

Royal New Zealand College of General Practitioners Response to *Meeting the Challenge*

The Royal New Zealand College of General Practitioners (the College) is the professional body and post-graduate educational institution that sets the standards for general practice, providing research, assessment, ongoing education, and support for general practitioners and general practice. College Fellows provide advice and expertise to government and within the wider health sector. The College aims to improve the health of all New Zealanders by supporting and strengthening high quality care and standards in general practice.

The College supports the general direction of the report and many of the recommendations. The College is pleased to see that the report's authors understand that increasing investment in primary care will play a large role in ensuring the sustainability and cost-effectiveness of New Zealand's public health system. This is a very positive outcome for New Zealanders and one that the College believes is long overdue. The College is looking forward to working with the Government on quality and safety issues as highlighted by the report. This is part of the process of allowing clinicians in the primary and secondary sectors to develop better integrated modules of care that provide better patient outcomes. The report acknowledges the importance of providing the right care in the right place at the right time and by the right person. The report also recognises the importance for New Zealand's health care system of developing our own qualified and sustainable health workforce. This is something the College has been concerned about for some time.

As a high level document, many issues will need to be worked out in detail and consequently the College reserves the right to change its views as proposals become more concrete.

The Ministerial Review Group (MRG) report accurately identifies a number of structural inefficiencies in the current health system. The College supports the emphasis on the need to coordinate services and reduce unnecessary duplication. In this context, we support the establishment of the National Health Board and the national shared services agency. How well these bodies function may ultimately depend how the linkages and relationships are adjusted between these bodies and existing organisations such as DHBs and PHOs.

While we are pleased to see the recognition the report gives to workforce planning, we share the NZMA's concern about moving workforce policy and planning out of the Ministry of Health and into the NHB with the creation of a National Health Workforce Board. We are concerned that:

- a) The primary concern is that such a shift runs the risk that the policy will be heavily influenced by the day to day operational needs of the DHBs and will not address adequately the needs of primary care.
- b) The NHWB seems to replicate the HWAC which was relatively ineffective.

The College welcomes the recommendation that the PPP be scaled back to help progress the qi4gp initiative led by the College and IPAC. Qi4gp will positively influence the quality and information infrastructure that underpins quality patient centred primary care in New Zealand.

The College would have liked to have seen more attention in this document to utilising a primary care and public health/health promotion focus to build healthy communities. Initiatives like Cornerstone and better practice management systems (PMS) will contribute positively to quality improvement.

The College is concerned that projects that are already being undertaken and that are supported by the Report should not be put on hold or funding be delayed while waiting for the implementation of the recommendations. Specifically the establishment of the interim governance group recommended in Annex 3, 3.5 be given high priority.

Our comments in regard to specific recommendations made in the report are set out below.

Section 5 - Closer to home: new models of care

The MRG recommends that the Government:

- (a) Require the NHB (for national services) and the DHBs (for regional and local services) to report annually on the development of clinical networks and assess their cost-effectiveness in helping to deliver seamless care for patients,

We agree.

- (b) Clarify that the role of PHOs is: to do more to keep people well; to reduce avoidable hospital admissions and unplanned readmissions; to share responsibility for shifting services from secondary to primary settings when sensible; and to reduce unnecessary GP referrals,

This alters and widens the role of PHOs and is consistent with the Government's intention to strengthen the capacity of PHOs. We support the principle, but it will be necessary to ensure funding is available to support these changed requirements, particularly where new services are being shifted into the PHO environment.

- (c) Reduce the management fees paid to PHOs with an enrolled population of less than 40,000 and use the resulting savings to help these PHOs to transition to a stronger management configuration (e.g. via amalgamation, confederation, or some other arrangement for sharing managerial support).

The College understands the underlying rationale but is concerned that this may eliminate some successful, clinically-led PHOs and could stifle useful innovation. In particular, some small PHOs do an excellent job meeting the needs of particular high needs population groups (often Māori or Pacific Islands and low decile). The College would be concerned to see such initiatives fail. It is important that in encouraging stronger PHO management configurations mechanisms are incorporated for empowering local small initiatives. The College believes that PHOs need to be effective in four domains: community engagement and relationships; clinical excellence; managerial competence and efficiency; and equity. If sizeable minorities and indigenous groups are receiving lesser quality of care throughout the healthcare system then it is likely that we will see inequities persist. To put it simply without equity there can be no quality, efficiency or community engagement.

- (d) Require DHBs to agree protocols and establish agreements, with contractual and financial incentives, among community, primary, and secondary providers to develop new models of care that are patient-centric, less fractured, and more cost-effective. This should include agreements to reduce avoidable hospital admissions and unplanned readmissions to develop cost-effective substitutes for secondary care to strengthen incentives for more efficient and effective use of referred services. Financial incentives for risk sharing should be strengthened for those PHOs who already have the capability to manage the financial risks associated with taking greater responsibility for the health of their enrolled populations. DHBs should also be required to report on the development of these agreements and assess their cost-effectiveness,

This expands on the earlier proposals, and makes sense. However, specific provision needs to be made for involvement of practices in these processes, not just DHBs and PHOs. Much will depend on the capabilities of the individual practitioners and the resource and infrastructure constraints of the practices. In the College's view, there are currently excellent models of patient-centric care in existence and developing around the country at the practice and at the PHO level. It is important to recognise and build on the existing good models, and not reinvent. There is a range of models, and no one size-fits all communities. It is vital to evaluate and continue to evaluate what is effective and what is not, and to build upon the strengths.

