CLINICAL LEADERSHIP AND QUALITY IN PRIMARY CARE ORGANISATIONS IN NEW ZEALAND

Report commissioned by the Clinical Leaders Association of New Zealand for the Ministry of Health

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PREFACE AND ACKNOWLEDGEMENTS

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The views expressed in this literature review do not reflect those of CLANZ or the Ministry of Health.
CONTENTS

1. EXECUTIVE SUMMARY

2. INTRODUCTION

3. THE DEVELOPMENT OF PRIMARY CARE ORGANISATIONS
   3.1 Formation and development of PCOS
   3.2 Achievements of PCOs
   3.3 The National Primary Health Care Strategy

4. METHODS AND SOURCES OF INFORMATION

5. QUALITY INITIATIVES IN PCOS AND OTHER RELATED ORGANISATIONS
   5.1 Overview
   5.2 Organisational infrastructure to support quality initiatives
   5.3 Impetus for becoming involved in improving quality
   5.4 The mandate for a quality focus and its reflection in policies and plans
   5.5 Quality initiatives implemented in PCOs
      5.5.1 Health service activities in GP-led PCOs
      5.5.2 Enhancing standards of practice in GP-led PCOs
      5.5.3 Information technology and other organisational support for quality improvement in GP-led PCOs
      5.5.4 Quality Activities in non GP-led PCOs

6. QUALITY ACHIEVEMENTS

7. TOWARDS PRIMARY HEALTH ORGANISATIONS
   7.1 Becoming a PHO
   7.2 A population focus including information systems
   7.3 Towards becoming multidisciplinary organisations
   7.4 Co-ordinating care across service areas
   7.5 Consumer and community participation
   7.6 Treaty of Waitangi Maori relationships
   7.7 Pacific people relationships

8. LEADERSHIP DEVELOPMENT PROGRAMMES
   8.1 Education and training programmes
   8.2 The need for clinical leadership development

9. CLINICAL GOVERNANCE - THE ROLE OF CLINICAL LEADERSHIP
9.1 Clinical leadership in governance and management
9.2 Quality structures
9.3 Clinical governance

10. OVERVIEW OF QUALITY DEVELOPMENTS IN PCOS

10.1 Overview of the project and information sources
10.2 Review of quality developments – incentives, achievements
10.3 Indicators of quality
10.4 Clinical leadership and clinical governance – a new role for clinicians
10.5 The equity issue: the key challenge for clinical leadership
10.6 Establishing primary health organisations
10.7 Non-GP leadership models of quality organisations
10.8 Clinical governance
10.9 Building a new leadership culture

References
Bibliography of other New Zealand publications and documents relating to clinical quality

Appendices
Appendix 1 A review and analysis of clinical leadership/governance in addressing issues of quality the New Zealand health system
APPENDIX 2 Primary Care Organisation (PCO) Reports: General Practitioner PCOs
APPENDIX 3 Primary Care Organisation (PCO) Reports: Non-General Practitioner PCOs
1. EXECUTIVE SUMMARY

Background

1. Primary care organisations (PCOs) have become a key feature of the New Zealand primary health care landscape in recent years. PCOs, including independent practitioner associations (IPAs), large practices and those serving Maori and disadvantaged populations, now involve over 90% of GPs as members or employees.

2. PCOs are expected to play a key part in the implementation of the national Primary Health Care Strategy. It is expected that PCOs will become or form primary health organisations (PHOs) with a focus upon;

- population-based funding and outcomes
- becoming multidisciplinary organisations
- coordinating care across service areas
- promoting consumer and community participation and
- building Treaty of Waitangi and Pacific people relationships.

3. A key feature of PCO development has been a strong quality focus driven largely by clinical leadership. New forms of what is now being called clinical governance are being established. There are high levels of commitment to the integration of clinical with financial accountability as part of the management of quality. Despite this these developments remain largely unexplored.

4. This study was commissioned by the Clinical Leaders Association of New Zealand (CLANZ) with funding from the Ministry of Health. It is a broad overview or scan examining clinical leadership and quality in selected PCOs. It is one of a ‘trilogy’ of studies, including a parallel study of clinical leadership and quality in 10 district health boards (DHBs).

5. The purpose of this study was to document and analyse;

- clinical leadership and organisational arrangements within selected PCOs
- the main achievements in improving clinical quality
- progress towards becoming PHOs
- the development of clinical governance.

Methods and sources of information

6. All PCOs were initially approached regarding the study. Subsequently an invitation to contribute was sent to 10 GP-led PCOs which were personally visited and key members and staff interviewed. Reports on PCOs were prepared based on these visits and subsequent documentation, including web sites.

7. Three non GP-led PCOs were contacted. These were the Midwife and Maternity Provider Organisations (MMPO), Health Care Aotearoa (HCA) and the New
Zealand Private Physiotherapists Association Physiotherapists Association (NZPPA), the latter regarding their practice accreditation programme. Reports were received from nine GP-led PCOs making a total of 12 reports which were then used to prepare an overview and analysis of the findings.

Organisation and incentives for quality initiatives in PCOs

8. A variety of organisational arrangements had been established to develop and support quality initiatives. Eight of the nine GP-led PCOs had established a clear infrastructure for quality through one or more committees. Only one PCO had no specific organisational structure supporting quality but individual managers were expected to be responsible for quality in their areas. Committee membership included quality co-ordinators, managers and facilitators as well as GPs and practice nurses.

9. In HCA a separate quality programme Te Wana had been developed. In MMPO the board of management was responsible for quality as one of a number of roles. The NZPPA had set up an accreditation Council.

10. In GP-led PCOs an important impetus for quality improvement arose out of budget holding for pharmaceutical and/or laboratory referred services. Other important drivers were professional values and clinical leadership. Contracts with the Health Funding Authority were also significant.

Quality initiatives in PCOs

11. Quality initiatives ranged across personal health, population health and referred services management. Within personal health, disease management projects such as diabetes were important as were specific care packages, eg sexual and mental health. Population health services included immunisation for children and older adults, screening programmes for cervical and breast cancer, smoking cessation and other lifestyle programmes.

12. Quality improvement was an important focus in prescribing and laboratory referred services management, including the development of guidelines, information systems with personalised feedback, pharmacy facilitators and peer group review.

13. A range of quality indicators to measure practice performance was being explored in PCOs. These were based upon factors such as immunisation and screening levels, patient satisfaction and practice organisation and management. Some PCOs were developing scoring systems to identify practices needing assistance to achieve appropriate quality standards.

14. A variety of quality initiatives were being explored in non GP-led PCOs. NZPPA had developed a set of standards by which to accredit practices. This was being supported by ACC following the finding that accredited practices had significantly lower rates of ACC claiming. HCA had developed a special quality programme Te Wana which was being progressively rolled out in its member organisations.
MMPO had developed a standards review process and were building a midwifery data base to monitor quality.

Quality achievements

15. PCOs were asked to identify their most significant quality achievements and factors which facilitated and impeded these. The most important achievements came under the headings of:

- immunisation programmes with coverage over 90% being achieved in child immunisation
- successful implementation of diabetic services with the establishment of the disease registers and high percentages of HBA1c being recorded and targeted
- successful screening programmes for cervical and breast cancer with increasing levels of coverage, supported by recall systems and training programmes
- information systems supporting building of quality systems.

16. Facilitating factors mentioned included the national Primary Health Care Strategy, GP accountability and clinical leadership, CME/CNE programmes and a supportive infrastructure, including information systems.

17. While financial incentives are significant in budget holding they appear to play a relatively minor role in the overall drive for quality within a PCO. Key drivers were consistently stated as being professional, achieving better outcomes for patients and communities.

18. Important barriers to quality achievements included; lack of appropriate funding, poor quality data for referred services management, low GP morale, lack of recognition by the funder of achievements and the changing external environment.

Towards becoming PHOs

19. Considerable uncertainty and anxiety was expressed about what a PHO might be and whether PCOs might evolve into PHOs. The characteristics of a PHO referred to above were seen to be important features of quality to which many PCOs were aspiring.

20. All GP-led PCOs were able to estimate a population which they served based upon merged practice registers. Many PCOs had also undertaken needs analysis studies of their populations and were promoting the use of NZ Dep 96 scores in registers.

21. All PCOs are building multidisciplinary relationships especially with practice nurses. Most have appointed practice nurses to boards or were planning to do so. There was a strong emphasis upon practice nurse training.

22. Many new relationships are being built between PCOs and other provider groups in both primary and secondary care. These included Maori and Pacific people and services in mental health, care of the elderly and diabetes services.
23. PCOs are exploring a wide range of models of consumer and community participation including appointing community representatives to boards and committees, establishing separate community boards, undertaking patient satisfaction questionnaires and consultation processes.

24. A wide range of relationships are being built between PCOs and Maori including preparation of Maori health plans, appointments of Maori to boards, development of joint ventures, promoting cultural awareness and ethnic registration in practices. Similar relationships were being built with Pacific people services.

Measuring and improving quality in practices

25. An important development is the move to measure quality more specifically through a range of indicators. These include immunisation levels, patient satisfaction scores and effective practice systems. Development of practice indicators is an international development. New Zealand initiatives may be as advanced as anywhere in actual application to measure quality and target practices where the need for quality improvement is identified.

26. All PCOs emphasised education and training programmes in improving quality, including CME and CNE. There was also emphasis upon clinical leadership training although it was recognised that there was a need for a national programme for clinical leadership development.

27. A critical issue facing leadership is addressing the wide and apparently inappropriate variation in per capita utilisation and expenditure between within and between PCOs. The preliminary evidence that lower per capita expenditure is associated with better quality needs further investigation as it could provide the key to the successful implementation of the national Primary Health Care Strategy.

Clinical governance - the role of clinical leadership

28. The concept of clinical governance is being widely discussed and in fact practiced in almost all PCOs. However only one PCO, First Health, has formally adopted the term. What is clear from the study is that clinical leadership at governance level has been a critical factor in the quality achievements referred to above.

29. Clinical leadership has also been important in the promotion of quality initiatives in the non GP PCOs MMPO and NZPPA. The question arises as to whether new forms organisation by midwives and physiotherapists, such as developed by GP-led PCOs, may lead to more successful promotion of quality in these disciplines.

30. Despite the wide range of quality initiatives being implemented there was a remarkable lack of sharing of the experience being gained. It is clear from the study that there is a need for a national research, development and evaluation strategy for clinical leadership development, including learning from and building on this experience.
31. Building a new leadership culture, not only in primary care but within the DHB system, would appear to be a critical factor in the success of DHBs. It would assist in bringing together the currently divergent cultures of primary and secondary care, personal, public health and disability and between different disciplines.

32. A more integrated system through a new leadership culture is much more likely to succeed in achieving better quality and health gains than the current fragmented arrangements. CLANZ may offer a critical role in promoting this culture in conjunction with a national programme for health leadership development generally.
2. INTRODUCTION

Primary care organisations (PCOs) have become a key feature of New Zealand’s primary health care landscape in recent years (Malcolm, Wright and Barnett, 1999). They are expected to play an important role in the implementation of the National Primary Health Care Strategy (Minister of Health, 2001). The predominant PCO model is the independent practitioner association (IPA) formed by individual GPs and practices to develop contracting relationships with funders. IPA membership may now total 80% of the FTE GP workforce. Additionally there are a variety of contracting arrangements including large practices, Maori and Pacific people groups and those serving disadvantaged populations, eg union health centres. FTE GPs, as members of all PCOs may now total over 90%.

The key factor in these developments has been the emergence of a new form of clinical leadership that is accepting collective and professionally driven accountability for quality and cost of care. This is a radical departure from previous clinical roles.

GP-led PCOs are not the only clinical discipline with formal contracting and quality organisational arrangements. Some midwives have come together to form a Midwife and Maternity Provider Organisation although at this stage representing only a minority of midwives. Physiotherapists are also looking at similar developments.

A key feature of this development is not solely the management of public money to achieve public goals. There is a strong quality focus driven by clinical values and aspirations. Earlier surveys of PCOs showed that a wide variety of quality initiatives were being implemented (Malcolm, Wright and Barnett, 1999; Malcolm, Barnett and Wright, 2000). New forms of what is now being called clinical governance had been established (Wright et al, 2001).

Despite these important developments almost no surveys have been undertaken to document these quality initiatives, to analyse what has been implemented or what the key drivers have been.

This project, a scan of clinical leadership and quality initiatives in selected PCOs and related organisations, was commissioned by the Clinical Leaders Association of New Zealand (CLANZ) and funded by the Ministry of Health. It is one of a ‘trilogy’ of studies to examine the role of clinical leadership in promoting clinical quality within New Zealand and internationally. The two other reports are a literature and experience review of New Zealand and international experience in this field (Wright et al, 2001), and a scan of clinical leadership and quality initiatives in 10 selected district health boards (DHBs) (Malcolm et al, 2001).

Given the limitations of time and funding a scan of selected PCOs, rather than a detailed study, was all that could be realistically undertaken.

The overall aim of this study was:

- To document and analyse clinical leadership arrangements within 10 selected PCOs on clinical quality initiatives and processes and to seek views on the use and meaning of the term clinical governance.
More specific objectives were to review and report on:

- the background, development and organisation within each PCO
- the range of quality initiatives being implemented
- the role of clinical leadership in initiating and driving quality
- the main achievements in quality and the associated facilitating and limiting factors
- progress in achieving community and consumer participation, promoting community health and multidisciplinary relationships
- education and training programmes to promote quality
- the extent to which clinical governance, either formally or informally was being developed within PCOs.

As well as GP-led PCOs it was also decided to include three other groups with quality initiatives. These were Health Care Aotearoa and its quality programme Te Wana, the Midwife and Maternity Provider Organisation (MMPO) and the New Zealand Physiotherapy Association Accreditation Scheme.
3. THE DEVELOPMENT OF PRIMARY CARE ORGANISATIONS

3.1 Formation and development of PCOS

PCOs are a relatively new development within the New Zealand health system (refs). A study in 1999 showed that some 84% of GPs were, at that time, members of PCOs (Malcolm, Wright and Barnett, 1999). PCOs were defined, in that review, as organisations which provided comprehensive, generalist care, with primary medical care as the core service, and which had a contractual relationship with the Health Funding Authority (HFA).

At that time PCOs included 21 independent practitioner associations (IPAs) with 2107 GP members, 10 contracting practices, 86 GP members, two “loose networks” without formal budget holding contracts with 389 GP members, and some 28 community owned and driven PCOs with 60 GPs.

It is known that since that time that some “loose networks” have become incorporated into IPAs and some IPAs have merged. Existing IPAs have continued to expand membership. Given the dynamic state of the primary care environment, the current PCOs numbers and membership remains somewhat unclear but it is estimated that over 90% of GPs and now in some form of PCO.

PCOs were established to develop contracting relationships with funders, initially regional health authorities (RHAs). For RHAs the primary incentive was potential control of demand driven expenditure through PCO budget holding. For PCOs the new arrangements were an opportunity to put general practice and primary health care into a stronger position, to improve health outcomes for patients and communities and to promote quality general practice among members.

3.2 Achievements of PCOs

Surveys of PCOs have consistently shown that their top goals were ‘achieving better health outcomes for patients’ and ‘making better use of primary care resources’ ((Malcolm, Wright and Barnett, 1999). To achieve these goals they have established governance, management and organisational strategies, including information systems, communication relationships and corporate accountability processes.

They have established an increasing set of external relationships, with non-GP primary care providers, with local communities and with and/or between primary and secondary care. Most are building relationships with other disciplines, eg nursing, and are seeking to improve health outcomes through enrolled population health strategies. New disease management services have been implemented, eg for diabetes, and new services established, eg in sexual health and mental health. There is increasing evidence of the effectiveness of clinical leadership in changing clinical behaviour towards improved quality outcomes, eg prescribing less antibiotics, higher immunisation levels..

Previous surveys have shown a strong focus on promoting clinical quality in these initiatives (Malcolm, Wright and Barnett, 1999). Clinical leadership has been the key
driving factor. These organisational developments could be labelled clinical governance although the term has not, until recently, been applied to PCOs.

### 3.4 The National Primary Health Care Strategy

These achievements have enabled the government to formulate the Primary Health Care Strategy (Minister of Health, 2001). Key components of the strategy relevant to this review are:

- that it is part of the overall New Zealand Health Strategy
- a focus on improving health outcomes and reducing inequalities
- it is to be based on multidisciplinary primary health organisations (PHOs) co-ordinating care for enrolled populations
- a strong focus on consumer and community involvement
- PHOs are to be population-based and funded
- PHOs are to be integrated into and funded by DHBs
- continuously improving quality.

However there is considerable uncertainty regarding aspects of implementation of the strategy. Of particular relevance, relating to this report, are:

- changing governance and organisational structures with an expected evolution from PCO to PHO status
- uncertainties about relationships with the newly formed DHBs especially as contracting bodies
- wide variation in utilisation and expenditure both within and between PCOs with serious inequities in the distribution of resources
- uncertainties about relationships between quality and expenditure but with increasing evidence that better quality is associated with lower expenditure
- the need find a strategy to address inequities in access through shifting resources, both within and between PCOs, and from over- to under-funded services
- the role of clinical leadership in these changing arrangements and the extent to which this leadership can effectively influence clinical behaviour
- the promotion of quality and how existing gains can be protected and built upon.

This study has sought to explore these issues in further depth.
4. METHODS AND SOURCES OF INFORMATION

In order to achieve the above objectives a detailed plan was prepared by the study group. A background statement (Appendix 1) was prepared and sent to all PCOs inviting comment and participation. A relatively low level of response was received from this initial contact.

It was decided that 10 PCOs be approached individually and invited to participate through personal discussions and personal visits. A list of topics considered important to achieve the objectives was prepared and presented to PCO leadership in the course of face to face discussions. Discussions almost always included the PCO CEO/general manager together with, in many PCOs, a clinical leader. In some cases discussions were taped and subsequently used for writing up the overview report. Documents were requested including annual reports, strategic and quality plans and other relevant information.

Completed reports were received from Whangarei IPA (WHIPA), Comprehensive Health Services (CHS), Integrated Primary care Services (IPCS), ProCare Health Limited, First Health, Pinnacle, Rotorua GP Group, Wellington IPA (WIPA) and Pegasus Health.

In addition to the GP-led PCOs three other organisations with quality related developments were approached. These were the Midwife and Maternity Provider Organisation (MMPO), Health Care Aotearoa (HCA) and the New Zealand Private Physiotherapists Association regarding their practice accreditation programme.

Given the pressures on PCOs from many quarters it was difficult to acquire the necessary reports and information within a limited time frame. The actual finalisation of reports following the personal visits took, in most cases, well over three months. One PCO personally approached provided no further response.

A summary overview report was prepared for most PCOs on the basis of personal discussions and documents. A draft report was sent to the PCO followed up with, in almost all cases, telephone discussions to achieve a ‘signed off’ report by the PCO. Reports were finally assembled from nine GP-led PCOs and the three others listed above and these are presented in Appendices 2 and 3.
5. QUALITY INITIATIVES IN PCOS AND OTHER RELATED ORGANISATIONS

5.1 Overview

Based on the reports from each PCO (see Appendices 2 and 3) this section provides an overview of the quality initiatives in the nine GP-led PCOs and the three other PCO related organisations for which reports have been prepared. The findings are presented under the following headings.

- Organisational infrastructure to support quality initiatives
- Impetus for becoming involved in improving quality
- The mandate for a quality focus and its reflection in policies and plans
- Quality initiatives implemented in PCOs.

5.2 Organisational infrastructure to support quality initiatives

Table 1 provides an overview of the GP-led PCOs supporting infrastructure for quality. Eight of the nine PCOs have established clear infrastructure support for quality via one or more committees. In three PCOs the responsibility for quality lies with generic clinical committees, three PCOs and possibly a fourth had specific quality committees (one was unclear). One PCO has a number of committees with responsibility for quality in specific areas. Only Pegasus appeared to have no organisational structure supporting the quality initiatives. However, individual managers were expected to be responsible for quality in their areas, with oversight from the Board of Directors.

The membership of these quality committees varies somewhat between PCOs. Overall membership tends to be drawn largely from the GPs and practice nurses. Many committees also involve pharmacy facilitators. Three PCOs included a person with specific responsibility for quality, eg quality co-ordinator or manager of quality and performance. One PCO, while not providing a comprehensive list of its quality committee membership, did indicate that it included two consumer representatives. Where quality specific committees exist, their primary focus is quality assurance, how to implement and support it. On the other hand where quality responsibilities were housed in clinical committees quality was only one of a number of the roles undertaken.

Organisational arrangements supporting quality varied in the three non-GP led organisations. HCA’s organisational infrastructure to support quality programmes is Te Wana. In MMPO, the Board of Management appears to take on responsibility for quality and clearly this is one of a number of roles. In addition to the expected professionals the membership also includes two consumers and one Maori member. The New Zealand Society of Physiotherapists Accreditation Council also has a lay member and it focuses solely on accreditation matters, reporting via the New Zealand Private Practitioner Association, a special interest group of the New Zealand Society of Physiotherapists.
### Table 1  Organisational infrastructure and support for quality initiatives.

