right to access the Employee Assistance Programme on phone: 0800 102 482 if you experience any issues as a result of attending the focus group.

How we will operate

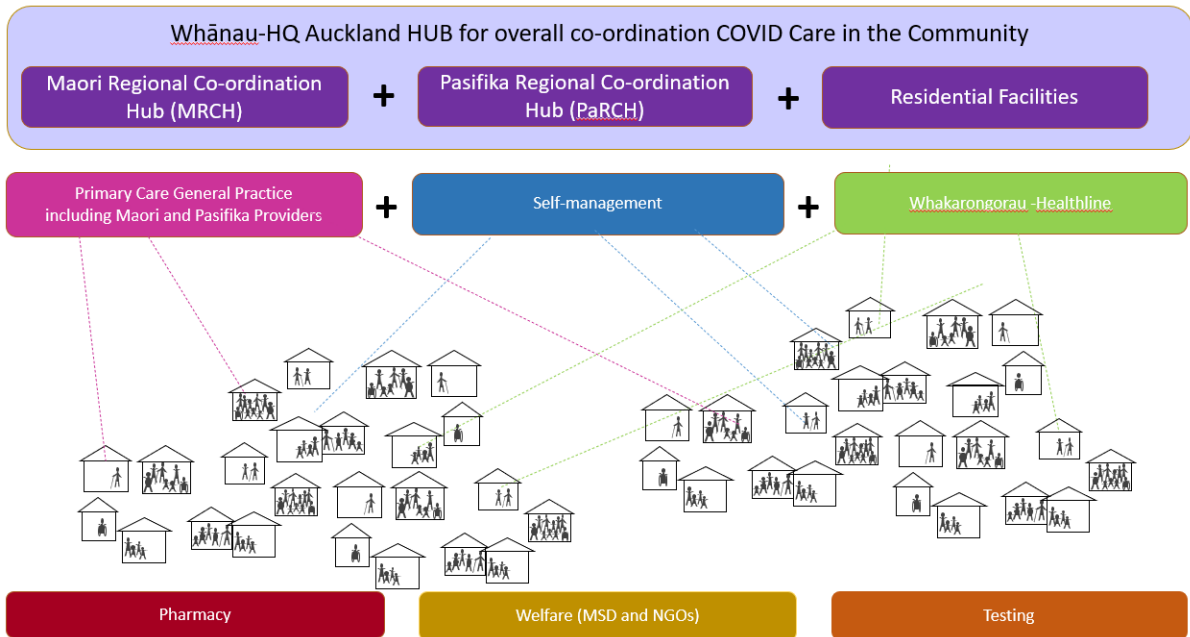
- The focus group will be held in a private setting, and you may withdraw your consent and leave the discussion at any time before or during the focus group.
- The facilitator will remain neutral with no position of power over you.
- Your privacy is very important, and (enter hub name) and Te Tāhū Hauora use many safeguards to protect your privacy and follow privacy laws.
- Personal and health information is a taonga and will be treated accordingly. XX hub and Te Tāhū Hauora will respect the data sovereignty principles of whakapapa, whanaungatanga, rangatiratanga, kotahitanga, manaakitanga and kaitiakitanga to ensure that the data generated from the focus group is protected and used appropriately.

If you have any questions regarding this process, please contact us on the details below.

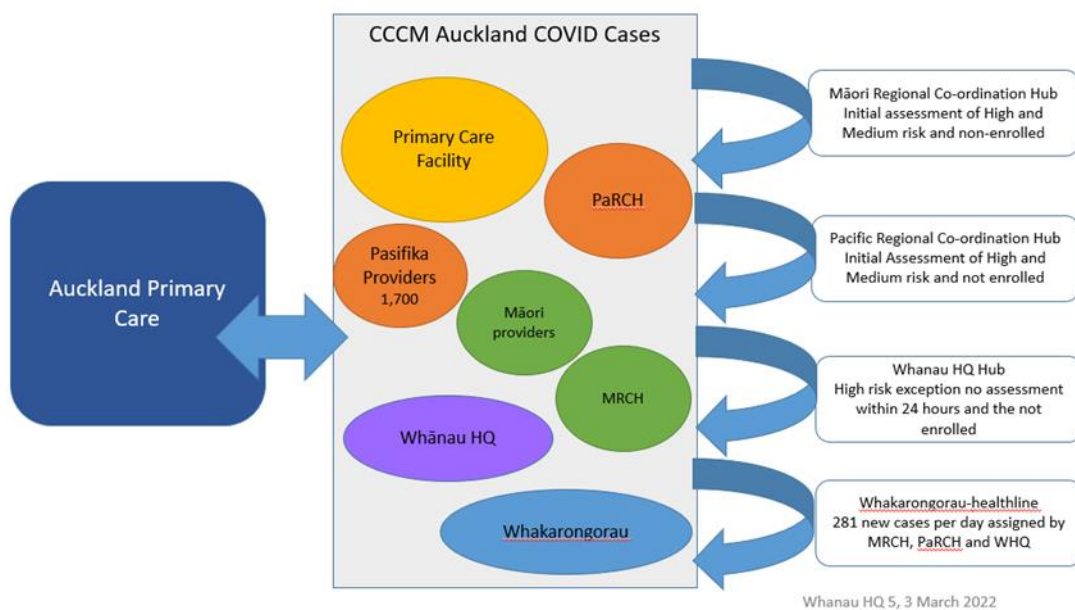
Contact details

Appendix 2: Overview of COVID-19 care connections for Auckland | Āpiti hanga 2: He tiro whānui ki ngā hononga manaaki KŌWHEORI-19 mā Tamaki Makaurau

As provided by Whānau HQ.