- (e) The NHB should assume responsibility for the preparation of nationally consistent contracts that DHBs, PHOs, and others might choose to use for the purpose of meeting the requirements in recommendation (d) above. These contracts should include some form of revenue and cost sharing where appropriate,

We agree in principle but note that the contracts need to be structured effectively. In particular, the NHB should include a range of contracts that are suitable for the PHOs, IPAs and individual practices in primary care.

- (f) Reassess the role of the PHO Performance Programme in the light of the development of these broader arrangements,

The PHO Performance Programme (PPP) has been in place for sufficient time for an evaluation to be worthwhile. The College agrees that reassessment is essential. In the College's view evaluation will allow the Minister to assure that resources are being deployed in primary care to maximise quality care for patients.

- (g) Ensure that the NHB, DHBs and PHOs work together to develop shared electronic access to a common patient records based on a distributed approach (see Annex 3) and within a reasonable timeframe, and

We support an emphasis on developing shared electronic records with a view to improving patient care and enhancing connections between primary and secondary care. The College and IPAC's qi4gp programme of work is designed to address the need for a comprehensive electronic patient record.

- (h) Within three years, the Government should seek an assessment of those PHOs that are not successfully meeting the requirements of their role with a view to removing them.

We agree that there should be an assessment of PHOs.

Section 7 - Improving patient safety and quality of care

- (a) The quality programmes initiated by QIC are used as a foundation to develop the next phase of national quality and safety programmes that address patient safety and continuous quality improvement. Existing initiatives should become business as usual for DHBs, who should assume the funding for them as the existing QIC budget is worked through,
- (b) The current PHO Performance Programme should be scaled back for a period and the resulting savings used to help accelerate the introduction of quality improvement for primary care using the Q14GP as a starting point,
- (c) An independent national quality agency is established to replace QIC and with responsibility for helping providers across the whole sector improve patient safety and service quality, with the following roles and characteristics:
 - (i) The agency is independent of the regulatory, funding and performance monitoring agencies of government, reporting directly to the Minister and with its own staff,
 - (ii) The agency's role should be to: develop a menu of 'certified' programmes for providers to choose from; develop safety and quality standards and guidelines; benchmark and gather comparative data on what works and why; run workshops aimed at helping clinicians and managers to make improvements; and publish national reports of quality indicators e.g. serious and sentinel events,
 - (iii) The agency should act to ensure sector buy-in to its programmes, recognising that programmes will not be sustained if they are mandated and forced on the sector,
 - (iv) Agency funding should be a mixture of top sliced PBFF (recognising the proportion of the agency's time devoted to DHBs), and charging private providers who want to use it for managing the implementation of agency-certified programmes, and
 - (v) At some point, this agency should become more independent of government and be funded by a mixture of fee-based quality programmes and financial subscriptions from public and private member organisations.

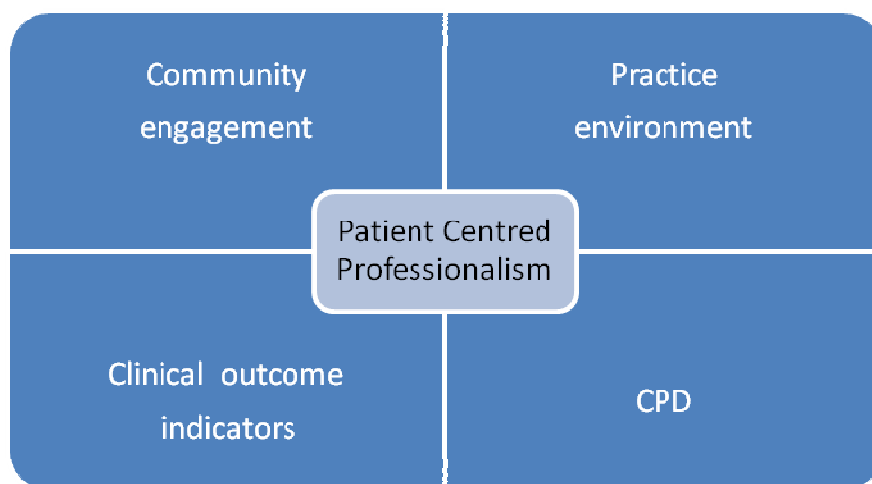
The College supports consolidating a focus on quality and safety within the health system. In particular, the College would like to be assured that there is extensive primary care input into, and collaboration in, the development of certified programmes for use in the primary care setting.

In relation to the PHO Performance Programme the College supports the recommendation to accelerate quality improvement in primary care using the qi4gp programme.