<table>
<thead>
<tr>
<th>1</th>
<th>GP-led PCOs</th>
<th>Membership</th>
<th>Scope of Committee(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Comprehensive Health</td>
<td>Clinical Projects Manager, GP member, Quality Coordinator, Pharmacy Facilitator, Practice Nurse Development Co-ordinator/ Project Manager.</td>
<td>Oversees all clinical projects not solely quality.</td>
</tr>
<tr>
<td>2</td>
<td>First Health</td>
<td>Clinical Directorate – Clinical Director, Associate Clinical Director, Manager Quality &amp; Performance, Manager Maori Health, Clinical Management Committees (each) – 4 GPs 1 Practice Nurse, 1 Practice Manager, 1 FH local manager, 1 Clinical Manager</td>
<td>Clinical Directorate provides management services to the local Clinical Management Committees. Scope appears to extend across clinical matters including quality.</td>
</tr>
<tr>
<td></td>
<td>IPCS</td>
<td>Various</td>
<td>Quality is a part of their responsibilities.</td>
</tr>
<tr>
<td>3</td>
<td>Pegasus</td>
<td>NB. Individual managers carry the responsibility for quality.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Pinnacle</td>
<td>1 Pinnacle directors, 2 GPs, 2 QA Co-ordinators and Pharmacist Facilitator</td>
<td>Quality</td>
</tr>
<tr>
<td>5</td>
<td>ProCare</td>
<td>Representatives of GPs, practices nurses inc NZNO, RNZCGP, Univ of Auckland and consumers</td>
<td>Quality</td>
</tr>
<tr>
<td>6</td>
<td>Rotorua General Practice Group</td>
<td>3 GPs, 1 Practice Nurse, Quality Co-ordinator and General Manager.</td>
<td>Develops, implements and monitors quality activities.</td>
</tr>
<tr>
<td>7</td>
<td>Wellington IPA</td>
<td>6 GPs including Professor of General Practice, 2 Practice nurses, 1 community appointee, Pharmacist facilitator, Project Manager: Quality, GM Information.</td>
<td>Total overview of Quality initiatives, including coordination of other project based committee workplans</td>
</tr>
<tr>
<td>8</td>
<td>Whangarei IPA</td>
<td>4 GPs, 2 Practice nurses &amp; Clinical Project Coordinator.</td>
<td>Adds quality processes to programmes, provides a quality plan, advice &amp; recommendations to Board.</td>
</tr>
</tbody>
</table>

#### 2  Non GP-led PCO-type organisations

| 1  | Health Care Aotearoa MMPO       | Not known 3 elected midwives, 2 consumers, 1 Maori and 1 Member of the NZ College of Midwives. | Accreditation of members Quality one of a number of roles.                         |
| 2  | NZ Society of Physiotherapists  | Accreditation Council comprises: 2 NZPPA members from accredited practices, 1 Executive member of NZPPA and "lay" member. | Accreditation matters are sole focus of the Council.                                |
5.3 Impetus for becoming involved in improving quality

Among the GP-led PCOs it appears that one impetus for the development of a quality focus has emerged from work done in budget holding for pharmaceutical and/or laboratory referred services. Another impetus has clearly been the quality requirements of the previous HFA contracts. These, while couched in non-prescriptive terms, required PCOs to develop both a quality plan and a Maori Health plan.

In addition to these more obvious spurs six of the nine participating PCOs stated that professional values and clinical leadership provided a significant impetus in the development of an organisation-wide focus on quality issues. Two of these PCOs (ProCare and Pinnacle) have gone as far as getting ISO – 9001 accreditation. ProCare has also developed a New Zealand version of the American/Canadian HEDIS - Performance Report on Ambulatory Care (ProAc) - which it launched as a means of measuring quality improvements.

The non-GP led PCO-type organisations had quite different reasons for getting involved in improving quality. The New Zealand Society of Physiotherapists’ initiative in setting up an Accreditation Council was a professional initiative led by the values of a small group within the organisation. In the case of MMPO the statutes relating to midwifery required some basic quality work to be put in place. MMPO has further developed its quality initiatives.

HCA had initial contract requirements from the funder (HFA) regarding quality. However the nature of the organisation has led it to develop a specialist community-based quality programme in conjunction with the Australian Quality Improvement Council (previously known as CHASP). This programme has been adapted to fit New Zealand circumstances, making it unique.

5.4 The mandate for a quality focus and its reflection in policies and plans

With the exception of the New Zealand Society of Physiotherapists for whom this was not stated, all the organisations have high-level statements regarding quality or excellence in any one or even all of, their mission statements, statements of purpose, vision, values, goals and/or objectives. At least one organisation (CHS) provided consistent focus on quality beginning with its vision and following through in its mission statement, it's value statement, and subsequently in its goals.

While the HFA previously required each of these organisations to develop a quality plan the material they provided does not always stipulate that one exists. Pinnacle had developed an innovative approach to its quality plan implementation by using a balanced scoreboard approach across the organisation. Their five-year quality assurance plan sets out nine quality objectives/indicators on which practices are rated 0-100 on their performance across a range of quality categories.
5.5 Quality initiatives implemented in PCOs

5.5.1 Health service activities in GP-led PCOs

Table 2 illustrates the range of health activities for which PCOs have developed a quality focus. These range across personal health, population health and referred services.

- **Personal Health**

  Within personal health, disease management activities cover, for example, heart disease, diabetes, respiratory illnesses, sexual reproductive health, and otitis media, made up the bulk of service activities. Other activities mentioned by individual PCOs include dyspepsia, and rheumatic fever.

  Considerable attention has also been given to specific care packages for various groups within the population or in their own right. These include elder care, mental health, children and adolescents, Maori Health, Pacific Island Health, and terminal care. In the area of elder care Pegasus participates in the provision of care which is integrated with the care provided by the hospital services and the voluntary and private organisations in the Christchurch City area. Both ProCare and WIPA are in the process of developing mental health services that link to other sectors. Pinnacle already has an integrated mental health service – GPs, nurses, pharmacists, hospital case managers, and a psychiatrist ‘hotline’ for GP access.

  It is expected that most PCOs will have a plan for Maori health, as they were previously required to do so by the funder (HFA). Pinnacle has a Maori Health Action Plan and a Maori Advisory committee. However, it should be noted that only these organisations identified this in the current survey. Two Auckland PCOs, Pinnacle and Pegasus Health have also developed a focus on Pacific Island health or working with Pacific Island groups. Other care package activities include ultrasound services, minor surgery, community and extended care, shared services across a semirural area, rural practice issues and management of acute demand.

- **Population Health Services**

  Immunisation programmes both for children and for older adults (influenza) are universal programmes within population health services. Screening programmes for breast cancer and cervical cancer are also commonly found. Other activities in population health include a dietary focus (via a community dietitian), hepatitis B, smoking cessation, breast feeding, and dental enrolment.

- **Referred Services**

  Almost all of the PCOs studied have been involved budget-holding for referred services for pharmacy and/or laboratory services. Common activities undertaken to improve quality in these services include:
<table>
<thead>
<tr>
<th>Activities mentioned</th>
<th>CHS</th>
<th>First Health</th>
<th>IPCS</th>
<th>Pegasus</th>
<th>Pinnacle</th>
<th>ProCare</th>
<th>Rotorua</th>
<th>WIPA</th>
<th>WHIPA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal health</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>1  Disease management</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Heart disease</td>
<td></td>
<td></td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>1.2 Diabetes</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
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<td>1.3 Respiratory</td>
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<td>1.4 Sexual and reproductive health</td>
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<td>1.5 Otitis media</td>
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<td>2.1 Elder care</td>
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<td>2.2 Mental health</td>
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<td>2.3 Children &amp; Adolescents</td>
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<td>2.4 Maori health</td>
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<td><strong>Population health</strong></td>
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<td>3  Immunisation</td>
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<tr>
<td>3.1 Screening</td>
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<td><strong>Referred Services (pharmaceutical and laboratory)</strong></td>
<td>☑</td>
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</tbody>
</table>

NB The information shown above is indicative only. It is based on information obtained during a short interview and the limited material, if any, that was sent to the authors.
- the use of prescribing guidelines and preferred medicines lists
- guidelines for laboratory services
- the development of information systems with personalised feedback on performance pharmacy facilitators, bulletins and newsletters to members
- frequently the development of targets and/or indicators.

Some PCOs have set up a Pharmacy Committee.

5.5.2 Enhancing standards of practice in GP-led PCOs

Table 3 provides an indicative list of some of the activities undertaken by PCOs to enhance the standards of practice. The most commonly cited activities relate to staff development for GPs, practice nurses or other practice staff. In general terms this has tended to take the form of continuing education for GPs and practice nurses with other approaches, eg special courses for other practice staff. In addition, one PCO noted that it was looking at the occupational safety and health issues in its practices.

A number of PCOs have set up peer review, cell groups and focus groups - mainly resulting from their work on referred services, as a means of providing support staff to gain feedback and improve quality. Also deriving from the work done for referred services budget holding is the development and dissemination of guidelines, practice standards, decision tools.

One PCO (Pinnacle) has implemented a system based upon nine quality indicators to rate practices on a scale from 0-100. The quality indicators and the points attached to each are listed as follows.

<table>
<thead>
<tr>
<th>Objective/indicator</th>
<th>Score of 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunisation rate of 2, 5 and 18 years olds</td>
<td>12%</td>
</tr>
<tr>
<td>Cervical smear rate enrolled population of eligible 20-70</td>
<td>9%</td>
</tr>
<tr>
<td>Maintain breast screening register</td>
<td>5%</td>
</tr>
<tr>
<td>Practice health and safety</td>
<td>10%</td>
</tr>
<tr>
<td>Essential emergency/ resuscitation equipment available in</td>
<td>5%</td>
</tr>
<tr>
<td>Ethnicity coding</td>
<td>10%</td>
</tr>
<tr>
<td>Disease coding and use of electronic medical records</td>
<td>17%</td>
</tr>
<tr>
<td>Patient satisfaction survey</td>
<td>7%</td>
</tr>
<tr>
<td>Personnel training</td>
<td>25%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

Practices with lower performance and appearing to need support are visited and assisted to improve performance. This process is non-judgmental and facilitatory. It has been found that a key factor underlying poor performance is the training, organisation and management of the practice.

Similar but less formal approaches have been adopted by other PCOs.
<table>
<thead>
<tr>
<th>Activities mentioned</th>
<th>CHS</th>
<th>First Health</th>
<th>IPCS</th>
<th>Pegasus</th>
<th>Pinnacle</th>
<th>ProCare</th>
<th>Rotorua</th>
<th>WIPA</th>
<th>WHIPA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff development</strong></td>
<td></td>
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<td></td>
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<tr>
<td>• CME/doctors</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>• CNE/practice nurses</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>• Other practice staff</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td><strong>Practice health &amp; safety</strong></td>
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<tr>
<td>Consultation skills with Maori/Pacific Island ethnic groups</td>
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<td>Mentoring</td>
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<tr>
<td>Peer review/cell groups</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Quality indicators</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Incentives to practices to undertake staff development</td>
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<tr>
<td>Participation in RNZCGP Standards-trial &amp; evaluation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Guidelines/practice standards/decision tools/</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
</tbody>
</table>

NB The information shown above is indicative only. It is based on information obtained during a short interview and the limited material, if any, that was sent to the authors.
5.5.3 Information technology and other organisational support for quality improvement in GP-led PCOs

The range of activities adopted by PCOs to support quality improvement can be seen in Table 5. In this group of PCOs at least, much work has clearly gone into putting in place the appropriate information technology and then setting out to manage it well. Register management e.g. for disease management and/or practice management has figured largely in the work of PCOs over recent years. It also appears that attention is being paid to getting the best out of the information collected by:

- ensuring that it is collected in a standardised manner
- reviewing and analysing it
- providing reports to members on the analysed data.

Over and above these more standard activities some interesting developments have occurred. For example First Health has developed a partnership with Waihealth and Union Health as part of the Maori Health Gain Project to improve their data communication. Pegasus and Pinnacle (through its Quality plan) have adopted the approach of providing financial incentives for practices to adopt the appropriate information technology systems.

Other support activities for quality have included the development of guidelines, preferred medicines lists, and the development of measure and indicators. Also in this category are satisfaction surveys of either consumers and/or providers. Clinical audit and feedback is also been adopted by PCOs. Pegasus have used this to establish its Qualmark system where practices achieving appropriate standards are then able to use Pegasus branded materials. Pegasus has also instituted a Decision Support Team for members to consult.

First Health assists its practices by providing them with individual integrated quality reports. Both CHS and IPCS have put effort into building strategic partnerships relationships to support their practices. CHS has also undertaken a community needs analysis. ProCare has developed one of the more innovative approaches via the development of its quality awards, which were recently presented at a Quality Ball.

5.5.4 Quality Activities in non GP-led PCOs

- The NZ Society of Physiotherapists

The NZ Society of Physiotherapists has developed a set of standards, which is in its 6th edition (see http://www.physiostandards.co.nz). These standards cover three broad areas – management and planning, client care and human and physical resources. Continuous quality improvement is a theme throughout these standards, which are available in a self-assessment format on the website.

Any practice submitting itself for accreditation can not only test itself at the website but they also receive face-to-face education in preparation for the survey. An ACC comparison of accredited against non-accredited practices demonstrated the
<table>
<thead>
<tr>
<th>Activities mentioned</th>
<th>CHS</th>
<th>First Health</th>
<th>IPCS</th>
<th>Pegasus</th>
<th>Pinnacle</th>
<th>ProCare</th>
<th>Rotorua</th>
<th>WIPA</th>
<th>WHIPA</th>
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<tbody>
<tr>
<td>Information technology &amp; information management</td>
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<td>• Register management</td>
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<tr>
<td>• Standardised information collection</td>
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<tr>
<td>• Analysing, reviewing and dissemination data</td>
<td>√</td>
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<tr>
<td>Other quality support for members/practices</td>
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<td>• Guideline, preferred medicines lists, indicator development</td>
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<td>• Surveys</td>
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<tr>
<td>• Clinical audit and feedback</td>
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advantages of accreditation and there are now 186 scheme members with 54 accredited practices.

- **Health Care Aotearoa (HCA)**

HCA has developed two modules of its quality programme, Te Wana – the Core Module and the Community and Primary Health Care Service Delivery Module. The core modules contain a set of indicators and standards which aim to promote quality outcomes for customers, guide staffing and service development in a manner which encourages quality improvement, evaluation and accountability. The standards that were developed in conjunction with stakeholders promote good practice in:

- consumer and community involvement
- management and administration
- planning and evaluation of activities
- staff development, and
- service delivery.

Following the development of New Zealand standards these were agreed with the Australian QIC. Subsequent to this a website has been developed and training workshops held. Thirteen services have entered the programme and 40 more have expressed interest. Work is underway to extend the programme into community-based Mental Health and links are established with other quality programmes e.g. Standards New Zealand.

- **MMPO**

MMPO have put in place:

- a standards review process which reviews the practice of each midwife,
- complaints resolution committees in all the NZ College of Midwives regions,
- a midwifery database based on midwifery statutory requirements and the needs of the National Perinatal database,
- an information resource centre in Christchurch,
- a midwifery mentoring scheme
- a midwives medicines information bulletin.
6. QUALITY ACHIEVEMENTS

PCOs were asked as to what they regarded as the most significant quality achievements, factors facilitating these achievements and barriers limiting them.

The following are examples only of what were listed as the most significant achievements.

- The development of successful immunisation programmes, both childhood and as well as influenza, with high levels of coverage. Childhood immunisation coverage of over 90% was being achieved in a number of PCOs. This the

- Successful implementation of diabetic services were commonly mentioned. Associated with this was the establishment of disease registers, high levels of HbA1c being recorded and supportive training programmes, including for practice nurses.

- Screening programmes for cervical and breast cancer were progressing well with increasing levels of coverage, again being supported by infrastructure, recall systems and training programmes.

- Information systems supporting the building of quality systems was seen to be important in a number of reports. Associated with this was the establishment of an appropriate infrastructure including practice registers, recall systems and high levels of NHI and ethnicity recording.

Facilitating factors were seen to be important and again the following is only a sample of those put forward.

- The primary health care strategy was seen to be important in facilitating progress

- GP accountability and clinical leadership were an important factor in promoting a new culture.

- CME/CNE programmes had been important facilitators.

- A supportive infrastructure, including information systems, was also mentioned by a number of PCOs.

Important barriers mentioned included:

- lack of appropriate funding
- poor quality data for referred services management
- low GP morale
- a lack of recognition by the funder of achievements
- the changing external environment.
7. TOWARDS PRIMARY HEALTH ORGANISATIONS

7.1 Becoming a PHO

In almost all cases uncertainties and even anxieties were expressed about what a PHO might comprise. Was it an entirely new organisation or could PCOs evolve into PHOs? Section 3 has discussed the key aspects of PHOs. The following are examples only of the most significant achievements of PCOs relevant to the concept of a PHO. A number of PCOs felt that they were already evolving to PHO status. The evidence presented, and discussed below, tends to support this view.

Uncertainties and anxieties were also expressed about relationships with DHBs. Although these in most cases were seen as much improved over the past 12 months there was concern about the limited understanding of the roles and functions even of PCOs, let alone PHOs, on the part of the DHB.

An example of rapidly developing positive relationships was seen in Northland. This flowed from the appointment, earlier this year, of a General Manager Primary Care with overall leadership responsibility and strategic planning of an integrated primary health care service throughout the district, both government and non-government provided. No other DHB visited had made such an appointment and relationships were still largely seen to be on a contracting rather than a leadership, collaborative basis.

This section reviews evidence provided on key quality developments relevant to progressing to PHO status, under the following headings:

- a population focus including information systems
- towards becoming multidisciplinary organisations
- co-ordinating care across service areas
- consumer and community participation
- Treaty of Waitangi Maori relationships
- Pacific people relationships

7.2 A population focus including information systems

Population registers. All GP-led PCOs studied had established population registers of enrolled populations based on their general practices. They were able to assign not only populations to individual practices but were merging practice registers to ensure that people were counted only once. All were able to identify what they considered to be a population largely unique to their PCO and most were establishing disease registers eg diabetes, asthma, etc.

However, as discussed below there are questions about the extent to which there is an overlap between PCO registers and other non-PCO providers. Furthermore, few if any PCOs have analysed their practice registers to determine needs adjusted per capita expenditure for GMS and referred services for their individual practices.

Needs analysis Many PCOs have undertaken studies of the needs of their populations and are promoting the use of NZDep96 scores in practice registers. Some were
recognising that they have responsibilities to underserved groups within their communities who may not be registered with them.

7.3 **Towards becoming multidisciplinary organisations**

All PCOs were building multidisciplinary relationships especially with practice nurses and to a lesser extent pharmacists and midwives. Most have appointed practice nurses to their boards or are planning to do so. There was a strong emphasis upon practice nurse training, including multidisciplinary training. However it was not possible in this review to seek the views of practice nurses and other disciplines on these developments.

7.4 **Co-ordinating care across service areas**

Many new relationships have been built between PCOs and other provider groupings including between primary and secondary care. Examples of these relationships include the following;

**Within primary care;** with Maori and Pacific island groups and local trusts– many examples, see further below, with Plunket – many PCOs.

**With secondary care;**

- integration Task Force in Auckland since 1998 to progress integration initiatives including child, mental and older persons health
- mental health service developments – eg in Auckland, between WIPA and Capital and Coast DHB, Wellington, and Pinnacle and Health Waikato, Hamilton.
- sexual health services - eg WIPA and Capital and Coast
- Eldercare Canterbury - between Pegasus, geriatricians and the DHB and its predecessors
- diabetic services - between a number of PCOs, diabetic specialists and DHBs
- formal liaison relationships being established between most PCOs and DHBs.

Most of these new relationships have been initiated by PCOs with, at times in the past, a limited response from DHBs and their predecessors. There have been notable exceptions to this, eg South Auckland.

Overall relationships between PCOs and DHBs are said to be rapidly improving in the new DHB environment. However there is still uncertainty and concern about contracting relationships and how they will be worked out between PCOs and DHBs.

7.5 **Consumer and community participation**

PCOs have been exploring a wide range of models of consumer and community participation. These include the following.

- Appointing consumer/community representatives to boards of governance - only CHS, WIPA and MMPO of the PCOs studied have so far done so. WIPA has appointed two community participants to the board of the Greater Wellington Health Trust.
- Appointing consumer/community representatives to PCOs, including quality committees
- Establishing separate consumer/community boards - Pegasus and WIPA
- Appointing consumer representatives - eg Pinnacle in its districts
- Establishing formal liaison with consumer bodies eg cancer, child groups
- Patient satisfaction questionnaires - many PCOs
- Consultation processes, documents.

A number of PCOs are formally considering models of consumer participation or have plans to implement agreed arrangements. However, the wide range of models, uncertainty about what is likely to work, and a number of failed experiments, indicate that there is a need for much wider sharing of the experience so far gained or being explored.

What is clear is that there is a willingness and commitment to promote community and consumer participation and that there are serious attempts to do so. What is also clear is the need for an evaluative study to explore successes and failures to determine what models are likely to prove to be most effective. From discussions it would appear that a separate community board might prove to be the most successful model.

7.6 Treaty of Waitangi Maori relationships

PCOs were required, in their contracts with funders, to establish relationships with Maori based upon the Treaty of Waitangi. Basic requirements include the preparation of a Maori health plan addressing health gain priority areas and ensure Maori participation at all levels.

A wide range of relationships is being built between PCOs and Maori including iwi and Maori providers including:

- the preparation of Maori health plans
- appointment of Maori advisers to boards
- establishment of Maori advisory committees
- development of joint ventures between the PCO and Maori providers
- promoting better access to services including immunisation programmes
- promoting cultural awareness and understanding in consultation relationships
- promoting ethnic registration in practices.

A more detailed analysis is needed to clarify progress and factors that have been important in developing quality relationships. A number of PCOs report that, although they have worked hard to develop relationships and joint ventures with Maori at both iwi and provider level, progress has been slow and, at times, frustrating. A more detailed description and analysis is needed of progress in this important field to develop a better understanding of issues needing to be addressed if successful relationships are to be built.

7.7 Pacific people relationships

A number of PCOs have established relationships with Pacific people along the lines listed above under Maori, including advisory committees, and collaborative relationships with Pacific Island health providers. Detailed information was not sought regarding
these developments. Again there is a need for a better understanding of progress and factors facilitating and inhibiting it.
8. LEADERSHIP DEVELOPMENT PROGRAMMES

8.1 Education and training programmes

It is clear from the attached reports that education and training programmes play a large part in PCO development, including promoting clinical quality. These include:

- well-attended CME with attendance accredited with RNZCGP
- CNE programmes, sometimes in conjunction with GPs, leading to nurse accreditation
- a wide range of other programmes involving many different providers
- bringing GPs and specialists together for joint sessions and promoting collaboration
- collaborative processes for developing best practice guidelines, eg disease management
- meetings with pharmacist facilitators and quality co-ordinators
- developing distance learning programmes for members
- peer review meetings to support quality initiatives
- technology training sessions
- cultural development programmes
- leadership development programmes
- provision of study awards.

8.2 The need for clinical leadership development

It was apparent from discussions with clinical and other leaders in PCOs that there was a strongly perceived need for leadership development programmes. Pinnacle has an in-house strategic leadership course tailored to primary care: attended by directors, GPs, nurses, practice managers and staff. However few of the above programmes focus upon developing clinical leadership although it clearly plays a critical part in PCO development.