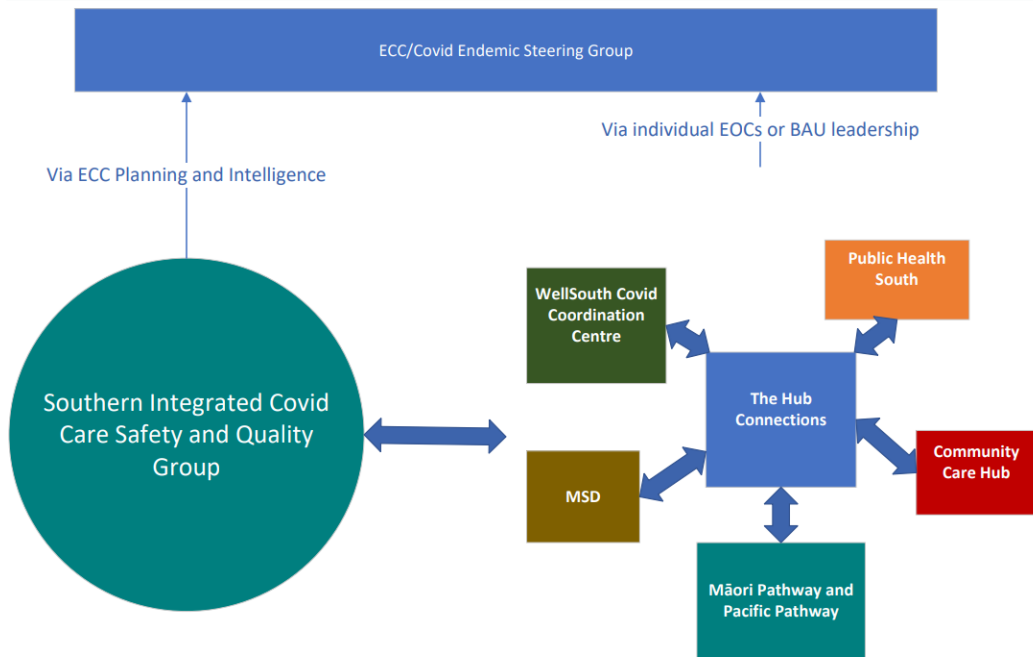


Managing people with Omicron across Auckland



Appendix 3: Southern COVID-19 quality and safety, overview of connections | Āpitianga 3: KŌWHEORI-19 kounga me te haumaru ki te tonga, he tiro whānui ki ngā hononga mō

Southern Covid Quality and Safety overview of connections, 12 April 2022



Glossary | Te kuputaka

Diabetesity

A modern epidemic that indicates the coexistence of diabetes and obesity.

Fānau

Is not actually a Samoan word but rather a transliteration of the diaspora for Whānau

Māori Regional Coordination Hub (MRCH)

An independent Metro Auckland Māori health care provider that provides frontline whānau Māori-centred COVID-19 community care.

Northern Region Health Coordination Centre

The collective of the Northland and Auckland regions operating the response to the COVID-19 pandemic.

Pacific Regional Coordination Hub (PaRCH)

A Pacific Regional Coordination Hub (PaRCH) was designed simultaneously to take all Pacific cases and refer high-risk fānau to Pacific providers. Partnering with a collective of Pacific health care providers (the Collective) has been critical to the Pacific response in the Northern Region, as they have led the way in providing culturally responsive, and first language speaking, care in response to the pandemic. The collective includes: Pasefika Family Health Group; The Fono; Langimalie/Tongan Health Society; Bader Drive Doctors; E Tu; Southpoint Family Doctors, and South Seas Healthcare.

Polymerase chain reaction (PCR) testing

A common testing technique used to amplify DNA sequences and detect the presence of a pathogen from the replicated genetic material. The PCR test is considered reliable in detecting the presence of SARS-CoV-2 and has been found to be accurate in 97.2 percent of cases.

Rapid antigen testing (RAT)

Currently Aotearoa New Zealand's primary testing tool for COVID-19. RAT results are available quickly – usually in 20 minutes or less.

Soft intelligence

The methods and behaviours used to seek and understand the kind of health data that is difficult to capture, classify and quantify in order to develop understandings that can form the basis of appropriate health interventions.

Southern Integrated COVID-19 Care Safety and Quality Group (SICCSQC)

A governance group with representation from across the southern health care system and associated agencies. Where system-wide issues/gaps are raised and addressed, including sharing examples when the health system was working well.

Te Aka Whai Ora – Māori Health Authority

An independent government statutory entity set up in 2021 and tasked with managing Māori health policies, services and outcomes.

Te Ara Tika

A set of Māori ethical principles that draws on a foundation of tikanga (Māori protocols and practices).

Te Whatu Ora – Health New Zealand

A public health agency established in 2022 to manage the provision of health care services in Aotearoa New Zealand.

Te Whare Tapa Wha

One of the Māori health models that helps in understanding Māori health needs, involving the concept of four cornerstones to health: taha tīnana (physical health), taha wairua (spiritual health), taha whānau (family health) and taha hinengaro (mental health).

Wai 2575

The Waitangi Tribunal Health Services and Outcomes Inquiry initiated in November 2016 to hear all claims concerning grievances relating to health services and outcomes of national significance for Māori.

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