The College wishes to stress the importance of focusing on quality at the practice level. Integrating the whole practice team, practice systems and the community is essential. The College has a proven track record with quality initiatives including developing and maintaining a national set of standards and clinical quality indicators, in consultation with clinicians and clinical networks. Aiming for Excellence (A4E) was created in 1999 as the RNZCGP's standard for general practice and has been regularly updated. The primary care sector has been involved in developing and updating the A4E standard and the general practice networks have been early adopters. The process of continuous review offers an opportunity to primary care to continue to collaborate in the refining of current standards and the development of future standards. CORNERSTONE is the programme by which practices become accredited against the A4E standard.

Out of 1086 general practices in New Zealand around 720 are registered and active in the CORNERSTONE programme, of those 367 have achieved accreditation. A further 28 practices have achieved a second cycle of accreditation (a cycle being three years). This is a considerable achievement considering CORNERSTONE is a voluntary programme, and is poorly incentivized at the practice level. In fact there is a financial disincentive for practices to participate fully, because of the degree of commitment required. CORNERSTONE has achieved a worthy reputation among funders, with financial support for development, implementation and participation from ACC, the Ministry of Health and numerous individual PHOs. It has also received favourable support from the Health and Disability Commissioner and has an international reputation. Countries such as Ireland and Canada are actively pursuing local adoption of a variation of CORNERSTONE. The College would like to see CORNERSTONE accreditation rewarded.

The RNZCGP has improved the quality and safety of general practice through CORNERSTONE. The next focus is on clinical practice improvement. CORNERSTONE (and the Aiming for Excellence standard) is the foundation block for a quality system for primary health care. An enhanced CORNERSTONE programme (qi4gp - Quality and Information for General Practice) will integrate with measures to ensure the competence of practitioners, the involvement of other primary health care team members, community engagement and adequate access to robust clinical outcome indicators that can be tailored at a practice, network, PHO or DHB level (see diagram). It will be a modular framework which can be adapted by other primary health care groups to provide greater assurance of safe, high quality, community appropriate care. An enhanced Cornerstone would align continuing professional development (CPD) and quality assessment and improvement processes for other health workers to ensure the community has a safe and effective workforce. In the College view, the robustness and value of quality must both encourage the workforce to up-skill and provide patients with assurance of competency and its ongoing enhancement.



Ensuring that these matters are addressed is vital to the success of the strategy to shift services from secondary care to primary health care. More structured community engagement strategies and coordinated multidisciplinary care will help facilitate the implementation of IFHCs by making supported self-management central to practice configuration.

This work is an integrated systems approach to practice environment and practitioner performance. The aim is to support practitioners and practices to deliver high quality health care by utilising comparative quality assessment measures. Practitioner groups develop and access appropriate clinical outcome indicators from a database of clinical outcome quality indicators. This work will contribute to a strong evidence base for primary care service delivery. As a result of this work patients will experience a lower rate of preventable medical error, coordinated multi disciplinary care and the most appropriate community based care for their condition. The College wishes to emphasise the importance of creating and incentivising the creation of learning organisations (e.g. Cornerstone) through shared learning processes. Without these there is limited scope for cross organisation learning.

The other collaborator in qi4gp – IPAC, will develop and integrate Information Technology Practice Management Systems for primary health care.

The College hopes that this programme of work might be advanced as quickly as possible.

Section 8 - Identifying the services people need: funding new services

The MRG recommends that the SPNIA process be abandoned and replaced with:

- (a) A reconfigured and strengthened NHC with the role of evaluating all new – and an ongoing selection of existing – health and disability services. This role to include:
 - (i) Assessing the extent to which new health and disability services are clinically safe and should attract public funding based on their effectiveness and cost,
 - (ii) Determining the conditions under which new publicly funded services should be made available, including the eligible patient group, restrictions on the provider (e.g. tertiary hospitals only) and/or the situations in which the new service should be used (e.g. trial only),
 - (iii) Selectively reviewing funding for existing interventions to identify which should no longer qualify for public funding based on their effectiveness and cost, and

The College would want to see that primary care is represented on the new NHC. This is particularly relevant in the context of services being shifted from secondary care into primary care.

- (d) The scope of Medsafe's activities be extended to cover regulation of the safety of medical devices, in conjunction with the Therapeutic Goods Administration in Australia. Given the scarcity of regulatory expertise, this could involve a process for recognising the regulatory decisions of similar jurisdictions as applicable in New Zealand, at least in the first instance.

The College supports a move to better ensure the safe assessment of medical devices.

Section 9 - The right service in the right place

The MRG recommends that:

- (a) The Minister establish a positive list of national services that will be planned and funded by the NHB and financed by top slicing the PBFF currently allocated to DHBs for that purpose. The NHB would then contract with a selection of DHBs to deliver these national services for the entire country,
- (b) The NHB establish a transparent process for advising the Minister about which services currently planned, funded, and provided at the national, regional, and local levels should be organised at a different level in future,
- (c) DHBs be required to produce RSPs across a wide range of services. The initial plans should focus on planning and funding for vulnerable services as well as those whose longer-term clinical and financial viability clearly depends on servicing a larger, regional population,
- (d) DHBs be asked to delegate authority to their Chairs and CEOs to make decisions on their behalf at the regional level and who will become the regional service's governance body accountable for the development and implementation of the RSP,
- (e) In those rare cases when DHBs cannot agree on the RSP, these disputes be escalated to the NHB for resolution and that it identifies the most clinically and financially viable option that delivers a quality service,
- (f) The NHB contract on behalf of the Minister with DHBs for regional and local service and planning, and delivery, and monitor DHB performance, thus taking this function out of the Ministry,
- (g) That over the next 12 months the Ministry be asked to work through the various policy and machinery of government issues associated with devolving all of the \$2.5 billion of NDE currently managed by the Ministry to either the NHB (national level) or DHBs (regional and local level) and advise the Government accordingly (Annex 4),
- (h) That the Ministry of Health's role focuses increasingly on providing policy advice, administration of regulations, monitoring the NHB, and servicing the Minister's office.