There was support for leadership development such as the concept of a National Health Leadership Development Centre. This would create an environment within which clinical leaders can come together to build a shared culture of quality and understanding. However feelings were expressed regarding the need for it to be driven by providers and not centrally. Such a proposal has not yet been formally discussed with PCOs.
10. CLINICAL GOVERNANCE - THE ROLE OF CLINICAL LEADERSHIP

9.2 Clinical leadership in governance and management

In GP-led PCOs leadership at the governance level is overwhelmingly by GPs. Some PCOs have appointed non-GP members to boards with only one PCO appointing a community representative. Clinical leadership is also strongly involved in board committees and plays a key part in some aspects of management with the appointment of clinical leaders who may work under management.

Clinical leadership also plays a key part in the peer or cell groups. For example ProCare has 22 cell groups each with 15 members meeting monthly with a leader who is responsible for preparing materials, leading discussions and providing reports, e.g. the development of guidelines.

From the discussions and reports presented in Appendices 2 and 3 there was a continuing affirmation from management of the critical role which clinical leadership played in the development of PCOs. Much of the innovation came from GP leadership as did commitment to the implementation of the new quality initiatives.

9.2 Quality structures

As indicated above a wide range of quality structures, including at governance and operational levels, have been established to promote quality. These include:

- overall quality programmes ranging across provider organisations and groups, e.g. Te Wana for HCA and physiotherapy practice accreditation
- portfolio membership at governance level and quality committees as part of governance
- quality committees as part of management
- personnel with specific quality functions
- information systems to measure and monitor quality
- quality indicators developed to measure quality performance
- feedback systems to promote quality behaviour.

In almost all cases these have evolved out of innovative developments within PCOs. There has been almost no prescription/guidance from funders and little sharing of experience across PCOs.

9.3 Clinical governance

Only First Health has formally adopted the term and practising it as a policy and strategy throughout their organisation. However the concept of clinical governance is being widely discussed and practiced in almost all PCOs.

For example, ProCare comment that from the outset they ‘fortuitously and intuitively’ understood the key notions of clinical governance and leadership and structured the organization accordingly. Early on cell-peer groups were set up as a supportive
environment to underpin change. A quality committee formed with GPs, consumer, practice nurse and cultural representation. ProAc –(Performance report on Ambulatory care) was established as the key quality reporting mechanism. Engaging key stakeholders was one of the keys to success.

The implications of this will be discussed below.
10. OVERVIEW OF QUALITY DEVELOPMENTS IN PCOS

10.1 Overview of the project and information sources

As stated in the introduction this project presents the results of a scan of a selected number of PCOs. Funding and time constraints precluded a more detailed review. The authors have some reservations regarding the nature and quality of the information drawn upon. This report is based upon information supplied by the PCOs that were approached, complemented by follow-up discussions both personally and by telephone.

In relatively few cases was it possible to obtain from PCOs a full set of formal documents such as annual reports, strategic or quality plans. The production of such documents has been limited by factors such as heavy pressures on time. Nor has it been possible to check from alternative sources the accuracy of the information provided. However there is a level of consistency in what has been provided and which is supported by previous studies.

Attempts were made to gain the information within a standard format and, for a number of reasons, it was not possible to keep to this. PCOs were encouraged to be forthcoming on what they thought had been important quality initiatives and achievements. As a consequence a wide range of unstructured information was supplied which has required a qualitative rather than a quantitative presentation. The alternative would have been to have imposed a structured questionnaire with the consequent limitations of such an approach.

10.2 Review of quality developments –incentives, achievements

The discussion above has identified a wide range of quality initiatives ranging from governance through management to operational levels. There is a strong sense in all PCOs, both GP-led and others, that quality is a pervasive and important concept.

At the governance level most had clinical or quality committees with responsibility for quality including in specific areas of care. At the management level there were often specific people appointed to drive quality including quality facilitators and co-ordinators. Activities that might have been seen by funders to have a primarily financial focus, such as budget holding, were consistently presented as primarily quality rather than financially driven.

While financial incentives were significant in the budget holding they appear to play a relatively minor part in the overall drive for quality within the PCO. Key drivers were consistently stated as being professional, and achieving better outcomes for patients and for communities. This commitment to quality was evidenced in both the provision of new services, the development of new relationships and a strong focus upon development of appropriate infrastructure to support, deliver and monitor quality outcomes.

There was a sense of pride in many reports and discussions regarding substantial achievements including for new services. These included:

- specific disease programmes eg diabetes and respiratory disease
- population health services, eg immunisation and screening programmes
- a strong emphasis upon the building of supporting information systems such as population and disease registers and recall systems.

A key facilitating factor was GP clinical leadership supported by education and training programmes. Contracting specifications of the funder were seen if anything to have a neutral or even negative effect upon innovation and quality initiatives.

### 10.3 Indicators of quality

The aim of promoting, measuring and improving quality outcomes has led to a new feature – the development of quality measurement systems including quality indicators. Perhaps the most advanced of these was a system developed by Pinnacle, discussed above in Section 5.4.2. Nine quality indicators had been developed and implemented and were being used to rate member practices with the purpose of rewarding achievement and identifying where help was needed.

Implementation of this requires a sophisticated information system, which was becoming established although there were limitations in the current software systems. Other PCOs were equally advanced in information system development and their ability to categorise practices but had not developed a rating system as such. All PCOs visited were developing systems based upon their own innovation and design with relatively little exploration of other systems, including in PCOs or internationally. ProCare had developed a system based upon the US HEDIS quality system.

There is a growing interest in New Zealand and internationally in the development of general practice quality and indicators to measure it.

The RNZCGP, in order to promote quality in general practice, has developed a system of accreditation of general practices (RNZCGP, 2001). A set of standards has been produced with indicators including; the rights and needs of patients, access and availability, barriers to access, practice facilities and systems, practice and patient management, human resource management, professional development and research.

These indicators, however, are focused upon structures, and to some extent processes, rather than the outcome indicators established by some PCOs.

In Australia an extensive consultation Delphi process led to the development of a priority set of 15 indicators as listed in Table 6 (Jeacocke et al, 2000). There are many similarities between this list and those being developed by New Zealand PCOs. However it lacks both a patient/consumer perspective as well as indicators of the quality of practice management both of which are seen to be important by New Zealand's PCOs.
### Table 6  The set of 15 indicators of general practice quality developed by the Newcastle Institute of Public Health in conjunction with general practice stakeholders in Australia

<table>
<thead>
<tr>
<th>Top 15 Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of all children older than 7 years of age who have been appropriately immunised as measured by ACIR</td>
</tr>
<tr>
<td>Proportion of adult patients who have been screened for hypertension according to the RACGP recommendation</td>
</tr>
<tr>
<td>Percentage of sexually active women under 70 having a record of receiving a pap test in the last 2.5 years</td>
</tr>
<tr>
<td>Percentage of all adult women over 50 years of who have had a mammogram performed in the last two years</td>
</tr>
<tr>
<td>The proportion of non-insulin dependant diabetics seen over the last month with a record of an HbA1c being performed in the last 14 months</td>
</tr>
<tr>
<td>Proportion of all adults aged over 65 immunised against influenza per year</td>
</tr>
<tr>
<td>Proportion of practices providing after hours care for patients</td>
</tr>
<tr>
<td>Percentage of unsatisfactory pap smears performed by general practitioner over a three month period</td>
</tr>
<tr>
<td>Proportion of consultations in which antibiotics are prescribed</td>
</tr>
<tr>
<td>Percentage of asthmatics seen in a month with a documented asthma management plan measured prior to the start of the consultation</td>
</tr>
<tr>
<td>Percentage of patients with left ventricular failure on an ACE inhibitor</td>
</tr>
<tr>
<td>Percentage of medical records with up to date patient summaries based on an audit of randomly selected records from patients examined in the previous week</td>
</tr>
<tr>
<td>Proportion of practices using computerised prescribing packages within a division of general practice</td>
</tr>
<tr>
<td>Percentage of all adults (&gt;18 years) with a previously documented cholesterol test within the last 5 years</td>
</tr>
<tr>
<td>Ratio of antidepressant to benzodiazepine use (&gt;2 weeks)</td>
</tr>
</tbody>
</table>

Developing indicators of clinical quality in general practice has been given increasing attention in recent years. A recent systematic review was published of studies of quality of clinical care in general practice in the UK, Australia and New Zealand (Seddon et al, 2001). The quality indicators reviewed were entirely clinical conditions, eg asthma, cardiovascular disease, diabetes and hypertension. The review showed that published research in the field presented an incomplete picture of the quality of clinical care in terms of its methodological rigour and comprehensiveness. In almost all studies reviewed the quality of care did not attain acceptable standards of practice.

In commenting on this review Khunti (2001) noted that it did not provide information on methods which had been successfully used in general practice and improving quality of care. Nor did it indicate whether the drive for monitoring of clinical care came from the practices themselves or from other local or national initiatives. He pointed out that monitoring must be used in conjunction with a wide variety of methods of implementing change. He stresses that, more important than merely reporting on indicators, is the study of management systems which demonstrate that significant change can be achieved.
Campbell, Roland and Wilkin (2001), in a report on progress over 18 months in clinical governance in primary care groups and trusts, noted that substantial progress was being made in organisational development. This was beginning to bring about a significant cultural change in general practice. However they stated that what had not yet been shown was that any of this activity had improved the quality of care. It was still too early to tell.

It is clear from the evidence presented in this study that PCOs have gone down the track of actually establishing management systems to specifically promote and monitor quality improvements. Furthermore the evidence also demonstrates that significant improvements in quality of care are being achieved.

10.4 Clinical leadership and clinical governance – a new role for clinicians

This review has demonstrated the critical importance of clinical leadership in driving the initiatives and achievements reported. Clinical leaders, in conjunction with management, have planned and implemented a wide range programmes with a strong focus upon quality. To support these developments they have strongly promoted education and training programmes to build leadership capability.

It would seem surprising that, for the most part, this capability has arisen from within the systems established. Funders and national strategies appear to have had only a limited role. GP leadership has been a key factor in the development of the RNZCGP over the last three decades and the associated drive to improve standards of general practice and to achieve specialty registration. What is new, however, is that GP leadership, operating at the provider level through PCOs, may be proving to be more effective in promoting quality than through external professional and accrediting bodies.

A wealth of experience has been accumulated by PCO leadership. Yet there is almost no sharing between DHBs or PCOs of this experience. The successful development of clinical leadership in New Zealand could be the centrepiece of a national strategy for quality improvement. A key part of this strategy might be the establishment of a national centre for health leadership development bringing together clinical leaders, management and DHB board members to promote a comprehensive quality culture.

Associated with this is the need for a national research, development and evaluation strategy for clinical leadership development. Despite its importance relatively little is as yet known in New Zealand about effective models of clinical leadership and what works in addressing quality issues, including how to change clinical behaviour.

10.6 The equity issue: the key challenge for clinical leadership

Perhaps the most critical issue facing GP leadership in changing clinical behaviour relates to the wide variation in per capita utilisation and expenditure in primary care resources between practices. Studies have consistently shown a variation of three times between top and bottom per capita expenditure decile practices after standardisation for age, gender and income.

There is firm evidence that low per capita expenditure is associated with poor access to care. There is also increasing evidence that lower expenditure is associated with better
quality. However almost no research has been undertaken to demonstrate this relationship adequately or to develop strategies to assist clinical leadership in changing this behaviour. Changing clinical behaviour would be much more effective if it focused on quality as well as cost, rather than just cost alone. Finding such a strategy will be critical to the successful implementation of the National Primary Health Care Strategy.

A related issue referred to above is the considerable uncertainty about PCO registers. All PCOs were able to identify a defined population which they felt was unique to their PCO. However such numbers do not take into account those patients who are registered with other PCOs, with non-PCO GPs and who receive care from time to time from A&M centres and other non-practice type services. Pinnacle capitation system makes offsets for accessing after-hours from the A&M centres. Practices can either choose to offset against actual consultation or have a block fee based on historical utilisation.

Studies of this issue in Auckland in 1998, using merged PCO register data held by the Northern RHA, showed that there was a wide overlap between PCO registers (Malcolm, 2000). The percentage of records unique to a PCO were found to be widely variable, the highest being 79.1% in a relatively stable population. Much lower figures were found for disadvantaged populations where large overlaps between registers reduced the percentage of unique records to the 20-30% range. Assumptions by PCOs about the size of their populations may therefore be seriously inflated. As a consequence they are likely to be over- rather than underfunded on a population-based funding formula. Few PCOs have therefore grasped the significance of the problem they face with the implementation of the funding formula.

10.6 Establishing primary health organisations

The discussion above has demonstrated that almost all GP-led PCOs are moving to fulfil many of the requirements of PHO status. Continuing concern is being expressed by PCOs that their attempts to move towards a PHO model have been given little recognition. Legitimate concerns also continue to be expressed by groups such as nurses and consumers that PCOs are still heavily GP dominated.

Nevertheless, changing the dominant and isolated GP culture so far has been remarkably successful, given where this culture was even five years ago. Much of the impetus for this change has come from GP leadership. There are limits to the rate of change which can be successfully achieved among rank-and-file GPs. GP leadership must keep in touch with members if the changes are to continue. Setting up a separate PHO organisation may do little to progress these changes and may significantly impair progress.

Furthermore questions are being raised about the need to establish a new organisation. The DHB itself could provide the leadership which might otherwise come from a PHO. The developments in Northland referred to above, may be a more effective alternative. A general manager, primary care, exercising overall leadership, strategic planning and integrating the public with the non-public sectors, may be more successful in moving the complex and fragmented primary health care system into the DHB framework.

10.7 Non-GP leadership models of quality organisations
Although GP leadership is the predominant model discussed in this report reference has also been made to the significance of other forms of clinical leadership. A model of clinical leadership is emerging led by midwives although at this stage it represents only a small minority. MMPO argues that, like GP-led PCOs, it is providing a substantial value-added dimension to the quality of midwifery services, including the promotion of monitoring and support systems.

There is uncertainty about the respective roles of the College of Midwives and groups such as MMPO in promoting quality. The situation is also complicated by the disputed, rather than collaborative, territory between GP and midwife-led maternity services.

Similar uncertainties face the development of more organised physiotherapy services. It is clear from the evidence in the attached report that physiotherapy clinical leadership has successfully promoted an accreditation process. However at this stage there appears to be little support for physiotherapists organising themselves into clinical provider organisations such as GP-led PCOs or MMPOs. From personal communication with ACC such organisations could be seen to be desirable to both improve the quality of physiotherapy services at the same time as leading to lower ACC costs.

10.8 Clinical governance

As discussed above only First Health and the RNZCGP have firmly stated their support for the concept of clinical governance. The College sees clinical governance as including the following:

- extending the work of GPs through continuing medical education and continuous quality improvement
- responding to increasing demands for public accountability from all parts of the health sector, both public and private.
- increasing the quality of service provided to patients eg through improving immunisation rates
- introducing systems for detecting, discussing and learning from significant events
- involving patients in discussions about performance measures.

They see clinical governance as having potential to improve quality of care and reinforce patient confidence in quality. Requirements to further these aims include the need for additional resources to be invested in promoting clinical governance and a national framework as part of the implementation of the primary care strategy.

Wiles (2001), expressing a College view, states,

“While we have some misgivings as to the term clinical governance whether the term clinical governance accurately explains the process, we nonetheless support the concept.”

Whatever the ‘label’ it is clear that clinical type governance processes are well established in PCOs including non-GP led PCOs. Key features of an emerging model of clinical governance of a New Zealand concept of clinical governance within primary care would include the following.
Developing collective professional accountability for the management of clinical activity of members to improve quality and make better use of primary care resources.

Managing new integrating relationships between members, between other primary care professionals and the community and between primary and secondary care.

Implementing a primary care infrastructure including staff appointments, an information system to computerise, merge and manage practice registers, analyse laboratory and pharmaceutical data and provide personalised feedback to members.

Peer group formulation of clinical guidelines and monitoring of performance to promote better quality, evidence-based practice.

Managing corporately an increasing set of primary care resources to achieve better health outcomes for patients and communities.

In contrast to the top-down UK model of clinical governance this process is largely driven from the ‘bottom-up’, or perhaps more appropriately ‘middle-up’. Clinical leadership, as has been constantly reiterated, is the key factor driving these new developments.

10.9 Building a new leadership culture

Given the strong evidence for the significance of clinical leadership from this study there is a need to build a stronger and more pervasive leadership culture. The other parts of the ‘trilogy’, referred to in the introduction, a study of clinical leadership and quality internationally and a parallel study of clinical leadership in DHBs have also demonstrated the critical role of clinical leadership in the promotion and success of quality initiatives. Studies have also demonstrated a major convergence in a number of DHBs towards a partnership between corporate/managerial cultures and clinical cultures, a critical factor in achieving better quality outcomes.

However it is also clear that there is relatively little sharing of the important experience which is emerging. It is also apparent from this and the other studies, that clinical leaders, along with managers, need education and training programmes to support them in their new roles.

The reforms of the 1990's have also left a legacy of 'learning deficits' within health care providers, characterised by fragmentation, competition and reactiveness. Opportunities for shared learning among health professionals, managers and consumers are crucial to the development of 'learning organisations'. Breakthrough improvement in quality and patient safety is unlikely to occur unless there is a systematic approach to organisational learning and culture change.

Therefore, a critical strategy in addressing quality and financial issues is the building of a common health leadership culture throughout the health sector, bringing together the currently divergent perspectives of personal health, primary and secondary, disability, public health, and different disciplines.
CLANZ has considered these developments and issues and sees the establishment of a National Centre for Health Leadership Development as a critical and urgently needed strategy in successful DHB development. The objectives of the Centre might be as follows.

1. To establish a development base for the education and training of health leadership within DHBs, inclusive of all services, both provided and contracted out.

2. To bring together the emerging national experience in health leadership development, both managerial and clinical, to enable the sharing and promotion of this experience.

3. To develop skills and competency in individual health leadership.

4. To develop skills and competency in organisational learning and leadership.

5. To build a national leadership culture integrating leadership functions between managers and clinicians, between primary and secondary care and between different disciplines and agencies.

6. To promote research, development and evaluation of health leadership and organisational learning, including participatory, action research and shared learning within DHBs willing to become open 'learning laboratories'.

The Centre would become a key focus for the development of new and innovative leadership strategies and the building of a culture of collaboration and commitment to achieving shared outcomes in the health sector.

It would promote the integration of services across a wide range of boundaries, primary and secondary, personal, public, disability, etc, and be a key factor in successful development of DHBs. It would enable the exploration of ways to achieving better health outcomes within existing resources.
References


Bibliography of other New Zealand publications and documents relating to clinical quality


Appendix 1

A review and analysis of clinical leadership/governance in addressing issues of quality the New Zealand health system

A project being undertaken by a team funded by the Ministry of Health through the Clinical Leaders Association of New Zealand (CLANZ) 19 April 2001
Contact: Laurence Malcolm laurence.malcolm@cyberxpress.co.nz Ph 03 329 9084

CLANZ, established in 1998, has been contracted by the Ministry of Health to undertake a number of clinical leadership development projects. One of these is a review of the development of clinical leadership and governance within New Zealand and its potential to address quality issues. CLANZ has contracted with a project team led by Laurence Malcolm and including Lyn Wright, Pauline Barnett, Chris Hendry and Michael Powell. The team brings together a wide range of New Zealand qualifications and experience in this field.

The promotion of clinical quality has become a critical international issue. The most immediate concerns in New Zealand arise from the Gisborne Hospital 1999/00 and recent cervical screening inquiries. However there are many wider issues including; preventing adverse events, bringing clinical leaders into new forms of accountability for quality and cost, and addressing clinical quality at governance and ‘system’ levels eg in health service organisations, such as DHBs.

The project will link closely with initiatives are being undertaken by the Ministry of Health, National Health Committee, DHBNZ, Independent Practitioners Association Council (IPAC) and other organisations. It will seek to contribute to a national consensus in building an integrated picture of the ‘quality jigsaw’ and the role that clinical leadership might play in addressing quality within clinical operational settings. We intend that the results be widely shared and discussed in workshops. It is expected that the project will lead to the provision of clinical leadership training programmes.

The project includes three key parts, the first being a literature and document review. This will draw upon both New Zealand and international experience in the development of clinical leadership and clinical governance and its intersection with clinical quality.

Secondly the project will include an analysis of quality programmes within primary care organisations (PCOs) and the role of clinical leadership here. Previous work by members of the team, undertaken for the Ministry of Health in 1999, showed substantial progress towards a developing model of clinical governance. However, further documentation is needed of progress PCOs are showing in quality initiatives. In conjunction with IPAC, and other PCO representatives, some 10 PCOs will be selected for further study. We believe that this project will substantially improve the availability of information and evidence to assist both PCOs and the wider health sector in understanding and hence promoting successful initiatives.

Thirdly the project will seek to document and analyse clinical leadership related to quality developments within DHBs. We appreciate that DHBs are currently under major developmental pressures. In order to minimise work we are initially seeking existing documentation, followed up with questionnaires to key informants from both
management and clinicians. Again we want to work closely in conjunction with the Ministry and DHBNZ. From a DHB perspective we expect that this project will provide valuable assistance to DHBs through sharing of information on experience to date and how clinical quality, in conjunction with clinical leadership, can be more successfully promoted in DHB settings.

We believe this to be a key project in promoting the success of clinical quality initiatives. We welcome further comment on this project and your full support in its implementation.
APPENDIX 2

Primary Care Organisation (PCO) Reports: General Practitioner PCOs

2.1 Comprehensive Health Services
2.2 First Health
2.3 Greater Wellington Health Trust (WIPA)
2.4 Integrated Primary Care Services
2.5 Pegasus Health
2.6 Pinnacle
2.7 ProCare Health Limited
2.8 Rotorua General Practice Group
2.9 Whangarei Health Care
2.1 COMPREHENSIVE HEALTH SERVICES

The following information was provided from discussions with CEO Hugh Kininmonth, documents supplied and from the CHS website (http://www.chs.co.nz)

1. Overview of the formation and development of CHS

Since its formation in 1993 CHS has seen progressive expansion of its membership, its enrolled population and range of activities. It is now a primary care organisation (PCO) of 107 general practitioner (GP) members in 46 practices. It has a registered population of 130,000 patients with 20-30,000 casual patients on its ‘books’. Through its members it provides services to North Harbour communities stretching from Auckland Harbour to Warkworth. Services provided by CHS include GP development and continuing medical education (CME), practice nurse and practice staff development, information technology support, primary referred services analysis and management, integrated care projects and quality initiatives.