The College recognises the resource and workforce constraints in the current system and agrees that such centralised planning would be helpful. However we are concerned that paragraph (c) may not be viable with the current structure of 21 DHBs.

Similarly, the College would be concerned if implementation of these recommendations were to adversely impact current or future projects and services. It is essential that appropriate transitional arrangements are in place.

We agree with the consolidation of the residual roles of the Ministry of Health, subject to the comments made on the first page of this response about the need for appropriate primary care workforce planning and consultation with the primary care sector.

Section 10 - The right capacity for the future: making better investments

The MRG recommends that:

- (a) The roles and functions ascribed to the NHB in this report would be transferred to the CHFA, who would operate as the NHB. The Minister will need to reconsider the current membership of the CHFA Board in order to ensure that it is best placed to manage its new roles and functions. As part of the transition arrangements, a temporary establishment board might be appointed to manage the transition, and
- (b) The proposed NHB is made responsible for capacity planning and funding, including workforce, capital, and IT.

The College has a keen interest in the future viability of the GP workforce. We support the recognition of workforce as a major issue, and the coordination of work in this field. However, we are concerned that the general practice workforce issues may be subsumed within a structure that is primarily focussed on DHB workforce issues. It will be vital that the NHB coordinates with whichever body ultimately is responsible for training. It is not clear how the proposed NHB structure would interact with the CTA/MTB proposals recently presented to the Minister.

Section 12 - Shifting resources to the front-line

The MRG recommends:

- (a) The creation of a Pharmac-like national shared service agency with a mandate to manage the assessment, standardisation, management, purchasing, and/or supply chain management of any of the common back office functions of DHBs that are referred to it by the Minister of Health (Annex 4), and
- (b) The NHB be required to:
 - (i) Establish a process for working through the entire range of common DHB back office services to identify a list of services that are best supplied by a single national provider, starting with non-pharmaceutical hospital procurement (Annex 4), and
 - (ii) Depending on how long it will take to establish the proposed national shared service agency, manage the existing three shared service functions that we propose be shifted out of the Ministry and into the national agency (i.e. Healthpac, Audit and Compliance, Health System Reporting Information).

We support the concept of a national shared service agency. However it is not clear whether PHOs would have access to purchasing via this shared services agency. If this is to be the case, general practice will need to be involved in the development of the shared services agency.

Section 14 – Further work

The MRG recommends that the Ministry

- (a) Reviews the arrangements for the planning, funding, and provision of national, regional, and local laboratory and radiological diagnostic services with a view to determining the optimal planning, funding, and service configuration arrangements for New Zealand, and

- (b) Reports to the Minister on how to best address the other issues raised for further work in this section of the report.

The College is in favour of more nationally consistent planning of services, with the proviso that there is adequate sector consultation built into the planning process.

Section 15 – Conclusion

The MRG recommends that, within three years, the Government:

- (a) Seeks an assessment of the extent to which the public health and disability sector is likely to be able to continue lifting performance without requiring an ever larger share of GDP, and
- (b) Identifies the changes in the New Zealand Public Health and Disability Act 2000, or replacement legislation, required to simultaneously secure the sustainability and lift the performance of the public health and disability system so it is ready to introduce these changes if a change in the legislative framework is deemed necessary following the assessment in (a) above.

The College agrees that there should be a continuous cycle of assessment, monitoring and service adjustment. However, rapid change can be destabilising and may result in inefficiencies as the new process is implemented. Therefore the College suggests that a five year review cycle may enable more realistic conclusions to be drawn from the data.

Annex 1 Current and Proposed Structures

The College supports the move to rationalise services by the creation of the NHB and National Shared Services Agency. However, it is not clear that the benefits of this will be realised whilst 21 DHBs remain. The College interprets the report as suggesting that the NHB/NSSA will in effect render the DHBNZ redundant and that the shared services will in effect result in DHBs merging.

Annex 2 Terms of Reference: Clinical Leadership and Quality

The MRG recommends that:

- (a) The NHB should develop a cultural change programme aimed at enhancing:
 - (i) Recognition of and support for health care leaders, including via an annual leadership award programme celebrating and showcasing outstanding health care leaders from all parts of the sector, and
 - (ii) The ability of clinicians and managers to form productive partnerships, both within the hospital sector and across sectors.

We agree.

The MRG recommends that:

- (a) DHBs should ensure that formal position descriptions are agreed, including annual performance expectations and leadership performance development plans for each formal clinical leadership role, from departmental to executive level in every organisation, and

We agree.