It is governed by a board of five including three GPs, a practice nurse and a community representative. It employs a staff of 10(7.2 FTEs). Although seed capital was initially provided by shareholders (since fully re-paid) it is now fully funded by MoH/DHB through a management contract, project funding and budget holding savings.

2. Vision, mission and goals/objectives of CHS

CHS’s vision is:

“To be a pre-eminent provider of quality health and disability services in New Zealand.”

Its mission is:

“To provide high-quality accessible health care for the community we serve.”

In its values statement CHS states that it will:

“...focus on quality, act with integrity, build inclusive strategic relationships based on equality and mutual respect.”

CHS goals are to;

⇒ Improve the health status of the communities served
⇒ Champion clinical and management quality
⇒ Maintain an excellent reputation for delivery of quality solutions
⇒ Build strategic relationships to develop the position of primary care within the health and disability sector
⇒ Optimise operating outcomes without compromising care.

There is a strong emphasis upon quality in these statements.
3. Quality initiatives implemented by CHS

3.1 Organisation of quality initiatives

This is the responsibility of the CHS Clinical Committee made up of the Clinical Projects Manager, a GP Board member, Information Management Coordinator, Practice Nurse Development Co-ordinate/Project Manager and Pharmacy Facilitator that oversees all clinical projects.

3.2 Referred service budget holding as a quality strategy

As with many PCOs, CHS established a pharmaceutical budget holding strategy early on in 1995. From the perspective of CHS this was primarily to promote quality prescribing behaviour and to generate savings to develop new services. A comprehensive range of strategies were implemented including: a broad organisational infrastructure, information systems, peer review groups, prescribing guidelines, personalised feedback to members, facilitator visits, bulletins to members, and incentives to encourage participation and informed decision-making.

An evaluation of this strategy in 1997 showed that significant savings had been made. However, perhaps more importantly, the evaluation found: the development of a sense of collegiality and accountability, greater sensitivity to quality issues, acceptance of the need for evidence based decision-making, exposure to peer review and the building of a sense of identity within a new and broadly based organisational framework.

Facilitating factors have been; contracting and funding support, dedicated clinical leadership, the potential for savings and the increasingly felt need to promote good quality general practice with prescribing seen as a critical area for quality improvement.

However important inhibiting factors have prevented the full potential of pharmaceutical management/budget holding, and other quality strategies. These include; difficulties in determining a budget, a complicated funding formula, poor quality and untimely data, lack of clarity of objectives and organisational changes with moves towards contracting with DHBs and becoming PHOs. These issues have exacerbated a feeling of inequity within CHS compared with budgets from other IPAs - even those within Auckland which have (on average) 20-30% higher budgets per FTE GP member. It appears to CHS that historical behaviour rather than best practice are the drivers of budget setting exercises.

3.3 Other quality initiatives

CHS has also established a wide range of quality initiatives related to the achievement of the above goals. These are set out under the following headings.

Strengthening quality initiatives. These include, additional to referred services budget holding as above:

- GP professional development/continuing medical education (CME); monthly sessions to ensure the maintenance of professional standards and continual quality
improvement. These are open to all interested parties and not exclusively CHS GP members

- **Practice nurse development/continuing nurse education (CNE):** monthly sessions to promote professional development of practice nurses - again open to all interested parties
- **Practice staff development:** practice management courses including practice managers and receptionists
- **Terminal care services:** to improve quality of life and reduce hospitalisation in last three months of life, well supported and appreciated by patients and families
- **Community dietitian service:** to reduce risk of chronic disease, has shown dramatic reduction in BMI and other health status indicators in over 2000 patients seen-now supported by podiatry service for those at-risk of diabetes
- **Quality programmes/member practice support:** to gain the maximum benefit from primary referred services savings for the benefit of CHS communities
- **Podiatry services:** or people at risk of complications due to chronic disease threat are referred to a podiatry service free of charge.

**Managing the needs of the practice population.** These include;

- **Diabetes management:** formalised full primary care diabetes services for diabetic and at-risk patients within CHS practices, and to empower clients, practice nurses and GPs to better manage diabetes within the community; with practice registers, screening, recall, benchmarks and evaluation
- **Respiratory management (still fully developing):** formalised full primary care respiratory-illness services for at-risk patients within CHS practices using early detection, COPD guidelines, specialist referral services, benchmarks and evaluation
- **Information management:** enables analysis of all information requirements for CHS, including full computerisation and electronic claiming, prescribing and medical records
- **Practice registers management:** enables patient/population needs management by CHS practices with electronically recorded details of health risks and diseases, levels of immunisation and screening, etc.

**CHS is seeking to meet the needs of the whole community through;**

**Community needs analysis:** providing an understanding of the health and disability needs of the North Harbour community and services to meet these needs – needs analysis completed.

**Strategic partnerships:** building and maintaining positive relationships between other providers and community groups.

CHS also facilitates special initiatives in the areas of mental health, Maori health, child health, and disability support services with partner organisations and its members.
3.4 Child immunisation

An important quality initiative, driven by CHS leadership in a joint venture between Waitemata Health and IPCS, has been the child immunisation programme. This seeks to achieve an immunisation level in all practices of a minimum of 90%. There is strong emphasis upon cold chain monitoring and information management. All practices report their completed immunisation percentages monthly. Over the period 1998-2000 there was a steady improvement in almost all practices, with some reaching 100%. The aggregate immunisation rate for the CHS practice population of 2-3 year olds is 78%. Support is provided around standardisation of recall systems, electronic recording of the immunisation data and follow up for hard to reach children with transport to surgeries and home visits.

CHS has a close working relationship with Immunisation Advisory Committee (IMAC) having developed three database programmes for the IMAC.

3.5 Maori Health Action Plan

In the area of Maori Health CHS has developed a Maori Health Action Plan in partnership with Te Puna Hauora o te Raki Paewhenua, the Maori provider of primary health care services on the North Shore. In recognition of the Treaty of Waitangi, Maori health gain priorities and the high health needs of Maori, CHS in conjunction with Te Puna Hauora;

⇒ has undertaken an analysis of the needs of the Maori population
⇒ is forming relationships with other Maori providers
⇒ is providing cultural safety CME programmes to CHS GPs
⇒ has appointed a cultural safety team to handle complaints by Maori patients
⇒ has ethnicity recorded in all CHS practices
⇒ is developing services to better meet the needs of Maori patients.

Te Puna doctors are CHS members and joint training sessions take place. Te Puna has contracted CHS to provide training for nurses and many CME/CNE/community groups are held at their premises. Ethnicity records have now been gathered for 70% of CHS patients. These will be used to evaluate patient outcomes by ethnicity in the future.

4. The role of clinical leadership in CHS

Clinical leadership is factored into the development and operation of all activities undertaken by CHS at both the board and operational levels. This is especially evident in efforts to promote quality initiatives in general practices. The practice initiatives for 2001/2 will further enhance primary care clinical leadership in breast check/mammography screening, diabetes screening and immunisations.

The link between CME/CNE professional development sessions, small group meeting topics and pharmaceutical and lab usage information feedback, integration projects with Waitemata DHB and overall Information Management are all based on clinical governance and leadership to maximise the general practice take up of quality initiatives.
5. Achievements of CHS in quality initiatives, facilitating factors and barriers

Main achievements include;

Prescribing behaviours altered dramatically resulting in continued savings on budgets 20-30% below other Auckland IPAs.

Successful implementation of the CHS/Waitemata DHB diabetes programme over the last two years with;

⇒ ‘at-risk’ and diabetes registers and annual diabetes recall dramatically increasing proactive chronic disease management of patients.
⇒ an established population-focused in primary care chronic disease management
⇒ a community-focused partnership between CHS and Te Puna
⇒ primary/secondary care service integration
⇒ improved practice nurse skills.

Independent audit of CHS diabetes patients shows exceptionally good bio-chemistry levels. Initial information technology problems are still present but CHS practices are on track for 90% coverage by June 30, 2002 - well above the national 75% target.

Key facilitating factors have been;

- Close working relationship with Waitemata DHB (CEO is on Community and Public Health Advisory Committee) has resulted in several clinical areas incorporating direct referral to clinics GP review of GP referrals (orthopaedics) and GP contracts to reduce waiting list (Skin lesion removal). Joint discussions on IT system development is taking place to improve referral/discharge and patient update information exchanges.
- CME and CNE sessions, guidelines implementation sessions, incentive payments to practices for good quality registers, national guidelines, and formal /contracts and agreements with MOH re quality (although most quality initiatives have been CHS initiatives), audit and monitoring to access initiative payments, high level of in-practice support for Information management has significant links to performance monitoring, GP desire for highest possible quality of service.

Barriers blocking achievements include:

- poor data and extremely inexact budget setting both as a base in 1997/8 and annually. (Laboratory data is almost non-existent.)
- lack of ability to shift funding from secondary to primary care
- lack of questioning of status quo within hospital based services.

6. Community and consumer participation in CHS

The CHS Board has been restructured to reflect wider representation. A community consultation group was disbanded two years ago due to lack of interest. Two community
planning focus groups and patient satisfaction questionnaires are planned for October/November.

Maori relationships are developing through the important partnership agreement with Te Puna Hauora o Te Raki Paewhenua as discussed above.

7. **Action to promote community health**

A wide range of strategies has been established, including as listed above, eg;

⇒ community needs analysis and strategic relationships
⇒ diabetes and respiratory disease management
⇒ Maori health, mental health, and disability support programmes
⇒ podiatry service and dietitian service to all patients at risk of chronic disease
⇒ immunisation, cervical and mammography screening and recall in all practices with screening rates available from all practices.
⇒ other joint projects include Green Prescriptions (Hillary Commission), smoking cessation (Heart Foundation), sexual and reproductive health services (A+).

8. **Multidisciplinary developments**

All CHS CME (16) and CNE (25) sessions are open to all GPs, nurses, midwives and allied health professionals and interested parties. Other meetings take place on an ad hoc basis to discuss issues needing clarity around such issues as maternity, drug taking and child abuse with such entities as Child Young Persons and Families Services (CYFS), Police, Council of Social Services, and non-governmental organisations.

9. **Education and training**

There is a strong emphasis on training in CHS with over 40 professional development sessions planned each year and other meetings scheduled as opportunities arise. Monthly CHS Bulletin is widely utilised by a multitude of providers (eg Raeburn House social services provider, Council of Social Services, Hospice, local gyms, Waitemata Health, etc.

Each CHS member receives $325+GST per year to subsidise participation in conferences to boost clinical leadership expertise and leadership training.

10. **Clinical governance within the PCO**

A clinical governance process is well established as indicated above. There is a need for less and more streamlined national guidelines. The governance of the organisation incorporates both clinical (GP and Practice Nurse) input and community representation. The Clinical Committee governs all clinical projects.
2.2 FIRST HEALTH

The following report was put together on the basis of discussions with Director of Health Services Management Jonathan Simon and Jim Primrose and documents and comments sent by First Health.

1. Overview/background

First Health had its origins in the PrimeHealth joint venture in the Western Bay of Plenty in 1992. Since then it has expanded to eight primary health care groups (now known as “networks”) from Northland through Auckland, Waikato, Taranaki, Tairawhiti and Hawkes Bay. It works with a total of 300 general practitioners (GPs), 300 practice nurses, 300 practice management staff and serves a population of 510,000 enrolled in capitated patients ranging from urban to rural with a high percentage of deprived populations and Maori (ranging from 4.8 - 56.1%).

First Health is a not-for-profit limited liability company, in turn, is part of the Southern Cross Health Trust. It has its own Board of Directors 50% of which are community-based; the others are nominees of Southern Cross Healthcare. Each of the eight groups has a network governance committee consisting of GPs, practice nurses and management staff. It is planned to extend membership to include community and Maori representatives.

First Health is funded through contracts with the Ministry of Health inclusive of GMS, practice nurse, pharmaceutical and laboratory services. The contract is based upon risk holding, ie that carries the risk of going over budget. GMS payments to its members are entirely on a capitated basis. First Health provides services to its eight networks on performance management with a strong emphasis on information management, general management, including assistance to practices with contract negotiations and administrative support and relationship management including with community groups.

2. Mission, values and goals of First Health

The **mission** of First Health is:

‘Through the provision of management and information services we will create a culture of excellence by enabling general practitioners to focus on their core competency - health care. This is a reflection of our belief that the general practitioner and the primary care team are the best advocates and coordinators of patient care, supported by an integrated network committed to delivering high-quality health care every New Zealander deserves’.

The founding **values** are; quality equity and accountability. There is a strong emphasis upon quality here throughout the organisation.

First Health has a strong commitment to improving community health outcomes including for Maori. It has developed an approach to move towards primary health organisations as set out in the New Zealand Primary Health Care strategy, including population-based funding, health needs analysis, involving Maori and local communities and securing an environment of continuous quality improvement.
3. **Quality initiatives implemented by the First Health**

3.1 **Organisation of quality initiatives and programmes**

First Health improvement projects, including quality, are developed centrally in collaboration with the Clinical Management Committee (CMC) in each network. Each network is a performance-based organisation. Membership is conditional on a commitment to participate and perform and ongoing membership is conditional on continued participation and performance.

Guidelines, standards and practice protocols are formulated by individual networks related to aspects of service and care that have been determined to be of importance to local consumers, community support groups and Maori. Key performance goals and improvement strategies are identified by each CMC in collaboration with the First Health Clinical Directorate. These initiatives enable First Health to gain an understanding of the health status and health needs of the population served, leading to the development of sophisticated disease management strategies, specific to New Zealand, which enhance the delivering high-quality culturally appropriate, cost-effective health services.

The Clinical Director oversees the Clinical Directorate. Key personnel within the Clinical Directorate include the Associate Clinical Director, the Manager Quality and Performance and Manager Maori Health. This core group provides management services to the local CMCs.

Project implementation is supported by locality-based clinical support staff including Network Co-ordinators, Practice Nurse Development Officers, Education Co-ordinators, Nurse Educators and Pharmacists Facilitators.

3.2 **The management of quality**

First Health provides personnel qualified in both a health-related discipline and quality management to lead the implementation of quality plans for each network. The role of the quality management staff is to provide focus, encourage, coach, educate, assist and lead practices to achieve quality objectives. Practices are encouraged to develop their own quality plans consistent with those of the networks.

First Health actively manages and takes responsibility for the quality improvement processes using a range of proven techniques - personnel visits, group workshops, feedback, provider and patient education, analysis and review. As part of the quality improvement processes First Health has designed surveys and reporting systems to monitor progress. There are detailed reports focusing on particular discrete topics for example, disease management and prevention strategies, or physical safety issues. These reports are required to monitor progress and detect any signs in both favourable and unfavourable trends in service delivery.

3.3 **First Health quality and performance programmes**

First Health has developed a wide range of quality and performance programmes implemented through its networks. These are designed to improve health outcomes on
two levels, a practice or network population level and secondly the level of defined population in a specific locality. Performance targets are set for the practice network population level encompassing disease prevention and disease management strategies including individual practice as well as collective network goals.

At the population level a number of other initiatives are in place designed to respond to specific needs in a defined population and the New Zealand Health Strategy. These programmes are summarised below.

**Maori health plan:** includes building on existing relationships between Maori provider groups and First Health GPs, ethnicity coding and actively supporting Maori in enrolled populations eg through the involving Maori health workers in education workshops.

**Breast screening programme:** East Coast, Northland and *Prime*Health promotion through general practices.

**Cardiac disease prevention project and hypertension management project:** identification of at-risk patients to offer non-pharmacological interventions where appropriate.

**Promotion of cervical screening** resulting in consistently high levels of screening rates in the Midland networks where it was first implemented, eg rates ranging from 70-90%.

**Childhood immunisation:** is a priority for First Health practices with rates ranging from 69% in Northland to 98% in Taranaki.

**Consumer and provider satisfaction survey:** contracted through RNZCGP of patient satisfaction with services, with over 76% of practices now having surveyed patients.

**Individual integrated quality annual practice report:** in a standard format setting out practice specific clinical, practice and patient information for comparison with other practices and the network.

**Influenza vaccination programme:** recently implemented for at-risk patients and monitored to assess rates.

**Patient register management:** a standard enrolment form has been developed to ensure required information is captured when patients enrol including NHI levels of over 90% with ethnicity now being coded.

**Practice nurse development programme:** provides a framework for the delivery of population-based services through the practice nurse.

**Standardised information collection:** to enable better comparison between practices and networks, including disease coding and screening.

**Diabetes free annual review:** stresses electronic diabetes registers in all practices with evidence of increasing recognition and better management from this strategy.

**Patient-centred disease management:** is seen to be a key to effective disease management with patient information and education and based upon individualised care pathways, identifying tasks that the patient needs to focus, strategies to assist in dealing with problems with their GP’s assistance. There is a strong emphasis upon self-management, eg diabetes.

**Pharmaceutical and laboratory budget holding:** has been an important quality promotion process. This has been implemented over a number of years in seven of the
eight networks (budget management in the eight) with a stress upon improving quality of treatment while minimising expenditure and reducing waste. GPs receive a quarterly summary of their prescribing patterns compared with their peers in the 12 British National Formulary categories. Quality indicators have been developed using prescribing data and network demographics on drugs for asthma and hypertension management and use of antibacterials.

Activities to promote cost-effective prescribing and use of laboratory services include:

- focus group meetings
- pharmacist facilitators meeting with GP to discuss quality prescribing
- education of GPs on cost-effective prescribing
- promotion of use of best practice guidelines
- discussion of specific case management issues to optimise therapy
- providing written feedback on issues and queries raised.
- newsletters and bulletins
- preferred prescribing guidelines.

Conserved resources/savings from successful budget holding of pharmaceutical and laboratory services is split between national, 30%, individual practice initiatives, 30%, and regional services, 40%. Health action plans have been developed for the use of the national and regional resources to promote immunisation and other programmes. Practice allocations are used to improve practice quality in conjunction with the CMC.

4. The role of clinical leadership

Clinical leadership is seen to be a key factor driving the overall quality strategy including through the CMCs. Although quality has been required by funding contracts clinical leadership has greatly enhanced and expanded upon contractual expectations.

5. Key achievements in quality initiatives

All performance targets have been achieved, every year since inception of the quality/performance target programme. This has resulted in increased up-take of cervical screening services, increased uptake of childhood immunisation and influenza vaccinations, decreased HbA1c in the target population etc.

The key factors include the extensive First Health infrastructure and support services, and good information collection, analysis and reporting.

6. Community and consumer participation

With the development of DHBs and the recent release of the New Zealand Primary Health Care Strategy, First Health plans to extend community participation to the First Health Network Governance Committees.

A range of options for securing community participation are being considered, including nominations through the establishment of a community health forum, through DHB structures or seeking nominations from the public.
In all its networks, First Health has worked to develop relationships with Rununga or Maori Service Providers. The aim is to work together to improve the health services delivered to Maori. First Health understands that Maori are looking for a special relationship with their health professionals – one that fits with their tikanga. So First Health (and PrimeHealth) people make it a priority to grow in their understanding of cultural issues.

A Maori Health Action Plan has been developed by First Health and PrimeHealth with a range of strategies to promote closer relationships and improved health outcomes for Maori.

7. **Strategies to promote community health**

These include (see above) reinforced by practice disease registers and recall systems;

- promotion of immunisation and screening
- disease management programmes, eg diabetes and heart disease
- school-based health services
- strong emphasis upon Maori/Pacific people health
- smoking cessation project in PrimeHealth.

8. **Multidisciplinary developments**

There is a strong emphasis upon multidisciplinary developments within First Health with key roles for practice nurses and pharmacists, reinforced by a wide range of training programmes.

9. **Education and training**

First Health places a strong emphasis upon both GP and practice nurse education. The latter include;

- increase implementation of evidence based and best practice guidelines in targeted areas of disease management by working in collaboration with the pharmacist facilitator in the provision of education sessions
- strengthen the role of the practice nurses within those teams by ensuring all meet an agreed level of competence through support and education
- develop and maintain strategic relationships with other health service providers in mainstream organisations and with a particular emphasis on Maori service providers.

10. **Clinical governance**

First Health has played a key role in promoting the concept of clinical governance in primary care, including through RNZCGP. It sees clinical governance as a strategy pervading the whole organisation from Board level to practice level. Furthermore First Health has gone beyond its contractual responsibilities with the MOH to develop a system of accountability for monitoring and improving clinical performance. First Health is also putting into place mechanisms for the management of serious complaints.
GPs in New Zealand are voluntary members of organisations such as First Health. For this reason, any system of governance must not only meet the needs of First Health, but must be acceptable to participating GPs in order not to alienate its member general practice teams.

A national framework of clinical governance, professionally supported and politically endorsed, would promote the implementation of clinical governance within New Zealand.
2.3 GREATER WELLINGTON HEALTH TRUST (WIPA)

The following report was put together on the basis of discussions with the Chief Executive Officer (CEO) Cathy O'Malley and from the WIPA Annual Report 2001.

1. Overview of WIPA

WIPA is a primary care organisation established in 1995 and has grown to a membership of 136 general practitioners (GPs). It serves a total population of nearly 170,000 people in Wellington City, Porirua and the Kapiti Coast. GP membership has grown by 53% since 1998/99.

WIPA’s organisational structure revolves around the Greater Wellington Health Trust and its Board of Trustees. The Board consists of six GPs, elected by the membership, as well as a practice nurse and a practice manager appointed by the board. Two new community trustees were appointed in October 2000.

Reporting to the Board are management services, through the WIPA management company, and a number of technical committees and operational and development committees. The former are concerned with pharmaceuticals, laboratory services, and injury and workplace management, the latter with such matters as quality, mental health, sexual health, information technology and research, and nursing.

Community liaison is achieved through the Consumer Reference Group with a panel of three consumer advisers nominated by local councils, plus one WIPA appointee who advises on consumer issues and how to involve consumers in its various projects.

WIPA is funded on the basis of contracts with the MOH, budget holding savings and special projects.

2. Goals/objectives and strategies

WIPA has as its mission statement;

“General practice working for excellent, innovative and integrated health care for the people of greater Wellington.”

3. Quality initiatives implemented by WIPA

WIPA has developed an increasing range of programmes that promote clinical quality. The following is an overview of these programmes.

Decision support tools/clinical guidelines. These have been prepared to keep GPs and nurses up to date with the best clinical practice. Some 35 guidelines have been prepared including for the management of asthma, hypertension, otitis media, mental health and sexual health conditions.

Computerised disease registers. These have been promoted by WIPA to improve quality management within general practices. The following is the extent to which these
are being used *always* within practices; use of electronic medical records 85%, electronic prescribing, 92%, electronic laboratory reports, 83%, use of Read codes, 28%. These percentages are continually increasing.

**Diabetes management.** This has been promoted by WIPA over a number of years with diabetic registers in practices with number of expected indicators being recording such as; weight, blood pressure, HBA1c, fasting lipids. Levels achieved include; 1.9% of patients registered as having diabetes with an average HBA1c level of 7.5% in 90% of practices. Three specialist nurses working closely with trained practice nurses provide a diabetes education service.

**Asthma management.** This programme has focused particularly upon the Porirua area in conjunction with the Maori population and Ngati Toa. The project includes asthma nurse training both specialist and practice. WIPA monitors hospital admissions for asthma which are now showing rates below the national average.

**Chronic obstructive pulmonary disease (COPD).** This programme came out of a collaborative project with the HHS involving congestive heart failure and COPD. The programme includes spirometry services, training GPs and practice nurses in the smokescreen programme, developing access to nicotine replacement therapy and employing a respiratory support person for practices.

**Immunisation.** WIPA has worked to and has achieved high levels of immunisation now for a number of years. Immunisation rates at 15 months of age now range between 85-89%. Analysis of data by NZDep 96 and ethnicity is undertaken. WIPA’s coverage appears to be well above the national figures. Immunisation reliability is checked against the RNZCGP immunisation audit standards.

**Cervical cancer.** WIPA has promoted the coverage of cervical screening amongst eligible woman. The overall level of screening coverage has risen to nearly 70% and continues to increase. This has been largely achieved through the work of nursing staff.

**Sexual health service.** This was introduced in 1999/2000 following a prolonged process of negotiation with the HFA and other groups. The underlying feature of this development was that sexual health services should be largely based in general practice, a view that is now generally largely accepted.

Free sexually transmitted infection (STI) services are provided for those under 19 years and for those with financial hardship. It also provides free contraception services for those under 19 and for those aged 19-24 with financial hardship. The service includes both GP and specialist services in a range of settings. A consumer survey, carried out in March 2000, showed a high level of satisfaction with such features as access, reception, waiting times, etc. Those who had experienced both rated the service more highly than the previous service.

GPs and practice nurses are trained and a sexual health manual has been produced. The service undertakes contact tracing, undergraduate and postgraduate education and places a strong emphasis upon best practice in use of laboratory services.
The service is demonstrating:

- the importance of primary and specialist services working together
- effective and inclusive governance arrangements
- a key role for general practice with a strong emphasis upon improving clinical quality, participation of GPs and practice nurses
- large numbers of people willing to attend GP services
- combining sexual health with other health services in one site successfully destigmatising the service.

**Mental health programme.** Over the last three years WIPA has developed a working partnership between primary and secondary care services involving the DHB mental health services and the Wellington Mental Health Consumers Union. This has built a close working relationships with systems and processes to ensure continuity of care in situations most appropriate to consumer needs. The programme addresses financial and other barriers to general practice.

Key features of the programme include; shared governance, formal discharge processes to GP care, individual consumer health care plans, administrative, education and support to general practice, capitation funding for consumer visits to general practice and evaluation.

Important findings from an evaluation were; stable mental health status and general consumer satisfaction, positive GP attitudes to the programme, possible reduction in use of specialist services, patient satisfaction with GP services.

**School health services.** In 2000 this new service was initiated providing free GP and nurse clinics for disadvantaged children in secondary schools in Porirua. Boards of trustees were involved in developing policies ensuring parent consent and access to information. The service is provided to enable easy access for students and staff referral.

**Referred services pharmaceuticals:** For a number of years WIPA have promoted high quality prescribing and management of pharmaceutical expenditure. Targets and results for the programme are shown in Table 1.

<table>
<thead>
<tr>
<th>Targets</th>
<th>Results</th>
</tr>
</thead>
</table>
| To revise existing decision support tools (DSTs) | Six revised:  
  - Asthma  
  - Angina  
  - Acute Bronchitis  
  - Hypertension  
  - Repeat Prescribing  
  - Urinary Tract Infection  
  Further tools to be revised as updated evidence and national guidelines become available. |
<p>| To develop a cardiovascular risk factors audit, based around secondary prevention | Audit identified patients eligible for statins, and provided peer practice information for WIPA members. Results of the audits fed back to members during continuing medical education (CME) sessions. |
| To make a geriatric prescribing audit available for WIPA members | Developed two years ago, this audit continues to be made available, especially to new members. |</p>
<table>
<thead>
<tr>
<th>Targets</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>To continue to monitor the level of statin prescribing</td>
<td>The level of statin prescribing is stable at approximately 1800 items per month. This target is related to the cardiovascular risk factor audit.</td>
</tr>
<tr>
<td>To participate in the national campaign to improve antibiotic prescribing</td>
<td>Participated, distributed materials. Data not comparable with previous year, due to missing HBL NZMC number data.</td>
</tr>
<tr>
<td>To recommend a choice of antibiotic for Urinary Tract Infections</td>
<td>Recommendations on 1st and 2nd line antibiotics made as part of DST review.</td>
</tr>
</tbody>
</table>

WIPA has also promoted quality use of medicines through better COPD prescribing, preparation of a preferred medicines list, pharmacy facilitation visits, provision of drug information, developing national dyspepsia guidelines.

**Referred services laboratory.** Laboratory budget management is part of WIPA’s referred services activities. It manages utilisation through providing material for peer review discussion and disseminating guidelines and bulletins on best practice.

Targets for 2000/01 and performance against them were:

- to monitor overall laboratory expenditure
- to rationalise the level of lipid tests
- to rationalise the level of cervical smear tests
- to reduce the level of urine tests
- to reduce the level of liver function tests
- to produce an electronic lab form with appropriate tests available.

**Table 2  Laboratory expenditure trends Period July 2000 - June 2001**

<table>
<thead>
<tr>
<th>Test</th>
<th>1999/00</th>
<th>2000/01</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
<td>%</td>
</tr>
<tr>
<td>Lipid</td>
<td>20,446</td>
<td>21,507</td>
<td>5%</td>
</tr>
<tr>
<td>Cervical</td>
<td>16,304</td>
<td>14,659</td>
<td>-10%</td>
</tr>
<tr>
<td>Urine</td>
<td>20,330</td>
<td>18,391</td>
<td>-10%</td>
</tr>
<tr>
<td>Liver Function</td>
<td>24,818</td>
<td>24,232</td>
<td>-2%</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>4,534,941</td>
<td>4,600,345</td>
<td>1%</td>
</tr>
</tbody>
</table>

In light of reported laboratory expenditure increases of 11% nationally, WIPA’s laboratory expenditure has remained under control. Decreases in the volume of urine tests continue to be made for the third year in a row. Overall laboratory expenditure reduced by 3%.

**Referred services radiology.** In December 2000, WIPA contracted a pilot scheme to manage community referred radiology services in the Capital and Coast DHB (CCHDHB) district. The pilot provided free or heavily subsidised radiology to CCDHB patients whose referral was consistent with the National Radiology Referral Guidelines. It also sought to reduce unnecessary specialist referrals and provide better information on needs for radiology services.

The project appears to have been a resounding success with approximately 9,150 patients receiving free or heavily subsidised community radiology. There has been substantial
improvement in access, including for Maori, with a decline in specialist referral. The majority of referrals were appropriate, with a high level of abnormality found. The Community Radiology scheme has provided access to about 9,150 patients, some of whom would not have otherwise received radiology services.

4. The role of clinical leadership in WIPA

Clinical leadership at both governance and at operational levels has been a critical factor in the initiation, planning and implementation of the quality programmes referred to above.

5. Community and consumer participation

WIPA has worked to involve consumers in its organisation and activities. As indicated above in 1999/2000 a formal mechanism, the Consumer Reference Group was established with three consumer advisers nominated by local councils. WIPA is also developing strong links with the Porirua community through the Porirua Health Partnership involving local organisations including Maori health providers and secondary schools.

WIPA has also developed a Maori Health Plan based on Treaty of Waitangi principles to promote partnership relationships with Maori health providers. This plan also promotes the idea of mutual mentoring, encouraging Maori communities to share expertise and resources so that both groups can benefit.

6. Promoting community health

This is being achieved through the wide range of programmes listed. Many focus upon achieving specific health outcomes, eg immunisation, screening, sexual health and disease management.

7. Multidisciplinary developments

There is a strong focus upon building multidisciplinary relationships, eg with practice nurses on the Board and promoting practice nurse development as members of the primary care team.

8. Education and training

Training of member GPs and practice nurses is seen to be a key part of quality management. WIPA is accredited by the RNZCGP to provide CME to GPs, which includes peer review meetings. Courses are provided in the wide range of topics and are seen to be a key part of the quality improvement programmes listed above.
9. Clinical governance within the PCO

Many if not most of the programmes being developed and promoted by WIPA could be seen to be typical of a progressive model of clinical governance. There is increasing support for the term clinical governance being applied to this model.
2.4 INTEGRATED PRIMARY CARE SERVICES (IPCS)

1. Overview of IPCS

IPCS provides primary care services for the 174,000 population of West Auckland. It was established in 1995 and brings together 97 general practitioners (GPs) in 34 privately owned general practices ranging from one to six GPs. The combined patient register at May 2001 is 120,000.

A board of directors governs IPCS, which includes four GPs, one nurse and one community representative who is also a health policy academic. Two of the directors are also board members of the Waitemata District Health Board. IPCS is staffed by a general manager, network co-ordinator, business administrator and nurse coordinator 2/10. Accounting and information technology services are outsourced.

2. Goals/mission statement

“To facilitate through teams of committed Health Professionals, the delivery of integrated and comprehensive quality Primary Care to the population of West Auckland in accordance with principles of access, efficiency, effectiveness and consultation.”

3. Quality initiatives implemented by IPCS

3.1.1 Organisational arrangements for quality

The organisational structure of IPCS is as shown in Figure 1.

Figure 1 IPCS – organisational arrangements for quality
3.2 Formal contracts and agreements relating to quality

- **Primary Care Contract 2001 with the MOH**
- **Joint venture with Comprehensive Health Services** (PCO in North Shore) (immunization, diabetes, dietitian, pneumovax and immunization of hard-to-reach children projects).
- **Partnership with Pasifika Fono** – Pacific Island Health gain project, Data communication project (IPCS is financing Pasifika Fono Healthlink connection), Insync project (IPCS is monitoring and working on the quality of Pasifika Fono practice register, analysis of the demographics of the registered population)
- **Partnership with Wai Health and Union Health** – Maory Health gain project, Data communication project (IPCS is financing Wai Health Healthlink connection)
- **WestKids** which is a joint venture of child health providers in West Auckland including two DHBs, Pasifika Fono and Waipareira trust

3.3 Quality committee, terms of reference and membership

Quality is managed by the Clinical Policy Committee which meets monthly and includes 12 members, general manager of IPCS, 8 GPs, one of whom is a director of IPCS, and 3 practice nurses. IPCS facilitates GP Peer Review Groups and a Continuing Nursing education Programme. This programme was established with support for accreditation

3.4 Quality measures and indicators

IPCS quality measures and indicators are based on the following.

- **Population registration** including quality standards for registers
- **Service utilization** including ensuring quality data
- **Data communication** quality data exchange between IPCS and other providers
- **Clinical audit** analysis of variations in immunization, breast screening, cervical smears tests/per target population/per practice/per doctor
- **Disease management**
  - 32 of 34 IPCS practices have disease registers
  - analysis of morbidity in West Auckland
  - linking utilization and expenditure on referred services and pharmaceuticals to disease register is planned for the 3rd quarter of the year 2001.
- **Health outcome measures** (based on the disease register analysis and comparison of it with hospital discharge database)
  - reductions in hospital admission rates – comparison of combined hospital discharge databases
  - reduction of mortality and morbidity rates- by analysis of disease and practice register
  - reduction of the length of stay in the hospital and increases in outside of hospital treatment of chronic illnesses by analyzing combined hospital discharge database
⇒ change of health related behavior of the population - reduction in the level of smoking, healthy eating.

- **Practice support**
  ⇒ distributing information of best practice such as clinical guidelines, preferred medicine lists, plans disease management programmes and care pathways.
  ⇒ participation in the development of clinical priority assessment criteria for first specialist assessment and referral guidelines; use of guidelines by IPCS practitioners

- **Clinical leadership in IPCS**
  ⇒ IPCS leaders (general manager, directors, members committees) widely communicate organizational directions with all stakeholders through group meetings and presentations and seek future opportunities for the organization, taking into account all key stakeholders for the service delivery in the area.
  ⇒ IPCS leaders set, communicate and reinforce values, performance expectations with a focus on patients and learning, innovation, evaluation of the leadership system, including review of the organization’s performance and staff feedback in the evaluation.

4. **Achievements of IPCS in quality initiatives, facilitating factors and barriers**

- **Achievements include;** combined “clean“ practice register created, improvement in immunisation rates, improvement in active practice involvement in screening process, disease register created, all practices are on electronic data exchange system (labs, ACC, radiology, GMS), reduction in referred service utilisation.

- **Facilitating factors include; change** in government primary care strategy, anticipation of capitation, change in IT and health environment, better understanding of IT benefits.

- **Barriers blocking achievements include;** lack of funds and human resources, lack of government support and guidance, lack of information mindset among some IPCS members, general resistance to change.

5. **Community and consumer participation in IPCS**

There is a high level of cooperation and collaboration between West Auckland providers, community organizations, statutory agencies and Waitakere City Council. IPCS has actively worked to develop provider networks for collaboration on health projects. Examples include initiatives such as WestKids, Ranui Health Action Plan.

Strong relationships have been developed with ‘By Maori for Maori’ and ‘By Pacific Island For Pacific Island’ providers to improve the delivery of ‘mainstream’ services to Maori and Pacific peoples through joint venture with Waipareira Trust and Pacifica Fono. Mainstream enhancement is one of the key strategies identified by the HFA/MOH to improve the health status of these communities.
6. **IPCS action to promote community health**

- identifying public concerns with current and future services and addressing these proactively through a public consultation process
- health promotion and health awareness programmes through participation in all national health promotional campaign (smoking cessation, women’s health, flu and pneumonia vaccination, immunization, etc)

7. **Multidisciplinary developments in IPCS**

IPCS was originally an organisation of doctors and for doctors. With the change in the health care environment and future move to capitation the importance of practice nurses was recognised. All projects and discussions are initiated by GPs or practice nurses, developed in detail by steering groups and committees, analysed and approved board of directors, widely consulted with all IPCS members including nurses and implemented under doctors’ and nurses’ guidance.

8. **Education and training within IPCS**

IPCS is accredited with the RNZCGP to provide continuing medical education (CME) for West Auckland. GP attendance is in excess of 80%. CME is provided on the topics of conditions or disease-related education, alternatives to pharmaceutical treatment, appropriate assessment and diagnosis, and communication skills. Regular continuing nurse education sessions and facilitation of practice nurse accreditation are provided.

9. **Clinical governance in IPCS**

IPCS does not as yet have a formal policy but has a strong culture of clinical governance with clinicians being the main representative group on all board committees and groups.
2.5 PEGASUS HEALTH

The following information was provided by Pegasus Health.

1. Overview of the formation and development of Pegasus Health

Pegasus Health (formerly the Pegasus Medical Group) was formed in Christchurch in 1992 and signed a contract with the Southern Regional Health Authority in 1993 (the first Independent Practitioner Association contract in New Zealand). There are over 230 general practitioner (GP) members and more than 200 practice nurses who have signed a Memorandum of Understanding with the organisation in the Christchurch area. The patient register comprises over 290,000 people. Pegasus is a private, not-for-profit charitable company run by a seven-member board of directors, with a nurse-director to be added at the 2001 annual general meeting.

Up until recently Directors have been responsible for portfolio areas. This clinical leadership role has now been passed on to clinical leaders who work in tandem with relevant Senior Managers to provide the clinical input into practice and programme areas. The organisation is managed via the executive chairman and general manager. Senior managers are responsible for both administrative areas (Corporate Services, IT, Decision Support, Communication). In conjunction with their clinical leaders senior managers are also responsible for practice and programmes areas (Clinical Education, Practice Development, Community Care, Integrated Care, Population Health). Since 1999 Pegasus Health has been funded via a global budget contract and employs 70 staff in management, development and practice support roles.

2. Mission statement

The Pegasus mission statement, as set out in the Annual Report 2000:

“Managing change in health care through quality solutions.”

The statement of core purpose is:

“Pegasus Health is a collaborative association of general practitioners which seeks to measurably improve the health status of the people of Christchurch through the provisions of a comprehensive primary health care service integrated with secondary care.”

3. Quality initiatives implemented by Pegasus Health

3.1 Overview

From its formation Pegasus has taken a strong position on quality, and relied on two broad strategies. The first is an evidence-based approach. Its early successes with pharmaceutical and laboratory budget holding incorporated a strong evidence-based focus and the most recent projects, in community care and population health, for example, have used a similar approach. The second strategy has been the participation of
members, working alongside staff, in the development and implementation of projects. This high level of engagement has produced positive peer support and the development of team approaches.

Quality initiatives fall into three broad categories: the enhancement of skills and standards of practice; service and programme development; and infrastructure support.

3.2 Enhancing standards of practice

- **Clinical practice education.** Improving individual skills through clinical practice education enhances standards of practice. Small group meetings are held for both doctors and practice nurses, with a team of doctor and nurse group leaders involved in selecting issues and developing evidence, assisted by a small team of clinical practice facilitators. Nearly all GPs and most nurses now attend clinical practice education sessions. Members receive evidence-based bulletins and feedback on laboratory and prescribing practice. Clinical practice facilitators visit members regularly to assist with prescribing decisions. Practitioners with markedly different practice patterns also receive visits from a respected peer.

Since the introduction of the global budget the topics covered by small group education have expanded to cover wider issues, including Maori health, referral and admission issues, palliative care and other service matters.

- **Pegasus Qualitymark.** Pegasus Qualitymark is a standardised audit tool to assess the clinical, service and facilities standards of practices. Meeting Qualitymark standards is a prerequisite for using Pegasus ‘branding’ material. The programme assists practices to achieve the standards by the provision of a help manual.

- **Continuous Quality Improvement (CQI) Programme.** The CQI programme provides incentive payments for the achievement of performance levels in relation to key areas of quality in three broad areas: clinical care, appropriate systems, and skill development.

  ⇒ **Clinical care.** Performance is rewarded in areas such as immunisation levels and screening recall for achievement of predetermined levels of performance, eg for having 60% of the eligible practice population on a mammography recall register.

  ⇒ **Appropriate systems.** Performance is rewarded for establishing systems, eg procedures that enable the identification of people eligible for community service cards (CSCs) and high user health cards (HUHCs) or disability allowances, and assisting them to apply.

  ⇒ **Skill development.** Participation in specific areas of skill development as diverse as cultural awareness, advanced cardiac life-support and the construction of disease management registers.

The CQI programme encourages performance to appropriate levels and can be applied in different way as priorities change and in response to particular programme needs. The CQI has contributed to higher levels of performance in a number of key
areas such as immunisation, eg 94% coverage of registered two-year-olds, including those declining, 80% flu cover for the eligible population, mammography 69% coverage.

- **Team development and facilitation.** Besides participation in clinical education programmes, the practice team is strengthened through opportunities for further education and professional development. A Nursing Facilitator and Nursing Advisor support practice nurses, access to scholarships and further training. A special course for receptionists has been organised. Teamwork within practices is assisted by the presence of practice facilitators who visit practices to assist with information and the implementation of specific projects.

## 3.3 Service programmes and developments

- **Population health initiatives.** Pegasus has a population health approach to primary care that enhances quality and provides a focus on community health status. This includes the not only implementation of the very successful smoking cessation programme and population programmes (immunisation and screening, for example) for Pegasus patients, but the recognition of a wider responsibility to ensure access to services for those who do not attend.

- **The Pegasus Link Nurse** is working closely with other immunisation providers, for example, to help locate members of the community not yet immunised. A Memorandum of Understanding with Ngai Tahu and research in association with the Canterbury Pacific Trust are enabling Pegasus to plan for more accessible services for ‘hard-to-reach’ groups. The appointment of staff with public health qualifications and experience, including a public health physician, has significantly enhanced the capacity of the population health initiative.

- **Disease management.** Pegasus has taken a population approach to the management of chronic conditions such as diabetes, heart disease, asthma and COPD, with staff appointed in each area to assist practices, support educational initiatives and information system development.

- **Community and extended care.** The global budget has presented Pegasus with the opportunity to increase quality of care through the development of new programmes to provide alternatives to acute hospital admission. In association with the 24 hour surgery Pegasus now has:

  ⇒ a number of observation beds in a community setting
  ⇒ mobile diagnostic and treatment facilities, and
  ⇒ makes resources available for GPs to provide short-term home support.

This project has provided an alternative to hospital admission and ensured continuity of care.

- **Integrated care.** Pegasus was involved early with other providers and community groups in the ElderCare Canterbury Project, which developed a framework for integrated care development in a number of areas, including mental health (Access Canterbury). There are close working relationships with a number of other services, including the appointment of Pegasus doctors to work in the Emergency Department.
and Out-patient Departments of Christchurch Hospital. Integrated care experience improves communication and enhances the skills of those participating.

3.4 Infrastructure support

Pegasus is a large organisation with a global budget to provide primary health care services. If the increasing numbers of projects are to be implemented to high quality standards without placing great additional burden on front-line practitioners and nurses, then significant management and infrastructure support is required. Pegasus now has a staff of 70, over half of whom are directly involved in supporting doctors and nurses in their practice.

Additionally, a significant level of corporate support is required for resource management and information technology. An important infrastructure support for quality is the Decision-Support team that provides information for feedback to practices and practitioners, for monitoring the performance of projects and for planning new ventures.