- (b) DHBs should ensure that clinicians taking on full-time leadership roles are assured on appointment of formal support for return to clinical practice at the conclusion of the appointment.

We agree.

The MRG recommends that:

- (a) DHBs should ensure that formal clinical leadership roles are recognised by the allocation of sessional time during the working week to fulfil their duties.

We agree.

The MRG recommends that:

- (a) The Minister should seek advice on how best to encourage universities to:
 - (i) Further embed and develop the academic status of the discipline of clinical leadership, supporting research in multi-disciplinary models and further formalising academic achievement in this area, including via the establishment of relevant Chairs, and
 - (ii) Ensure undergraduate courses in all health disciplines to include formal attention to leadership development appropriate to each year of the curriculum, both in theory and in practice.

We agree. The College supports the recommendations which recognise the value of clinical leadership.

Annex 2, Section 2 Initiatives to increase elective services and reduce patient waiting times, improve access to timely primary and hospital services and improve productivity and quality of services for patients

The MRG recommends that:

- (a) Planning within DHBs to meet the Government's elective surgery targets should be led by clinicians from both the primary and hospital sectors in partnership with managers to ensure appropriate allocation of clinical priorities between and within specialties as well as capability between locations, and ensure suitable clinical provision is in place. In the occasional case where agreement cannot be reached within the specified timeframe, the matter will be elevated to the National health Board for decision, and

It is essential that primary care clinicians and their representative organisations be involved in planning elective surgery targets.

- (c) DHBs should review local primary care access to appropriate diagnostics to ensure appropriate direct access is made available in a planned and evaluated way, ensuring that all service demands are fairly and transparently prioritised.

We believe that in the interests of national consistency, including access to services, this should be carried out in accordance with nationally-established guidelines.

The MRG recommends that:

- (a) Clinical leaders should be supported to trial, develop, and lead the implementation of new scopes of practice and supporting workforce models.

There is a balance to be struck between meeting local workforce demands, and ensuring a nationally consistent level of care provided by particular health care practitioners. The public has a reasonable expectation of knowing precisely what services a health practitioner is trained and competent to perform. New scopes of practice should be developed in consultation with the colleges and educational providers who provide the training for the various health professionals.

The MRG recommends that:

- (a) Further work should be undertaken by the Ministry to promote examples of good practice in supporting primary care to manage unmet needs and to ensure implementation nationally.

We agree. We should be celebrating the beacons of good practice throughout the country and ensuring that examples of innovative clinical practice are disseminated as widely as possible. As Sir Isaac Newton said “If I have seen further it is by standing on the shoulders of giants.”

Annex 2, Section 3 Ways to establish clinical networks and leadership programmes to support these goals

The MRG recommends that:

- (a) Irrespective of their origin, clinical networks should:
 - (i) Have clear terms of reference and reporting arrangements,
 - (ii) Be led by clinicians with appropriate qualifications and a record of achievement in management – appointments to leadership positions should be for a fixed term and holders should maintain some clinical role,
 - (iii) Normally include representatives from across the breadth of health care and include an expectation of a holistic approach to recommendations,
 - (iv) Include regular measurement and reporting of outcomes and outputs in their terms of reference as well as assessment for impact in the local environment,
 - (v) Have a clear plan of how their quality and process outcomes will be given effect,
 - (vi) Expect to disband once they have fulfilled their objectives, and

Primary care has long had clinical networks of clinicians who draw together to advance projects of work, usually with a focus on improving clinical outcomes, or sharing processes that result in increased efficiency. Unlike the model posed above, such networks are usually characterised by a degree of informality. Further, the clinical networks tend to be ongoing, rather than time limited and constituted for a particular focus or to address a particular problem, although such working groups are necessary from time to time.

Considerable progress has been made by clinical networks in primary care and the College would not like to see the parameters of such networks to be dictated by a secondary care model.

We agree that it would be beneficial for there to be enhanced clinical networking between primary and secondary care. Indeed this will be essential in an environment where services are shifted from secondary to primary care, and resource prioritisation is needed more than ever.

- (c) Clinical leaders, particularly of those formal national networks established by the Ministry or NHB to meet programmed tasks and defined timeframes, should have a recognised allocation of time for the role and their employer reimbursed to enable back-filling of the position.

We agree that clinicians, whether in the primary or secondary sector, should be compensated for participation in formal MOH/NHB network activities. This has been a major barrier in respect of clinician involvement in policy development and implementation.

Annex 2, Section 4 Establishing and fostering greater clinical leadership in primary care and across primary and hospital care within DHBs – primary and hospital integration

The MRG recommends that:

- (a) PHOs should be assessed for their level of preparedness including governance and management capability and support infrastructure, clinical engagement, 'community' engagement, and then offered delegated budgets with accountability for, and take some financial risk around, delivering quality and financial outcomes,

We support the review of PHOs to ensure adequate accountability. However it is difficult to comment further without more detail about the proposal.

- (b) Where practicable and desired by stakeholders, co-location of PHO primary care services, hospital and related NGO services should be considered. This may include the development of Integrated Family Health Centres, virtual connections between existing entities or other configurations involving all components of primary care delivery, in a patient-centric manner. Such concepts would constitute primary care clinics made up of GPs, nurses, allied health professional and hospital specialists,

The College is interested in the concept of Integrated Family Health Centres (IFHC), under conditions in which the interests of communities, patients and providers are protected. It is essential that the needs of stakeholders (including general practices) are taken into account, and that these proposals are not driven by a "top-down" approach. The College emphasises that the important principle is integrating/coordinating services rather than necessarily having everyone in the same building. Some practices are already in effect running IFHCs, others would struggle to do so in light of existing funding structures and resource management and town planning constraints. It would be neither reasonable nor desirable to require all practices to morph into IFHCs, but encouragement, advice, and access to loans could encourage the further development of such co-located services and also the further development of virtually integrated facilities.

The College wishes to draw attention to the distinction between co-locating hospital services and co locating hospitals with primary care. The temptation to shift primary care to hospital premises and thereby reduce accessibility to those in the community, should be resisted.

- (c) DHBs will need to ensure that it is clear what their funding arms are responsible for and what responsibilities and risks have been delegated to PHOs as part of any delegated funding and risk sharing arrangement e.g. in order to avoid overlap or competition between funders, and

We agree, with the proviso that there is scope for renegotiation as services are shifted from DHBs to primary care.

- (d) DHB funding of PHOs should be less prescriptive about tying funding to a certain workforce mix and instead put a greater focus on the outcome they are looking for and allow primary providers to choose the best mix of the skills of GPs, nurses, and nurse practitioners in meeting that outcome. PHOs should make more of the opportunities they already have to consider workforce mix, new scopes of practice and using specialists as part of the primary health care team.

The College supports the role of the multi-disciplinary primary healthcare team, and the need for flexibility in workforce arrangements. However we are concerned about the capacity of PHOs to make evidence-based decisions in this complex field, and perverse incentives exist for decisions to be made that may not be in the long-term interests of patients. The skills mentioned above are complementary; no single role can replace any one of the others. There is a risk that PHOs might be driven to weight employment towards the cheapest practitioner team rather than the skill mix that is required to create best value in meeting community and individual needs. There is a balance to be struck between whether the cheapest care is the most efficient and effective particularly in the medium to long term.

Annex 2, Section 6 The acceleration of national quality and safety improvement programmes

The MRG recommends that:

- (a) An independent national quality entity should now be established to replace QIC and with responsibility for helping providers across the whole sector improve patient safety and service quality.

The College supports this continued emphasis on quality in health care.

The MRG recommends that the national quality entity should:

- (a) Establish formal linkages with one or more similar international bodies, but must concentrate on seeding and growing a local safety and quality culture, providing state of the art tools, skills and support and building New Zealand capability,
- (b) Develop the next phase of a national quality and safety programme that addresses patient safety and continuous quality improvement, and
- (c) Scale back the current PHO Performance Programme for a period and the resulting saving should be used to help accelerate the introduction of QI4GP.

As outlined above the College supports the establishment of the Quality agency and supports the development of a national quality and safety programme. The College would like to express an interest in contracting its services to assist the NQA develop a comprehensive quality system for general practice.

As previously mentioned we support the suggestion that the PHO PP could be scaled back to accelerate the qi4gp project.

The MRG recommends that the national quality entity should:

- (a) Be governed by an appointed board and report to the Minister. Clinical appointments on this board must be drawn from the breadth of health care providers.
- (b) Expect to become partially self-funding by the end of its third year of operation through the development of resources, teaching and learning opportunities and other supports for workforce development and education, and
- (c) Support prospective research and rigorous evaluation to demonstrate the transferability of real cash savings from improved safety and quality.

We support ensuring that there is a primary care focus on this body as the bulk of health care interventions are carried out in primary care and this is where the greatest impact can be made in improving quality systems.

Annex 3 Terms of Reference: Infrastructure, Capacity and Planning

The College expresses reservations about the role of substitution as a means of addressing workforce shortages. An assumption is often made that some roles are more interchangeable than they are, or that role substitution will be cheaper. Australia has invested heavily in the nurse practitioner role, but experience is demonstrating that, overall, this is not necessarily a cheaper option than the same service being provided by a GP. We suggest that the first approach should be to address the issue of workforce shortages/training needs within the existing health professional roles. Emphasis on new roles should not detract from efforts to ensure shortages in current workforces are addressed.

We support the expansion of nursing and allied health professional roles within the team environment provided all such groups are involved in designing how these teams will work together and how clinical responsibility will be apportioned.

At page 10 the report speaks about the development of workforce innovations such as the creation of physician assistants in surgical and anaesthesia roles, nurse endoscopists, advanced roles for hospital and community pharmacists and nurse practitioners in diabetes care.

If new roles are created, they must function within the context of the healthcare team, rather than in independent or autonomous roles. Further there must be a guarantee that such practitioners are adequately trained to work in that new scope of practice and the delineations between the roles must be clear.