4. Role of clinical leadership

Clinical leadership has been strong within Pegasus. Director members lead portfolio areas and until recently had a significant ‘hands on’ role in project management. With the emergence of a larger and more complex organisation this is no longer appropriate and a number of part-time ‘clinical leaders’ have been appointed to work alongside and provide support to senior managers.

Clinical leadership by both doctors and nurses is apparent in the small group education programme, with group leaders playing a pivotal role in managing that process and in all project planning. In addition, a relatively high proportion of Pegasus members are engaged in committee activity. In 1999-2000 (the year the global budget was implemented) 44% of all Pegasus members were involved in some way in a committee or working group, an extraordinary level of participation in leadership and planning roles.

5. Quality achievements

Activities listed under 3.2 and 3.3 above inevitably result in increased quality and improved performance. Key performance indicators established under the global budget contract are consistently met.

6. Community/consumer participation

A Community Advisory Board has been established to work directly with the Pegasus Board. In addition, there are a number of special projects which involve community and consumer participation, such as the establishment of a relationship with Ngai Tahu and the Canterbury Pacific Trust, and the activities of various integrated care projects.

7. Promoting community health

The appointments of a Manager of Population Health and a public health physician have significantly improved the capacity of Pegasus to place a community health promotion
framework over a range of clinical and service activities, such as screening and disease management. These appointments have also furthered the development of a Population Health Project.

This is a strategic approach to information that aims to develop an integrated approach to patient, clinical and administrative data. This will permit both Pegasus and practice profiling and will enable Pegasus to address population issues such as access and equity.

8. **Multi-disciplinary developments**

Pegasus has moved to a multi-disciplinary focus in its educational and project development strategies. A nurse director will join the Board in 2001, and the presence of a Director of Nursing, Nursing Liaison Committee and nurses actively involved in project planning ensure a stronger multi-disciplinary focus. Practice facilitators who assist with the implementation of Pegasus global budget projects report in increasing emphasis on teamwork in practices and the extension of practice nurse roles and responsibilities as part of this.

9. **Education and training**

Education and training through the small group processes have been a feature of Pegasus since 1993. Member, practice nurse and staff development through education and study awards provides additional opportunities for development. This is supplemented by specific upskilling as required for the implementation of new projects and participation in integrated care.

10. **Clinical governance**

Clinical governance, i.e. the acceptance of an organisational responsibility for quality by assisting individuals, ensuring appropriate systems and providing and encouraging clinical leadership has been a feature of Pegasus from its inception. The global budget contract has reinforced this approach. In fact, the implementation of the global budget would only be possible in a clinical governance framework where the organisation accepts responsibility for performance that is nevertheless delivered through independent practices.

Performance is achieved through high levels of participation in project planning, through setting up support systems for practices prior to implementation, through monitoring standards and providing feedback. Enhancing clinical practice and primary health care services through organisational efforts is the essence of clinical governance.
2.6 PINNACLE

The following information was provided from discussions with Chief Executive Officer (CEO) Ian Vickers and other staff and members of Pinnacle and from documents provided and the Pinnacle web site (http://www.pinnacle.org.nz).

Overview of the formation and development of Pinnacle

Pinnacle is a primary care organisation (PCO) legally structured as an Incorporated Society with charitable status. Formed in Hamilton in 1996, it is a network of general practices in the Midland region spread from Taranaki through the Waikato and Bay of Plenty to Gisborne, with a central base in Hamilton. It now has 92 practices and 230 general (GPs) as members and serves an enrolled population of some 330 000. Its membership also includes 100 practice nurses.

A quality orientated organisation, Pinnacle is ISO 9002 accredited for internal systems and sponsors a comprehensive quality assurance program and continuing medical education (CME) for members. This programme includes: practice nurse and practice staff, information technology support, primary referred services analysis and management, integrated care projects and quality initiatives.

It is governed by a board of eight representing each of the five district health board (DHB) regions in the network. The Executive Committee makes the decisions on membership and policy matters for the PCO. It employs a staff of 12 (10 FTE) and with a dispersed membership base, and relies heavily on participation from all general practice staff to maintain its committee structure and develop its project base.

Currently Pinnacle is undertaking approximately 40 projects, controlled both through the management structure and its six committees [quality committee (external), focus on quality (internal), clinical development, information technology, Maori advisory, Diabetes]. It is now funded by Ministry of Health/DHB through a management contract, project funding and budget holding savings.

As with other Midland PCOs GMS payment is extensively capitated, now 75 % of practices and increasing. Although members can withdraw from capitation none have done so. Practices remain on fee-for-service for mainly philosophical rather than financial reasons. There is a strong emphasis upon capitation reinforced with financial incentives. Capitation is seen to be a fundamentally important quality initiative as well as being of value in managing the practice business.

Pinnacle Incorporated is an incorporated society with charitable status that members join and which holds no contracts in its own right. Thus it represents a risk-free membership for GPs. All contracts, and hence risk, are held by Pinnacle Group Ltd. a limited liability company established by the original GP shareholders.
2. Vision, mission and goals/objectives

The vision of Pinnacle is;

“Pinnacle will become recognised as the best IPA in the country, because of its achievements in delivering the best possible commercial, professional and quality outcomes for member practices.”

Its core values are; building strength in general practice, assuring continued quality improvement in general practice, creating opportunities through innovation

Its strategic objectives are to; become more self-reliant for revenue, develop holistic support for members’ practices, deploy existing skills into unserved markets, transform data into strategically relevant information, develop partnerships with health care providers and funders.

3. Quality initiatives implemented

3.1 Overview

From its formation Pinnacle clinical leadership has strongly emphasised the importance of quality as a key strategy within the organisation. Pinnacle’s first quality plan was established within 6 months of signing its first contract with the HFA, and within 12 months it had achieved ISO9002 status, the first PCO in New Zealand to achieve this. There were pressures in contracts with Midland RHA and the HFA to focus primarily upon budget holding to reduce their demand-driven expenditure. However Pinnacle has always seen the management of quality as being the main driving factor, including in its budget holding strategies. Pinnacle believes that there is a close link between cost and quality.

Funders have tended to focus more upon aspects of health care that were measurable and placed a lesser value upon qualitative aspects such as the importance of relationship building, eg, between the GP and patients. With the devolution of primary care funding to DHBs concerns are now being expressed by the Waikato DHB regarding demand-driven expenditure with little understanding on part of the DHB about primary care.

Quality has been driven within Pinnacle by the need to ‘do things better’, by professional values and satisfaction, not by any personal gain incentives. The emphasis has been upon better clinical practice promoted by clinical leadership.

3.2 Quality Assurance (QA) Committee

Pinnacle has a comprehensive QA Plan developed by the QA Committee. The committee consists of two Pinnacle directors, another GP, the QA Co-ordinator and the Pharmacist Facilitator.

Pinnacle has a network of volunteer practices that review each new QA plan and provide comments on its value and applicability, prior to it being finalised.
3.3 Quality Assurance Plan Year 5

The QA Committee has each year produced a quality plan, now in its 5th year. The plan sets out nine quality objectives or indicators each of which is scored to give a total of 100 bonus points and provides suggestions and helpful information as to how targets can be achieved. The following table summarises the objectives/indicators in the plan. It also indicates the overall level of achievement in Pinnacle and the range of scores between practices.

Table 1 QA Plan objectives and achievements

<table>
<thead>
<tr>
<th>Objective/indicator</th>
<th>Target</th>
<th>Score of total</th>
<th>Pinnacle average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunisation rate of 2, 5 and 18 years old</td>
<td>80% of 2yr olds and reports on others</td>
<td>12%</td>
<td>85% coverage</td>
</tr>
<tr>
<td>Cervical smear rate of enrolled population of eligible 20-70 year olds</td>
<td>80% of eligible women</td>
<td>9%</td>
<td>80% coverage</td>
</tr>
<tr>
<td>Maintain breast screening register</td>
<td>Maintain system for recording breast screening data</td>
<td>5%</td>
<td>97% established</td>
</tr>
<tr>
<td>Practice health and safety</td>
<td>OSH manual, safety officer, three meetings/year etc</td>
<td>10%</td>
<td>92% met requirements</td>
</tr>
<tr>
<td>Essential emergency and resuscitation equipment is available in each practice</td>
<td>Maintain self-audit of equipment and medicines, etc</td>
<td>5%</td>
<td>95% in place</td>
</tr>
<tr>
<td>Ethnicity coding</td>
<td>Practices to continue coding all patients for ethnicity</td>
<td>10%</td>
<td>97% commenced coding</td>
</tr>
<tr>
<td>Disease coding and use of electronic medical records</td>
<td>Maintain disease register, coding for asthma, diabetes, hypertension, hypercholesterolaemia, cigarette smoking, ischaemic heart disease and heart failure, etc</td>
<td>17%</td>
<td>97% now coding</td>
</tr>
<tr>
<td>Patient satisfaction survey</td>
<td>Completed a patient satisfaction questionnaire and submit a summarised report with action points</td>
<td>7%</td>
<td>100% achievement</td>
</tr>
<tr>
<td>Personnel training</td>
<td>Continuing professional development of GPs, practice manager, reception and nursing staff</td>
<td>25%</td>
<td>85%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

Practices are scored from 1 to 100 on their performance in these nine categories and there is a wide spread of scores. Scores for some indicators can be negative, eg low-level immunisation and cervical screening rates. Overall practice management, including personnel training, appears to be a key underlying factor in poor performance on other scores. Effective business management is a critical factor in good-quality outcomes. Before developing the scoring system practices, in general, were ‘blissfully unaware’ of their quality level and their performance relative to other general practices.

There is no perceived correlation between quality scores and per capita expenditure on referred services or consultation rates. This analysis has not being undertaken in Pinnacle although it was recognised that it could be important to do so.

As a result of the consistent direction of Pinnacle’s quality initiatives over the last five years, Pinnacle has raised the average quality scores achieved by its membership considerably. Pinnacle now has three primary objectives in the further development of its quality initiatives:
- continue to reward high quality practice
• continue to develop the quality plan in a manner which is meaningful to its membership and the funder
• maintain the profile of both Pinnacle and its member practices as quality-focused operations.

In order to progress these three objectives Pinnacle has found it necessary to establish two new evaluation processes for its members:

- **Evaluation of prospective members.** Pinnacle’s Executive Committee now require that all prospective member’s practices be fully evaluated against the quality assurance plan as part of the application process. If the practices do not meet the minimum standard required by the Executive Committee, the applicants will either be denied membership, or offered Transitional Membership.

- **Evaluation of current members quality performance.** Each year the Executive Committee and QA Committee establish a minimum acceptable level of quality ‘achievement’ for the member practices. When the QA plan was first established there was no minimum achievement level, however in 2001 the level has risen to 60%. Those practices not able to achieve the ‘minimum’, are provided with feedback and support from the QA committee and QA nurse. If a practice continually fails to achieve the targets, then it may be expelled from Pinnacle, however this has only happened in the past if the practices demonstrate no desire to develop their quality systems. To date only two members have been asked to leave by the Executive Committee.

These processes have served both to protect the overall quality of Pinnacle and its member practices, as well as improving the consistency of the quality scores of practices.

### 3.4 Quality projects

Apart from its quality assurance plan Pinnacle is undertaking a wide range of quality related projects, including pharmaceutical and laboratory services management- as shown in Table 2. There is a need for continual review of the range of projects being undertaken and prioritising these.

**Table 2 A selection of projects currently being undertaken by Pinnacle**

<table>
<thead>
<tr>
<th>Project / venture</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linkage</td>
<td>A project (now a stand-alone organisation) developed by Pinnacle Health Waikato (HWL) and pathways. Provides intersectoral triage and brokerage services for the community, and support clients as they access the various services. Won 2000 Mental health Award for Innovation.</td>
</tr>
<tr>
<td>Mental Health Shared Care</td>
<td>A multi-stakeholder research project. Up to 100 patients currently managed by HWL adult mental health services are cared for by GPs, nurses and community pharmacists in the community.</td>
</tr>
</tbody>
</table>

1 Transitional Membership is a contracted agreement with the Ministry of Health which enables Pinnacle to work with a practice (usually on its quality systems) to bring it up to a standard that is sufficient to enable Pinnacle membership. This arrangement can last between 12 and 18 months.

2 By assisting rather than penalising the lower scoring practices, Pinnacle is slowly narrowing the distribution of quality scores achieved, rather than just moving the distribution curve.
<table>
<thead>
<tr>
<th>Project / venture</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Advanz** | An organisation established by Pinnacle to develop the following concepts:  
  - Evaluation and improvement of individual practices.  
  - Development and implementation of packages of care.  
  - Active practice-based research. |
| **School-based clinics** | Establish and maintain GP-ran clinics in 5 low-decile sites: 4 schools and Youthzone (Hamilton based community youth centre, supported by the council). |
| **Teledermatology** | Internet based communication and diagnosis processes for dermatology. Specifically developed to assist rural GPs more effectively interface with HWL Specialists. |
| **Taumarunui Community Trust** | Assist the community to establish a community trust for primary care services, and recruit additional GPs to the area. Administration of population-management and quality improvement systems on behalf of the trust. |
| **South Waikato shared services** | A project to enable improved support between practices in this semi-rural area. First phase has been to merge the after-hours services, moving some GPs from 1 in 2 roster to a 1 in 15 roster. |
| **Rural Issues Research** | Active research into Rural GPs perspectives on their circumstance and the way forward. |
| **Nurse Triage** | Series of initiatives - included research and field trials – intended to determine the style and level of triage services that will be of value to general practice. |
| **Qualitative Research** | Ongoing qualitative research. Examples of recent / current projects include:  
  - Different views of quality: research on the perspective of funders (HFA), providers (GPs) and the community.  
  - What the community considers ‘value’ and quality in primary care services. |
| **Diabetes get checked program** | The national diabetes project, however Pinnacle is collecting an extended dataset from its members and has developed IT tools that enable population and individual clients risk assessment and allow targeted information feedback to Practices. |
| **Smoking Cessation** | A series of initiatives intended to improve the focus on smoking cessation throughout the network. Initiatives include, disease coding, education, clinical trials (Zyban), administrating NRT patch coupons/subsidies, developing a Package-of-care for practices and helping practice to establish nurse-lead smoking cessation clinics. |
| **Spirometry** | A series of initiatives designed to improve the use of spirometry throughout the Pinnacle network. Including specialist training of nurses, comparative trial of the diagnostic scope of spirometers in general practice, discounting spirometry purchases, disease coding etc. |
| **JOGS (Justification Of ‘Green Script’ Study)** | Research into the value and impact of the ‘Green Script’ initiative. Research involves 800 patients over 2 years (currently 18 months completed). |
| **Health Check Project** | Research into the value of targeted health checks, specifically considering the perceived value to patients. Working group includes GPs, Nurses and Hamilton City Council of Elders representatives. |
| **Elective Services** | A series of initiatives involving the 5 DHBs that Pinnacle works with. |
| **Locum Service** | Establishing a ‘not-for-profit’ locum service for Pinnacle members |
| **Practice Benchmarking** | Evaluation of the Pinnacle network considering:  
  - Business health  
  - Provider health  
  - Ability to plan and work towards the future.  
  The intention being to establish a base whereby we can demonstrate benefits to our members on all of these. |
| **Project Leadership training** | Business and change management education for a multidisciplinary group, including Pinnacle staff, GPs, Nurses, Practice managers and Directors. Initiated December 99, first programme will be complete in December 2001. |
4. **The role of clinical leadership**

The clinical leadership role is critical in Pinnacle and has been a source of the vision, strategic planning and major innovation.

5. **Main quality achievements of Pinnacle**

The main quality achievements of Pinnacle have been:

- acceptance of a quality assurance plan and building quality systems
- successful implementation of capitation
- building a solid infrastructure of information management, quality systems and practice support and development.

**Facilitating** factors have been:

- stability of focus despite changes in board and staffing
- qualified and competent staff creating a flexible organisation
- trusting relationships between clinical leadership/governance and non-clinical staff.

**Barriers** include the continually changing external environment.

6. **Community and consumer participation**

Pinnacle has explored a range of community participation initiatives, none of which as yet, has been particularly successful. More recently local councils nominated a spokesperson with a health focus. Community representatives have been appointed to each district to liaise with the local community. However these are at the operational rather than the strategic level. The issue is complicated by the wide geographic spread of Pinnacle.

Pinnacle has prepared a Maori Health Plan and has a firm commitment to the Treaty and to work in partnership with Maori. It has a Maori advisory group, which has a formal advisory input to the Board. The group is broadly representative and includes Maori health professionals. Many overtures of support and collaboration have been made to Maori providers but these have only been partly followed up.

7. **Promoting community health**

There is a strong emphasis on community health programmes as listed above in the quality indicators, eg; immunisation, screening, smoking cessation, disease management, etc.

8. **Multidisciplinary developments**

There is a strong emphasis on building multidisciplinary relationships within Pinnacle.
9. **Education and training**

Pinnacle has a major commitment to education and training programmes, eg CME including disease management and change management, CNE and for practice managers includes the coordination of available training programmes. There is a strong emphasis on distance learning programmes and building a library of such programmes. An MBA type course on strategic planning, innovation and project management, etc, has been developed in conjunction with the University of Waikato.

10. **Clinical governance**

Clinical governance processes are well established within Pinnacle although it has not been consciously considered as yet as a policy.

A National Health Leadership Development Centre would be an important initiative to create an environment within which clinical leaders can come together to build a shared culture of quality and understanding and free of political influence.
This report was prepared by Dr Chris Boberg, Director and Chair of The Quality Committee and Mark Wills, Chief Executive, ProCare Health Limited.

1. Background

ProCare Health Limited was formed in 1995. It now has 310 general practitioner (GP) members in 154 practices and serves a population of 525,000. ProCare spreads over three DHBs, Waitemata, Auckland and Counties Manakau. It has a Board of six directors, four of whom are elected by GP members and two of whom are appointed as community representatives and for their business experience. It has a Chief Executive and 10 FTE staff. Its activities include an increasing range of services to members, new primary care services and integrating relationships with secondary care services. Its organisational structure is as follows.

Figure 1 ProCare – organisational structure

![ProCare – organisational structure](image)

Its committee structure is as follows.

Figure 2 ProCare – committee structure

![ProCare – committee structure](image)

- The Quality Committee aims to develop quality programmes in order to improve health outcomes.
The Pharmaceutical Committee formulates pharmaceutical programmes with the objective of improving health outcomes and better managing the budget.

The ProCare Nursing Committee plans and implements Practice Nurse quality programmes and to advise the ProCare Board on Practice Nurse issues. It conducts ProCare Continuing Nursing Education regularly (aligned with GPs where possible)

The ProCare Maori Advisory Committee (ProMA) is designed to assist ProCare in adhering to the principles of the Treaty of Waitangi, advising the ProCare Board on the implementation of health programmes and issues relating to Maori

The Pacific Islands Advisory Committee advises the ProCare Board on implementation of health programmes and issues relating to Pacific people.

2. Vision/Goals/Objectives

2.1 Statement of purpose

“To be New Zealand’s leading independent provider of quality community based healthcare.”

This will be achieved by:

- Providing access to professional services for those who require them.
- Ensuring quality of services
- Integration of healthcare

2.2 Strategies

- Deliver patient-focussed services
- Take advantage of e-commerce/e-health opportunities
- Structure Pro-Care to support commercial and government funded activities
- Broaden the scope of services delivered through primary care
- Build a quality identity for ProCare
- Anticipate and respond to the expectations of funders.

We also wish to:

- Continue to improve the health status of all our patients and achieve quality outcomes.
- Support culturally appropriate solutions within our diverse community and seek to understand and incorporate patient and community needs
- Enhance collaboration with all key stakeholders in support of primary care solutions in delivering affordable quality driven health care
- Support a true quality culture within the organisation including further development of a quality culture within the practice teams.
- Encourage the growth and development of clinical leadership and governance within the membership and support of clinical and project champions and cell leaders.
Build on a successful and positive cell peer environment and culture enabling peer support and appropriate change management.

Continue the development and refinement of the quality framework with dimensions reflecting quality driven activities and timely reports on progress.

Reflect success with quality initiatives through annual quality awards for members and practice teams—both judged and audited.

Plan and develop targeted health promotion programmes supporting the shift toward preventative care as resources allow.

Employ evidence-based best practice guidelines to assist in disease management.

Champion continuity of care.

3. **Quality initiatives implemented by ProCare: Key milestones**

- Establishment of Quality Committee
- Formation of Cell Groups as peer groups for continuing medical education and peer group review
- Development and launch of ProCare Pharmaceutical Prescribing Guidelines.
- Performance Report on Ambulatory Care (ProAC) launched as a means of measuring quality improvements.
- Pharmaceutical and laboratory budget management. Using a quality, evidence-based approach to achieve pharmaceutical and laboratory savings of $16+ million
- Development of auditable practice standards including:
  - Immunisation vaccine cold chain
  - Infection control
  - Occupational Safety and Health
  - Privacy
- Implementation of quality based health programmes including disease management integration pilots
- Establishment of ProCare Nursing Committee
- Patient satisfaction surveys conducted on 30,000 patients to date
- ISO 9001 accreditation achieved by ProCare Health Limited
- Establishment of ProCare Maori Advisory Committee
- Launch of ProCare Pharmacy
- Launch of ProCare linkages mental health services
- Participation in the Royal New Zealand College of General Practitioners Practice Standards trial and follow up evaluation.
- Establishment of ProCare Pacific Island Advisory Committee.

An important quality innovation was the establishment of Annual Quality Awards in 2000 recognising excellence in primary care. The awards were presented at the Quality Awards Ball on 1 September 2001 and are divided into two categories, audited and judged. The six audited awards are in the following categories.

- Quality Points - the highest number of points for a member for the year
- Cell Leaders - highest level of satisfaction rating by cell group members
- Mammography screening - highest percentage practice
- NHI numbers - highest percentage practice
- OSH Audit score - highest practice
- Infection Control Audit - highest level of compliance.

The seven judged awards categories are as follows.

- Leadership contribution to ProCare emphasising clinical leadership
- Leadership contribution to ProCare by a practice nurse
- Quality project implementation for participation in ProCare quality initiatives
- Most innovative clinical project
- Cultural Health - for responsiveness to Auckland's diverse cultural needs
- Information technology - practice with the most improved use of technology
- Pharmacy award - to ProCare pharmacy for integrated care.