Annex 3, Section 2 Workforce

The MRG recommends that:

- (a) The formation of a National Health Workforce Board (NHWB) that will report to the NHB,

We share the concerns of the NZMA about the creation of a National Workforce Board reporting to the NHB. Previous multi-disciplinary arrangements - e.g. the Health Workforce Advisory Committee - failed to make progress on workforce issues principally because of their multi-disciplinary composition. While we recognise that there are many issues facing the workforce as a whole, the solutions will vary from component to component. A “one stop shop” approach will face major difficulties.

We believe that workforce planning, policy and development should be retained within the Ministry. The alternative is likely to ignore the needs of primary care at the expense of DHB/secondary care workforce planning - another reason why health workforce capacity should remain within the MOH. In our view the development of an industrial relations strategy needs to be kept separate from workforce policy work.

- (b) The NHWB would be responsible for:
 - (i) The planning, development and implementation of a NHWB,
 - (ii) Assessing future workforce needs, overseeing the planning and funding of postgraduate training (if the recommendations of the Ministerial Taskforce on the Funding of Health Workforce Training are accepted), and advising the Minister on changes in scope of practice and workforce innovations,
 - (iii) Working with DHBs in developing an industrial relations strategy that helps facilitate the changes in work practices to support the sector’s wider objectives for workforce development,

We agree that there needs to be a national workforce plan and that training needs should be viewed in a coordinated fashion.

The College is not in favour of the Minister advising on changes to scopes of practice as this seriously undermines the role of the Regulatory Authorities under the HPCA Act 2003. The Regulatory Authorities are better placed to advise on the appropriateness of scopes of practice in light of the training programmes available.

Annex 3, Section 3 Information technology

The MRG recommends that:

- (c) All primary care related IT projects such as GP to GP Notes Transfer, PHO Performance Programme, Qi4GP, electronic referrals, electronic discharges, electronic medication, and electronic laboratory should be integrated and rationalised under a new primary care information system initiative,
- (...)
- (e) The PHO Performance Programme be scaled back and savings be redirected to support the development of Qi4GP as part of a broader primary care information system initiative,

The College/IPAC qi4gp programme provides an ideal opportunity to progress the development of an integrated primary care information system.

While we agree that it is timely to reassess the PHO Performance Programme, we are aware that some members would be concerned about the impact on practices if payments were to be scaled back.

- (j) All other current responsibilities of the Ministry ID be transferred to the NHB, (k) A National Health IT Board be set up within, and report to, the NHB and replace the current HISAC. This board will provide a strategic leadership role for national health IT strategy and planning as well as governance over national collections and systems,

We agree.

- (l) The National Health IT Board will, on behalf of the NHB, work with the sector to develop a National IT Plan (including a national IT architecture framework) to advance HISNZ. This plan will be a rolling plan with local, regional, and national views, and a short, intermediate, and long-term perspective that it is aligned with the National Health Workforce Plan and National Health Capital Plan,
- (m) The National Health IT Board will be represented on the NHB single Investment Committee responsible for planning and funding IT and facilities programmes,
- (n) The National Health IT Board will ensure there is strong sector clinical manager and governance leadership of IT projects, and
- (o) The National Health IT Board will work closely with the HSMC initiative and the proposed primary care information system initiative to advance:
 - (i) The implementation of a safe, shared and transferable patient electronic health record for New Zealand health sector, using a distributed approach based on interoperability standards set by the HISO, and
 - (ii) The implementation of a consumer portal.

In principle, the College supports the idea of a National Health IT Board. However, national IT development needs to recognise and be responsive to clinical leadership in primary care. Primary care is the front line of health in New Zealand. It is where the most patient consultations occur and provides the best opportunity to avoid hospital admissions. Health IT must reflect and engage with the opportunities provided by primary care.

Similarly, the need for strong clinical leadership is also essential if developments are to improve the health of all New Zealanders.

Annex 4 Terms of Reference: Value for Money

The MRG recommends that:

- (a) The Heathpac (Sector Services – Information Directorate) be moved out of the Ministry to become part of the proposed new national shared services agency, probably operating as a subsidiary with its own governance structure.

We agree.

The MRG recommends that:

- (a) Audit and Compliance become a part of the proposed Heathpac subsidiary of the new shared services organisation, with an internal audit function and direct accountability to the board that is independent of management.

We agree.

The MRG recommends that:

- (a) MedSafe maintain its current status until the Therapeutic Products and Medicines Bill is passed and it becomes part of the ANZTPA. In the meantime, it would make sense to ensure that legislation allowed MedSafe to set fees to ensure cost recovery. We also recommend that the Government strongly supports Medsafe managing the NZULM when it is complete, and considers expanding the scope of MedSafe to include the regulation of medical devices.

We agree with these proposals, and welcome regulation of medical devices.

The MRG recommends that, with respect to the NRL:

- (a) The NRL remain as an independent unit within the Ministry of Health in the first instance,
- (b) The Ministry of Health acts to increase the commercial flexibility of the NRL, within the constraints of operating within the Ministry, and
- (c) The Minister of Health considers the opportunity provided by the new Radiation Safety Bill to investigate the 'one stop shop' option for scientific services underpinning the public health service.