3.1 Projects currently in progress

The projects currently underway in ProCare are shown in Table 1 below.

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<tr>
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<th>ProCare projects in progress</th>
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<tbody>
<tr>
<td>1</td>
<td>U22 Sexual &amp; Reproductive health</td>
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<td>2</td>
<td>Congestive Heart Failure</td>
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<td>Smoking Cessation</td>
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<td>Minor surgery</td>
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<td>Terminal care</td>
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<td>Pacific Island Consultation Skills</td>
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<td>Predict – CVD Risk assessment tool</td>
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<td>9</td>
<td>Diabetes get checked</td>
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<td>10</td>
<td>Disease Coding – Health measurement</td>
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<td>11</td>
<td>Acute Demand South Auckland</td>
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<td>Acute Demand Central Auckland</td>
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<td>Acute Demand North West Auckland</td>
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<td>14</td>
<td>Māori Consultation skills</td>
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<td>15</td>
<td>Home Alert – Personal Medical Alarm</td>
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<td>16</td>
<td>Breast Health</td>
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<td>17</td>
<td>Dyspepsia</td>
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<td>18</td>
<td>ACC packages of care</td>
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<td>Hepatitis B</td>
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<td>Waitemata grommet insertion FSA</td>
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<td>21</td>
<td>Guidelines for prescribing</td>
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<td>22</td>
<td>Follow-up prescribing programme</td>
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<td>23</td>
<td>New drug bulletins</td>
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<td>24</td>
<td>Mental health shared care (ITF)</td>
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<td>25</td>
<td>Older persons project (ITF)</td>
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<td>26</td>
<td>Paediatric asthma</td>
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<td>27</td>
<td>Congestive heart failure South Auckland</td>
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<td>28</td>
<td>COPD – South Auckland Health</td>
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<td>29</td>
<td>Depression</td>
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<td>30</td>
<td>Nursing MOU</td>
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</table>

4. Management and governance relevant to quality

- Performance Report on Ambulatory Care (ProAC), a quality measurement tool based on the American HEDIS system has been employed to monitor quality improvements since 1997. ProAC is being re-developed to reflect activity for the next 3-4 years and the development of improved monitoring systems for key performance indicators.
- Cell group activities and programme implementation, monthly since 1996.
- Practice level support with programmes assisting with technology implementation.
- Quality Committee, terms of reference and membership specified in a committee charter. (All committees have a charter).
- Balanced scorecard developed for the management of the organisation.
- Development of clinical guidelines, especially the pharmaceutical prescribing guidelines.
- Participated in RNZCGP practice standards trial.
- Targeting budget holding savings spend at initiatives to assist in patients’ access to services. For example, the U22 sexual and reproductive health programme has achieved a utilisation rate by young Maori of 22%.
- Patient satisfaction surveys: three surveys using the BPPQ (Better patient practice questionnaire) tool in all ProCare practices over three years (1997, 1998, 1999). This is peer reviewed in the cell groups and individual practices.
- Also undertaken two qualitative studies regarding consumer decision making and satisfaction with general practitioner services: 1995 Radford report and the 2000 follow up NFO-CM report.
- Two yearly board review.
- Outlier programme for pharmaceutical prescribing behaviour differing substantially from peers.
- Information systems being used to manage and monitor quality achievements.

5. **Clinical leadership and governance in ProCare**

Clinical leadership and governance are part of the foundation stones of the organisation. All projects and programmes have an identified GP clinical leader as part of the project team.

Clinical leadership and governance is also provided by the clinical management team including Integration Manager Dr Peter Didsbury, Medical Executive Dr John Cameron, the Chair of the Quality Committee Dr Chris Boberg and the Board Chairman Dr Tom Marshall.

The board of ProCare comprises four GPs in addition to two consumer representatives with specific areas of expertise. This ensures a strong clinical governance emphasis in all board decision making. In addition to the reports and recommendations from the ProCare committees, the performance report on Ambulatory Care (ProAC) is regularly updated and reported to the board.

Feedback received at the monthly Cell Group meetings is reported and acted on by the management and Board.

Feedback is also received through the established locality teams of ProCare GP’s in each of the DHB areas.
6. **What has been achieved through quality initiatives**

**Examples of results from quality initiatives:**

- Reduction in hospital admissions
- Improved patient satisfaction with services (especially coordination of services)
- Reduced secondary care costs
- Reduction in costs of health care to government (specific results too detailed to include here)

**Key factors facilitating these achievements**

- Dedicated Quality Committee and a strong commitment to underpin all activities with continuous quality improvement (CQI)
- Supporting cell group leadership and functioning in a CQI manner including quarterly meetings with cell group leaders

**Barriers blocking achievements**

- Insufficient funding for the organisation to fully support CQI and sector Quality Standards implementation.
- Continued rising practice costs and inadequate and falling returns are seriously blocking investment at the practice level in pivotal quality initiatives.
- Lack of due recognition for success with pharmaceutical and laboratory budget holding

7. **Community and consumer participation in ProCare**

- Quality Committee has two consumer representatives
- ProCare Maori Advisory Committee (ProMA),- dedicated advisory group for Maori consumers including representatives from the following:
  - Maori GPs, Ngati Whatua, Tainui, Waipeirera Trust, Kaumatua, ProCare Maori Liaison Officer, ProCare Board of Directors, ProCare management
- Pacific Island Advisory Committee
- Stakeholders involved in our committees include:

  ⇒ Shareholders/members, Practice nurses, University of Auckland, Consumers, Maori, Pacific Islanders, Pharmacists, Royal New Zealand College of General Practitioners, New Zealand Nurses Organisation, Pharmacologist, Epidemiologist, Public Hospitals.

8. **Promoting community health**

This is being achieved through; immunisation with Cold Chain standards and assistance in the practices with the recording and reporting of immunisation statistics

9. **Multidisciplinary developments in ProCare**
Establishment of the ProCare Nurse Committee in 1998. Including a substantial increase in Continuing Nurse Education provided every month. This committee is also engaged in strategic planning toward an integrated primary care team approach to empower practice teams.

Establishment of the dedicated Maori Advisory Committee ProMA.

ProCare Pharmacy was successfully launched during 2001 to support collaboration between the GP’s and pharmacists to improve the integration of services provided by ProCare GPs and pharmacists

10. **Education and training within ProCare**

- Cell leader Development and forum 3 monthly
- Cell Meeting attendance monthly 75-80%
- Clinical Leaders appointed for all projects

Health promotion programmes all have an element of education and training:

- some within cell group meetings eg congestive heart failure, diabetes motivation interviewing
- some in large group CME eg U22 sexual health, privacy
- some in practice teams eg hepatitis B screening training.
### Performance Report on Ambulatory Care - ProAC used to measure the overall achievement of ProCare
- not individual practices

<table>
<thead>
<tr>
<th>Dimension of Quality</th>
<th>Tools - Programmes (1)</th>
<th>Measures (2)</th>
<th>Weighting (multiplier) (3)</th>
<th>Goal (4)</th>
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(1) Specific tool, eg immunisation, guidelines, disease management programme
(2) Measure, eg % completed, % compliance, satisfaction rating
(3) Weighting of the score used to calculate the overall total
(4) Goal expected to be attained
(5) Weighted goal to be attained
(6) Actual level attained
(7) Weighted goal attained - can be compared with expected to assess achievement
2.8 ROTORUA GENERAL PRACTICE GROUP (RGPG)

The following report is based on a report sent by CEO Fiona Haldane and on discussions with directors and staff of RGPG.

1. Overview/background

RGPG was formed in 1991 by a group of Rotorua GPs contracting with the Bay of Plenty Area Health Board for immunisation services. A company structure and constitution, with a board of directors, was required to sign and manage the contract. The company employed New Zealand’s first immunisation co-ordinator. RGPG began a contracting relationship with the Midland RHA as a result of the 1993 Health Reforms.

Members comprise 42 principal, 12 assistant and 10 locum GP members and 52 practice nurse members. There are 19 practices serving 76,590 enrolled population. The Board of Governance consists of six GP members and a Company Secretary, with 2 practice nurses to be appointed in September 2001. The FTE staff employed total 8.25.

2. Goals/objectives of RGPG

The goals and objectives are as follows:

- comprehensive community enrolment
- comprehensive general practice membership
- infrastructure to support both PCO business objectives and improve community health
- provide management services to support general practice
- develop and enhance a quality culture.

3. Quality initiatives implemented by RGPG

3.1 Organisation for quality

A Board of Directors governs RGPG. Under the Board are four committees, Continuing Medical Education Committee, Information Management Steering Committee, Child Health Committee and the Quality Committee.

Quality is a primary focus of RGPG. It is governed by the Quality Committee made up of three GPs, one practice nurse, the Quality Co-ordinator and the General Manager. Complementary governance is by the CME Committee, Peer Review Teams and Pharmacy/Laboratory facilitators. All other focus groups overlay with the Quality Committee. This team has a direct relationship with the Board.

The Quality Committee develops, implements and monitors quality initiatives with the support the Board and management. There is regular audit and feedback to monitor achievements.
3.2 Definition of quality and contracts

RGPG aspires to a CQI model with benchmarking through peer review. Quality plans are reviewed annually and agreed with the funder. Contractual quality requirements are a subset of RGPG’s overall quality objectives. These include:

- quality plan associated with PCO capitation contract (performance related portion of remuneration)
- child health improvement plan
- secondary school clinic contract
- family planning services contract
- diabetes annual review contract.

3.2 Range of quality initiatives

These include the following.

**Development and application of quality indicators**, eg minimum age/sex register standards regarding capitation, immunisation rate, cervical screening rate, mammography rate, flu vaccination rate.

**Guidelines developed** and introduced include asthma and bronchitis in young children, upper respiratory infections, otitis media in young children.

**Budget management for pharmaceutical services**. This is seen as primarily quality driven. RGPG has favoured budget management as opposed to budget holding. It is accepted that financial management is a part of quality but the notion of profiting from budget savings is rejected.

**Clinical risk management** through a co-ordinated approach to clinical quality including: continuous auditing, reporting and feedback eg Quality Plan, CME, CNE, clinical audit, peer review, mentoring.

**Clinical audit** covering the following:
- cervical screening audit (six monthly)
- immunisation audit (monthly and six monthly)
- rheumatic fever prophylaxis (monthly)
- breast feeding information (monthly)
- dental enrolment at 15 month immunisation (monthly)
- diabetes management (monthly and annual)
- flu vaccination rates (annual)
- recording of smoking status (six monthly)
- maintenance of cold chain (six monthly)
- prevalence of asthma (six monthly).

**Disease management including disease registers** through:
- Read coding is adopted as the standard coding system for disease registration and consultation coding.
- a minimum disease set has been developed and implemented (approx. 30 in minimum set).
- training in use of read has been completed.
- an information management strategy is in place to move to full electronic patient record by end of 2002.

Although the infrastructure is in place for a generic approach to disease management, specific disease management is largely determined by contract funding for that purpose.

**Consumer satisfaction surveys.** These are conducted annually by selected practices (rotated).

**Addressing inadequate performance** is achieved through regular audit in a combination of; audit/feedback, guidelines/policies, CME, CNE, peer review, mentoring (clinical) and management support (processes). In most cases monthly performance feedback is enough to change provider behaviour.

**Information systems** being used to manage and monitor quality achievements include:
- patient management software used in every practice.
- minimum clinical information standards are implemented including electronic disease coding, electronic prescribing and laboratory investigation ordering
- minimum standards for reporting and clinical audit templates implemented
- audit and reporting data is collated and evaluated at PCO level.

4. **The role of clinical leadership**

*Clinical leadership has always been a fundamental driver of PCO activities. Most activity has been directed at a sustainable, generic infrastructure that will support all quality initiatives rather than being specific task orientated ie. a systemic approach to quality.*

5. **Achievements of RGPG in quality initiatives**

The strong emphasis upon quality, including its organisation and management, has led to important quality achievements by RPGP.

**The most important achievements** are;
- highest immunisation rates in NZ (consistently 92-93% over a period of years)
- flu vaccination rates significantly higher than regional and national averages
- highest % of diabetes annual reviews in New Zealand (89% of enrolled patients with diabetes)
- significant reduction in antibiotic prescribing for under 6 year olds
- 99.41% NHI allocation enrolled patients
- 81.85% ethnicity recorded enrolled patients
- 60% smoking status recorded enrolled patients over 15 years.

**Factors facilitating these achievements were:**
- systemic approach to quality
- ownership by the participants
- facilitative and supportive rather punitive strategies
- community enrolment (defined population)
- increased provider accountability
- co-ordinated CME/CNE, peer review, audit and feedback.

**Barriers blocking these achievements included;**
- practice management software vendors lag behind RGPG requirements
- software focussed on individuals as opposed to populations as well
- lack of consistency in reporting standards and defining populations between PCOs
- volume funded mentality as opposed to quality
- funders continue to increase targets for same reward
- balance of incentive / effort becoming distorted.

**6. Community and consumer participation**

A major focus this year is how to incorporate community participation in the organisation. The Pegasus Health and WIPA models are currently under review. The current Board has one non-clinical member who is the company secretary (an accountant).

Rotorua is fortunate in that there is one Iwi (Te Arawa). RPGP has worked closely with the Te Arawa health governance group over the last two years and is close to signing a Memorandum of Understanding with them. The Maori Health Committee is made up of members from both organisations and is concerned with operational aspects of Maori Health.

There is also an Iwi Advisor to the Board that involves collaboration at a strategic level.

**7. Promoting community health**

RGPG has always had a population focus as illustrated by the immunisation contract in 1991. A capitation contract in 1996 meant a move to a population focus by that time. Strategies to promote community health are an integral part of the quality plan. Quality is about managing populations.

Standard management and recall plans are developed and implemented in all practices for: immunisations, cervical screening, mammography, rheumatic fever, diabetes annual review and flu vaccination.

As indicated above RPGP has achieved, from a population focus;
- highest immunisation rates in New Zealand (consistently 92-93% over a period of years)
- flu vaccination rates significantly higher than regional and national averages
- highest % of diabetes annual reviews in New Zealand (89% of enrolled patients with diabetes)
- significant reduction in antibiotic prescribing for under 6 year olds.
Regular feedback is the key to achievement of targets. Peer review would appear to be the most powerful motivator. Financial incentives are not a motivating factor, however, and if it is not matched with effort it can become a negative factor.

7. **Multidisciplinary developments**

The Child Health Improvement Plan contract has facilitated co-ordination with other child health providers including:
- Midwives
- Plunket Nurses
- Child Health Trust
- Tipu Ora – Family Start
- KidZnet
- District Nursing (Rheumatic Fever).

Practice Nurses are full members of the organisation with participation in all operational and governance matters.

8. **Education and training**

These are achieved through:

- annual CME and CNE programmes that complement the annual quality plan
- peer review meetings also support quality initiatives
- the provision of on-going training in technology and systems to GPs, practice nurses and practice administrative staff to achieve quality goals
- facilitation of professional development programmes for all practice staff such as Treaty of Waitangi training.

9. **Clinical governance**

Clinical governance is viewed as an increasingly important issue. PCOs require support in acquiring the skills and resources necessary. Conceptually PCOs need to accept that they have responsibility for clinical governance. Experience would suggest that there would be better ownership if clinical governance was provider driven.
2.9 WHANGAREI HEALTHCARE PRIMARY CARE ORGANISATION

The following information was provided by, and from discussions with, the Chief Executive Officer (CEO) Christine Dyson.

1. Overview of the formation and development of Whangarei Healthcare

Whangarei Healthcare IPA (WHIPA) was established in December 1994. There are currently 56 shareholders not all of whom have been contracting with the MOH through WHIPA. Of the 56 members 52 are practising general practitioners (GPs) in 22 practices.

WHIPA shareholders practice in the area from Waipu in the South to Helena Bay in the North, and inland towards Kaikohe – generally the area covered by the Whangarei District Council. The 1996 census records about 66,000 residents for the District. There are sole practitioners in Paparoa, Maungaturoto, Hikurangi and Whangarei who are not in the IPA. All other GPs belong to WHIPA.

The Board includes 5 GP directors and in April 2000 a practice nurse with experience on the executive of the Tai Tokerau Practice Nurses Section of the NZNO, was invited to join the board as a co-opted director. A chairperson to hold office for one year is elected by the directors at the first meeting following the annual general meeting.

Staff include, CEO, Personal Assistant, Project Manager, Diabetes Resource Nurse, Professional Education Facilitator, Elective Services Guidelines Facilitator, Immunisation Co-ordinator, Accounts /Information Technology administrator. This is 6.2 FTEs

2. Mission and goals/objectives of WHIPA

Mission Statement

“To facilitate provision of the most effective and efficient health care for the community serviced by primary healthcare providers.”

Goals and objectives are centred on providing quality service to shareholders and the patient population alike.

3. Quality initiatives implemented by WHIPA

3.1 Organisational structure for quality clinical/project initiatives

The Clinical Committee includes the following: CEO, 4 general practitioners (one of whom is also a director), 2 practice nurses, and the clinical project manager. The Clinical Committee, which was established in the year 2000, adds quality clinical processes and procedures into programmes undertaken by WHIPA and provides a quality plan, advice, and recommendations to the board and management.
Formal contracts and agreements relating to quality

- **Primary Care Contract 2001 with MOH.**

- **Pharmaceutical budget management within the Primary Care Organisation (PCO) contract.** WHIPA has in the past employed as Pharmacist Facilitators, Pharmacists with Masters degrees in Clinical Pharmacology to work with GPs toward the goal of “Minimum prescribing for maximum patient benefit”. A number of prescribing guidelines was developed. WHIPA is currently re-focusing on pharmaceutical management and a programme is currently being developed. It is envisaged that this programme will be rolled out through the peer/cell groups who are positioned well to assimilate information and have maximum input into the process.

- **Immunisation outreach program** - The WHIPA Immunisation program is a collaborative approach with Plunket, Hauora Whanui, Northland Health, and WHIPA. This began as a small pilot project that was completed in October 2000. The program is now fully operational with a few changes from the original pilot to gain increased quality and efficiencies.

- **Diabetes “get checked free”** – WHIPA implemented a diabetes program in late 1999 to better facilitate, co-ordinate and generally improve the management of the disease within general practice. The “get checked free” project linked into the established program.

- **Pneumovax contract** - This is a joint project with Integrated Primary Care Services and Comprehensive Health Services PCOs.

3.2 **Other quality initiatives include:**

- Practice Nurse Development
- General Practice Development (looking at gaining efficiencies in the day to day management of general practice)
- Development of other disease management projects
- Practice staff development
- Information management
- Development of a Maori Health plan
- Regular discussions held between WHIPA and Northland Health regarding the IT issues involved in referral and discharge that will procure mutual patient benefits.

4. **The role of clinical leadership in WHIPA**

WHIPA aims for clinical excellence in all activities. The leaders of the organisation including CEO, the board of directors ensure that all ideas, initiatives and future plans receive input from the appropriate groups within the organisation. In addition communications systems are in place to provide an information rich environment for both GPs and practice nurses

GPs are involved at the early stages of projects and their input canvassed. This provides GPs with the opportunity to create their own design, which in turn promotes a more complete buy-in and commitment to an initiative. WHIPA respects diversity when dealing with practices, and values all input from key stakeholders.
5. Achievements of WHIPA in quality initiatives

Achievements include:
- Clean age sex register
- Improved immunisation rates and implementation of a strategy to reach “hard to reach” children through a collaboration team.
- Development of consistent disease coding across practices
- 99% of WHIPA practices have diabetes registers
- 100% of practices have received individual training sessions by the diabetes resource nurse
- Diabetes clinics set up in 85% of practices
- Diabetes course for practice nurses comprising a 12-hour course. 90% attendance
- Involvement with the elective services project that is to improve the care of patients who may require access to elective secondary services through enhanced primary care.

Facilitating Factors
- Increased focus on primary care from MOH
- Responsiveness, co-operation and input of general practitioners within WHIPA
- Team structure within the IPA
- IT development and acceptance by GPs

Barriers blocking achievements include:
- Lack of funding
- Poor data for pharmaceutical and laboratory services
- Lack of guidance from MOH creating an environment of uncertainty.

6. Community and consumer participation in WHIPA

WHIPA has memoranda of agreement with the following community organisations:
- Well Child Coalition
- Tai Tokerau MAPO
- Plunket
- Northland Health
- Cancer Society
- In addition WHIPA has developed strong relationships within the community over the past 5 years, and is endeavouring to build upon this work.

7. Promoting community health

Health promotional activities include:
- Smoking cessation program
- Nutritional advice to diabetes patients (teaching diabetic patients how to choose the correct food at the supermarket)
- Pneumonia vaccine project with IPCS and CHS
- Providing service for the Hepatitis B screening program that is a public health program.
8. **Multidisciplinary developments in WHIPA**

During the last year WHIPA has given increased focus on other members of the general practice team. This has included CNE programs, the development of a practice nurse forum within the IPA and education courses for receptionists. WHIPA intends to build upon this work over the next 12 months.

9. **Education and training within WHIPA**

WHIPA’s continuing medical education (CME) has played a large role in enhancing individual skills, awareness, behaviour, knowledge and attitudes. In addition good relationships have been promoted between GP and local and national specialists. CME at WHIPA provides a fertile ground for the development of new ideas, and acceptance of change, support and arrangements for accreditation / re-accreditation for GPs, and small group meetings to provide peer support.

CME is the vehicle to assist GPs across the continuum of change within the new health environment by ensuring quality education for members, which will enable GPs to gain new skills, be informed of new trends, and educational requirements.

During the next 12 months WHIPA is planning to research and place increased emphasis on different teaching techniques to provide different learning tools for GPs to use.

10. **Clinical governance within WHIPA**

WHIPA does not have a formal policy in place regarding clinical governance at this time.
APPENDIX 3

Primary Care Organisation(PCO) Reports: Non-General Practitioner PCOs

3.1 HealthCare Aotearoa Health
3.3 Midwifery and Maternity Provider organisation
3.3 The New Zealand Physiotherapy Accreditation Scheme
3.1 HEALTH CARE AOTEAROA

The following report was compiled from documents provided by HCA including Annual Report to July 2001, Strategic Plan 2001-2003, the Report on Primary Care Organisations (PCOs) for the Ministry of Health 1999 and Te Wana Quality Programme and Draft Strategic Plan.