Agree

The MRG recommends that:

- (a) The Ministry of Health be asked to consider if the NSU should remain a national service and be moved to the NHB, or if it is better to devolve its functions to DHBs to manage either regionally or locally. Unless unanticipated issues arise, this should be concluded in the 12 month timeframe for moving NDE.

The College thinks it desirable to maintain a nationally consistent approach to screening and would prefer the transfer of the NSU to the NHB.

The MRG recommends that:

- (a) The repositories and databases currently maintained by the various Ministry Directorates be moved into the proposed new national shared service agency, probably operating as a subsidiary with its own governance structure.

The College supports the rationalisation of repositories and databases provided that appropriate governance and management arrangements are in place. The College recognises that among some health consumers there is unease about the centralisation of potentially identifiable patient information. It is essential that any consolidation of data that takes a "person centric" view comply with and be demonstrably in line with privacy legislation.

Annex 4, Section 3 Selectively reviewing the rest-of-sector expenditure, including DHBs, to reduce waste and bureaucracy and improve spending quality and patient service

The MRG recommends that:

- (a) The management fee paid to PHOs with enrolled populations of less than 40,000 be reduced and some of the resulting savings be used over the subsequent year to help those PHOs amalgamate, confederate, or enter into other arrangements for sharing management overheads,

We support the principle but believe that provision must be made for small successful PHOs to continue.

- (b) DHBs be advised that barriers which restrict the ability of GPs to leave or join a PHO should be abolished, and

We agree.

- (c) DHBs be advised that new PHOs should be permitted, on condition that: (i) establishment funding is not provided (ii) that it is the preference of health care providers, and (iii) sound corporate governance, sound clinical governance, and effective community participation is demonstrated.

We agree.

The MRG recommends:

- (a) The creation of a Pharmac-like national shared service agency with a mandate to manage the assessment, standardisation, management, purchasing, and/or supply chain management of any of the common back office functions of DHBs that are referred to it by the Minister of Health,
- (b) The operational budget of this agency be funded by top-slicing the DHB funding formula,
- (c) That this agency will act as an agent for DHBs and will agree with them a notional (or actual) budget for the management, purchasing, and/or supply chain management tasks it undertakes on their behalf,
- (d) As long as a budget can be identified, then the board of this agency will make the final decision on what is purchased and the terms, conditions, and prices of procured items and the management of shared services (like payroll and supply chain), and
- (e) That the NHB be required to establish a process for working through the entire range of common DHB back office services to identify a list of services that are best supplied by a single national provider, starting with non-pharmaceutical hospital procurement.

We agree with the idea of a national shared service agency in order to achieve maximum efficiencies for the health sector as a whole.

Annex 4, Section 4 Review the reporting and accountability processes between the Ministry, DHBs and PHOs to improve focus and reduce unnecessary bureaucracy

The MRG recommends that:

- (a) With respect to the National Collection Annual Maintenance Programme, there is consultation between the DHB's patient management system vendors and other sector stakeholders earlier in the process (October) rather than waiting until late December.

We agree.

The MRG recommends that:

- (a) DHBs are clearer about what is needed for payments (versus monitoring contract performance) and that payment methods are simplified in order to reduce the cost and complexity of the payments system.

We agree.

The MRG recommends that a:

- (a) Working party is established with a range of sector representatives to develop a national framework for contracting, reporting and accountability that streamlines processes and ensures clear, timely accountability e.g. to align the DAP and SOI reporting, to investigate how the certification and exception basis can be used more widely, and to agree the process for identifying key IDP reporting requirements, and to develop the DAP into an action-orientated document that is more relevant to DHB priorities and performance.

We agree that Programme/Project Advisory Committees may be established for the planning and initial implementation of a specific programme/project. However where ongoing advice from expertise not available within the Ministry of Health is required, existing networks should be utilised first to inform policy and programme development, especially for contentious or complex issues or those where sector support is required.

We agree with the recommendations (a)–(h) about the establishment and constituency mode of meeting and review process for committees.

Annex 5 Commentary on Enhancing Clinical Leadership

The College endorses the overall tenor of this annex. A comprehensive and effective health system requires much better linkages between primary and secondary care. This requires good communications between the various professional groups.

An example of this in action is the Council of Medical Colleges which provides a forum for the various vocational groups to discuss and progress matters of common interest.

Another way of fostering linkages is to improve IT systems to reduce the silo effect between hospital-based secondary care and community based primary care. The efforts made at Hutt Valley District Health Board provide a practical example of ways to improve primary/secondary care communications for the benefit of patients.

The College supports the comments that effective clinical leadership requires access to reliable information on clinical outcomes, productivity and quality standards. It is with this in mind that the College and IPAC are advancing qi4gp.

The College supports increasing primary care access to diagnostics to more accurately identify which patients require referral or more timely access to elective services.

The shifting services initiative will enhance connections between secondary and primary care and we look forward to a more collaborative working environment.

Regarding the interface between elective and emergency services, the College endorses the need to ensure that primary care providers are supported adequately to manage patients who cannot be treated in secondary care within the available resources. Primary health care is best placed to conduct health promotion and manage people who have long term health conditions. These activities will do much to reduce disease burden and the complications that are often associated with long term conditions.