1. Overview of HCA

In 1994 Health Care Aotearoa (HCA) was formed by union, Maori and related health centres as a national network of non-profit primary care providers in what is called the ‘third sector’. HCA members are community managed organisations placing strong emphasis on providing services for low-income populations, and on working bi-culturally. They are referred to as “community managed” because their governance arrangements give primacy to patients and consumers.

HCA members now include about 19 PCOs, i.e. those providing primary medical care and related services, other non-medical services and specialist organisations such as mental health and alcohol and drug services, making a total of 49 provider organisations in the HCA network in 2001.

Third sector primary care organisations have developed in New Zealand for a variety of reasons including:

- a response to financial barriers to access for primary health care services, especially amongst low income populations
- in response to a desire of iwi and consumer groups to exercise more control over their primary health care services.

It is estimated that HCA PCOs serve a population of nearly 100 000 with about 40 FTE GPs.

Features of PCOs in the HCA network are that they:

- serve very disadvantaged populations as measured by the NZDep 96 scores
- have high proportions of Maori and Pacific Islanders
- have a high level of health need leading to prolonged consultations
- are all community owned and driven
- provide services which are subsidised with community funding, eg capital and voluntary labour
- tend to have a low uptake of CSC which adds to their disadvantage in HFA funding both capitated and GMS
- have a high patient/GP ratio, usually over 2000.

Unlike most IPAs, HCA is not funded for management of budgetholding or other contracted services. In recognition of the special needs of the populations served by HCA a grant was given by the Minister of Health in 1998 to provide new services. This funding was tied to the establishment of new centres working to the HCA model, and the establishment of a quality improvement programme for community-based services. Although this grant was important it did not provide for management-type services.
2. Mission of HCA

“To be a highly effective national support and lobbying network of primary health care providers which:

- are owned and controlled by their local communities and are not-for-profit
- care for registered populations of a low income people with high health needs
- use multidisciplinary health teams
- are committed to Te Tiriti o Waitangi
- provide affordable, inaccessible and culturally appropriate services.”

Its vision, values and objectives flow from this mission statement. Of particular relevance to this report is the section in the vision which states:

“That members will exemplify the model of care promoted by HCA ad will have a commitment to clinical excellence.” Also “The majority of members will be working with the Te Wana quality programme, which will be a robust, credible quality programme in primary health care sector, and being used by many others outside HCA membership”.

3. Quality initiatives implemented by HCA

3.1 The Te Wana programme

Kaupapa /Purpose

“To improve the health and wellbeing of all people within Aotearoa through the provision of an effective, comprehensive quality programme for community based services”.

The Te Wana programme was developed as a key part of the HCA quality project adapting the Australian QIC (formerly CHASP) standards for the New Zealand environment. There are two modules the Core Module and the Community and Primary Health Care Service Delivery Module. The Core Module contains a set of standards and indicators which aim;

- to promote quality outcomes for consumers
- to guide staffing, service development and to enable quality improvement, evaluation and accountability.

Their purpose is to develop a consistent, high level of quality across services. They do not aim to impose uniformity, standardisation or a minimum level of quality.

The standards can be used in a number of ways including;

- to facilitate and support the culture of a learning organisation
- to assist in implementing current models of quality into the service culture and operation
- to give a comprehensive and detailed assessment of the operation of a service
as guidelines for service development
as a quality management tool
as evaluative criteria for accreditation
as an educational call for students and staff
as a management tool to plan and evaluate services
as guidelines to best practice.

3.2 An outcome orientation

The standards are consistent with total quality management (TQM) and continuous quality improvement (CQI) in the following areas; teamwork, customer focus, and processes that contribute to outcomes rather than outputs as such.

The model facilitates the development of a learning organisation, emphasising partnerships and collaboration within an organisation, empowerment of workers in decision-making about work, effective communication processes to achieve a common vision and continuous quality improvement.

The standards are written with an outcome orientation. A greater emphasis is placed on the end result than on the structure and processes of the service. This approach promotes innovation, provides flexibility in achieving the standard according to local conditions and increases the applicability of the standards.

3.3 The standards

The standard promotes good practice in;

- consumer and community involvement
- management practice
- planning and evaluation of activities
- staff development, and
- administrative effectiveness.
- service delivery.

Through the indicators outcomes can be measured including the;

- level and extent of consumer satisfaction
- efficiency and effectiveness of service delivery
- comprehensiveness of services
- extent to which they plan for and meet the needs of the community of interest
- accessibility, appropriateness, effectiveness and consumer satisfaction.

The standards were drawn up after extensive consultation with a wide range of stakeholders. There is a particular emphasis that the standards be culturally appropriate with a strong emphasis upon Tiriti o Waitangi principles. The programme is a modular one with the Core Module covering consumer and community participation, consumer rights, clinical care, management and leadership, planning, quality improvement and evaluation, training and development work and its environment.
The only service delivery module which exists at this stage is the Community and Primary Health module (used in conjunction with the Core) which covers all aspects of service delivery, health promotion and records.

3.4 Application

The quality review, which aims to provide the service with a comprehensive and detailed assessment of its operation as a whole, has four stages:

- **Education and internal assessment** which takes about 12 to 18 months.
- **On-site review** by a review team generally spending a full week at the service.
- **Feedback** on the main findings on-site and through a subsequent draft and final report.
- **Follow-up action** to address areas needing improvement.

3.5 Accreditation

Accreditation for New Zealand services at present is with the Quality Improvement Council (QIC) Australia. HCA is promoting the development of an independent accreditation agency for these standards in New Zealand.

3.6 Implementation

From reviewing the results of six pilots in 2000 there has been important progress over the last 12 months in the development of Te Wana. Following consultation, the pilots have led to major changes in the standards. Training workshops have been held and a website developed. Agreements have been reached with QIC.

Thirteen services have been welcomed into the programme and negotiations are being held with a further 40 services interested. Workshops have been held for people around the country interested in becoming reviewers. Discussions are being held to extend Te Wana to community-based mental health services. Discussions have been held to maintain relationships with other quality programmes, including Standards New Zealand.

4. The role of clinical leadership in HCA

In contrast to other PCOs, progress towards quality and related achievements in HCA has been largely community led with a strong focus upon community and consumer participation. Clinicians have had an important role with considerable debate about the appropriate clinical standards for Te Wana, but this has been essentially subservient to a strong, consistent and expanding community leadership and development process.

A process to further develop the clinical component of Te Wana in consultation with HCA clinicians has been developed as a forerunner to the next edition of Te Wana that will come out in 2003.
5. Achievements of HCA in quality initiatives

What has been achieved? At this stage it would not be possible to quantify achievements in terms of outcomes despite the strong outcome orientation of Te Wana. Major progress in the establishment of the quality system in itself has been a key achievement.

Key factors facilitating these achievements have been the special funding from the HFA but perhaps more significantly the enthusiasm and dedication of HCA and its member organisations.

Barriers limiting achievements have been, as for so much of the other work coming under the scope of HCA, the grossly inadequate funding for services for disadvantage populations.
3.2 THE NEW ZEALAND PHYSIOTHERAPY ACCREDITATION SCHEME

This report was prepared by Gay Wood, Accreditation Coordinator, NZPPA.

1. Summary

In 1986 the New Zealand Physiotherapy Association (NZPPA) established an Accreditation Scheme with the aim of improving the quality of physiotherapy services. Physiotherapy leadership promoted the scheme. The scheme has achieved recognition by the primary funder of physiotherapy, the Accident Compensation Corporation (ACC) and has been shown to positively influence the performance of its adherents. It has also been shown that accredited practices are more cost effective than non-accredited practices. Despite large financial deficits physiotherapists have been convinced that a scheme run by the profession is best able to encourage behaviours such as continuous quality improvement and ongoing peer review throughout all practice areas.

However there are questions as to whether accreditation itself promotes good quality. Were the significant cost-effective outcomes achieved due to accreditation itself or were they the consequence of physiotherapists committed to quality independent of accreditation. Once the endorsed provider scheme has been adopted nationally, the success of the scheme from an ACC perspective may raise questions about the future organisation of physiotherapy services and the best ways in which the ongoing accreditation and quality improvement developments can be organised and funded.

2. Background

Physiotherapy services in New Zealand are provided by an estimated 2000 physiotherapists working in publicly funded health institutions. Some 55.2% work in community based clinics which are privately owned but which receive from 65 – 95% of their funding from the ACC. It is likely that between 400 and 450 practices have significant ACC funding. It is apparent that the nature of ACC has resulted in a quite different face for private practices in New Zealand compared to private practices in Australia, Canada or the United Kingdom where private funding is far greater.

On graduation, physiotherapists must be registered with the Physiotherapy Board of New Zealand and must hold a current Annual Practising Certificate, (APC) to practice. The Board administers the Physiotherapy Act (1949) and the accompanying Regulations (1979) but, as the dates indicate, these are out of date in terms of concepts of continuing professional education and in many areas of “good” practice. There is no regulation over physiotherapists setting up in practice, and in the past, only “market forces” have controlled this.

Since its inception in 1973, ACC has funded physiotherapy services on a fee-for-service basis. In the last five years payment has also been possible on an hourly rate. The only requirement needed for a physiotherapist to access ACC funding is to be registered to practice in New Zealand. Inevitably such a system has led to marked over-servicing with consistent and extreme examples of supplier-induced demand.
The ease with which physiotherapists have been able to set up in practice has resulted in an oversupply in many parts of the country but especially in the main centres. This has helped to perpetuate intra-professional competition in pursuit of a greater market share, which encourages even greater over-servicing. The very nature of physiotherapy, especially in the treatment of musculo-skeletal injury makes it difficult to decide when physiotherapy is no longer necessary. For example, the need for treatment for a patient of a sedentary occupation with a knee complaint may require less input than that for an elite sportsman with the same problem.

Physiotherapists receive $19.00 GST inc. per treatment and $47.00 GST inc. when an hourly rate is applied. These rates have been in place since 1989 with no increase over that time. Practices are currently finding it difficult to remain sustainable.

3. The Accreditation Scheme

Physiotherapists in New Zealand are represented by the New Zealand Society of Physiotherapists Inc. (NZSP) which is a voluntary organisation but which currently has 1,900 of the 2,500 registered physiotherapists as members. As well as branches based on geographical location there are a number of “Special Interest Groups” (SIGs) which provide opportunities for the development of interests in clinical specialties. The New Zealand Private Practitioners Association (NZPPA) is classed as an SIG but has a non-clinical interest and sees itself as primarily being about providing support for those in Private Practice and therefore dealing with business issues as they apply to physiotherapy practices.

In 1986 following suggestions about the need for ensuring a ‘quality product’ an accreditation programme, modified from Canadian and Australian programmes, to meet the New Zealand environment was set up and trials were undertaken. In 1991, the NZPPA appointed an Accreditation Coordinator. She reviewed the scheme as it was then and the basic structure still in place today was the result. An Accreditation Council was set up and a group of surveyors who were required to undergo training were appointed.

The Council was made of four members. Two of these were elected by the membership of the NZPPA and both had to be from accredited practices. The Executive of the NZPPA appointed the third and the fourth was a lay member.

Surveyors had to be working in areas which had experience of accreditation, some were working in the then Crown Health Enterprises (CHEs), and were perceived to be “Senior” members of the profession. Twelve were appointed initially and were offered contracts that covered issues such as confidentiality as well as rates of pay and expenses. There are currently 17 surveyors.

In 1992 it was announced that practices could apply to become accredited at no cost for that year alone to establish the scheme. Some 50 practices took up this option from the then estimated 350 practices. The driving force was seen to be to be the competitive edge that accredited practices may be seen to have compared to their non accredited peers. However, advertising of this status was frowned upon and the ethics of the parent NZSP carefully monitored features such as signage and other marketing tools.
3.1 The Standards

International literature has recently defined accreditation as:

“An external system aimed at improving the organisation and delivery of health services.”

Such a system is characterised by:

- explicit and valid standards
- reliable assessment processes and
- complementary mechanisms for improving quality.

Initially, the scheme had nine standards. In 2001, the Scheme is now using the “6th”
edition of the standards, which are available in a self-assessment format on the scheme’s
web site, http://www.physiostandards.co.nz. The current standards are:

a) Management and planning
b) Client care
c) Human and Physical Resources

criteria relating to continuous quality improvement are a theme throughout the standards.
The scheme particularly emphasizes the components of continuous quality improvement
and peer review as markers of general good performance.

3.2 The Scheme’s development:

The costs of the scheme were high with the NZPPA having to subsidise the scheme each
year at amounts varying from $20,000 to $60,000. A review was undertaken to assess the
scheme’s future. It did show up some limitations as a result of the small size and “do-it-
yourself” nature of the scheme. However, it was decided to continue as an autonomous
professional scheme. While physiotherapy practices were hardly queuing up to be
surveyed they were very positive about the fact that they did have a scheme and therefore
an apparent commitment to quality.

The lack of a financial incentive for practices to become accredited prevented the scheme
from achieving a high take up rate with the number of accredited practices moving from
fifty to as low as thirty five. This was the situation in 1998 when the Accreditation
Coordinator moved on and was replaced by the author of this paper. There was a growing
acknowledgment of the place of quality endorsed schemes over the nineties. The
NZCHS was accrediting increasing numbers of health institutions including CHEs/HHSs,
residential homes and private hospitals.

Government appeared to consider that some of the problems it faced in health care
especially with privately run establishments (rest homes and residential homes) could be
monitored if auditing systems were applied. Audit systems to meet regulations were
implemented and legislation that would require quality practice was initiated (the Health
and Disability Sector Standards Bill). Against this background the Accreditation
Coordinator decided that it could no longer be seen that marketing of those who had
achieved accreditation was unethical or in any way detrimental to the individuals or the profession.

Accordingly, a concerted attempt was made to provide funders with information about the physiotherapy accreditation scheme. Copies of the standards were circulated to the relevant hierarchy of ACC. A brochure was developed with information about the scheme and the details of accredited practices. This was circulated every six months to funders. Conferences that ACC sponsored that had anything to do with provision of physiotherapy services were attended and papers given to keep the issue of accreditation at the fore.

This was the first time that ACC had information on who was accredited. It became evident that ACC did look at the statistics that they collect about physiotherapy services and began to compare the performance of accredited practices versus non accredited practices from their perspective. Information about the differences was disseminated by ACC personnel to the profession and an increased awareness of the possibility of some sort of additional support for accredited practices was established.

At the same time, the number of practices submitting for survey, while up on previous years was still leaving the Scheme at a financial disadvantage. For this reason, in 2000 the Accreditation Council decided to restructure the scheme. In September 2000, the restructuring was complete with the setting up of a web site for members to access all necessary information and a face–to–face education session for each member practice in their preparation for survey.

In October, 2000, ACC released the results of a small study of physiotherapy provided for soft tissue injuries of the ankle. They had taken a sample of nineteen accredited practices and nineteen non-acc approved practices and looked at costs and treatment frequency for soft tissue injuries of the ankle in each case. Both groups were randomly selected (there were 54 accredited practices at that stage) and assessed on the basis of whether they received funding on a fee-for-service basis or on the hourly rate. Some 873 treatments were therefore included in the study.

The study showed that the percentage difference in both treatment numbers and costs were significantly less in the accredited group. ACC admitted that there were major flaws in the study but also pointed out that final treatment numbers and therefore costs are their greatest concern. They saw no need to take into account patient characteristics, provider characteristics and other factors when, in their view, it is obvious that the accredited group made substantial savings for them. The summary of their findings is seen in Table 1.

The publication of this information occurred at the same time as the restructuring of the scheme had begun and as ACC promoted the value they saw in accreditation. This resulted in a rapid increase in the numbers involved in the scheme. By December, 2000, there were 160 practices that had membership including the 54 accredited practices. At the end of the financial year (May 31, 2001) the scheme boasted 186 members and had a turnover of $96,000 for the previous year with a shortfall of only $1,700.
Table 1 – Percentage differences in treatment numbers and costs.

<table>
<thead>
<tr>
<th></th>
<th>Class 81*</th>
<th>Class 43**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accredited</td>
<td>Non-accredited</td>
</tr>
<tr>
<td>Average number Consults/Provider</td>
<td>4.36</td>
<td>7.05</td>
</tr>
<tr>
<td>Average Number consults/Injury</td>
<td>5.64</td>
<td>7.44</td>
</tr>
<tr>
<td>Average Cost/Provider</td>
<td>$85.45</td>
<td>$134.18</td>
</tr>
<tr>
<td>Average Cost of Treatment/Claim</td>
<td>$107.44</td>
<td>$145.61</td>
</tr>
</tbody>
</table>

* Class 81 – paid on a fee-for-service
** Class 43 – paid on an hourly rate.

At the same time as ACC was publishing the results of its study it was implementing a trial of “Endorsed providers.” To gain further evidence of the behaviours of accredited clinics and whether those behaviours would be sustained under different conditions ACC decided to trial specified accredited practices in three cities. While the Minister for ACC has not signed off the final results of this study it is known that:

- the positive features of accredited physiotherapy practices demonstrated in the ankle study were sustained
- other physiotherapy practices in the areas studied showed “improved” figures for treatment numbers and costs, although still not as “good” as the accredited practices.

4. The Current Situation:

There are currently 54 accredited practices and these are part of a total membership of 196 practices within the scheme. By the end of this year, following the year’s surveys, there is potential for the number of accredited practices to reach 83. The Endorsed Provider trial has continued in Rotorua and Wanganui (one practice in each city) and has recently been extended to Christchurch and Invercargill (11 and two practices respectively) with apparently good continuing results.

The profession continues to be divided about the value of accreditation. There are small “pockets” of considerable dissent. The most frequent arguments made against accreditation are the cost for small businesses (many are single operators), questioning of the relationship of accreditation and good clinical performance, and a professed commitment to being interested in only “treating patients.”

The characteristics of those becoming involved in the scheme has also changed from the highly compliant and professionally sophisticated practices of the early members. They tended to be the innovators and initiators of change within the profession. The scheme is
now having to deal with those who have far less understanding of the merits of accreditation schemes and who have little history of quality review systems.
3.3 MIDWIFERY AND MATERNITY PROVIDER ORGANISATION (MMPO)

Discussions with Paul Dadson, Manager and Norma Campbell, Midwifery Advisor provided most of the information for this report.

1. Overview of the formation and development of the MMPO

Midwifery and Maternity Provider Organisation Ltd is a legal entity established in 1997 to negotiate and administer contracts for midwifery services with the Health Funding Authority (HFA). Following restructuring of maternity services in the early/mid 1990s there was a move towards provider contracts budget holding for aspects of the cost of providing maternity services, augmenting income received from the national Maternity Benefit Schedule (S51).

The New Zealand College of Midwives (NZCOM) needed a strategy and structure to allow midwives to negotiate midwifery service contracts with the Health Funding Authorities. The MMPO was established in the Southern region (South Island excluding Nelson/Marlborough) and a contract was signed with the RHA in May 1998 to provide midwifery services throughout the region.

The MMPO, while an independent body from the NZCOM, was set up by it and continues to work closely with it. Membership of the MMPO is contingent upon membership of the NZCOM.

1.1 The goals/objectives of the MMPO are:

- To provide midwifery practitioners the choice of belonging to a maternity provider organisation that operates within a midwifery model.
- To ensure midwives, women and consumers determine that which makes a quality midwifery service.
- To have a structure that safeguards midwives against potential Commerce Commission actions.
- To ensure the professional role of the NZCOM is maintained and it can continue to position, develop, and service the profession of midwifery.
- To support the development of midwifery services.

At present the MMPO operates mainly in the South Island with membership currently restricted to self-employed midwives with NZCOM membership. Twenty per cent of all births in New Zealand occur in the South Island. The contractual restrictions on where the MMPO could operate were removed in 2000 which means that it is now accepting midwife members from anywhere in New Zealand.

1.2 The structure of the MMPO

The MMPO has a Board of Management of seven, representing midwives, consumers and NZCOM. There are currently three places on the Board for midwives nominated and elected by the membership, two places for consumer representatives elected by the current consumer representatives of NZCOM, one place for a NZCOM representative
and one place for a Maori representative. The Organisation currently has two paid employees, a manager and a data entry operator.

The **benefits** received by midwife members and women whose midwives are members of the MMPO:

- Commitment to negotiating contracts which will enable midwives to provide quality services to all their clients including women with special needs which may occur because of a women’s cultural, socio-economic or geographical situation.
- The organisation works in accordance with and recognises the need for midwifery practice to reflect partnership with women.
- Provision of a voice and advocate for midwifery service providers.
- Streamlining systems for claiming and data collection enabling the monitoring of services provided by midwife members.
- Management of a mechanism for contributing to a midwifery database as well as a comprehensive national perinatal database.
- A reduction in the time spent on administrative activities and negotiation of contracts by individual midwives by implementing and managing an integrated approach to service provision.
- A quality assurance program developed by MMPO members in partnership with NZCOM, based on the Standards Review processes NZCOM has developed.
- The establishment of mechanisms for a business interface with GPs, obstetricians, hospitals and any other health professionals involved in maternity and well child care.
- Facilitation of a complaints procedure which complies with the requirements of the Code of Rights.
- An opportunity for midwives to have input into the use of resources.

The MMPO is funded and paid according to the same rules as S51 with budget holding for:

- First trimester
- Ultrasound scans

### 3. Quality initiatives implemented by the MMPO

While the Organisation is managed by a non-clinician, clinical governance is enabled both through the make up of the Board membership and the strategic partnership with the NZCOM. Section 88 of the Maternity Benefit Schedule also has very clear quality requirements which all practitioners are expected to adhere to. The Organisation has developed mechanisms to assist midwives meet these.

**Specific quality initiatives currently in place:**

- **Standards Review Process.** This process was established by the NZCOM over 10 years ago and is now an accepted review process for all midwives providing continuity of midwifery care (role of lead maternity carer (LMC) or shared care with a doctor LMC). This process requires the midwife to:
  ⇒ review all ‘cases/women’ she has provided care for over the previous 12 months using a specific format focusing on both process and outcomes of care, eg intervention rates, adverse events etc.
⇒ review practice against the midwifery ‘Standards for Practice’
⇒ send evaluations to women cared for, these are then sent directly to the review committee and incorporated in the review
⇒ write a report on the review, including actual and projected professional development activities
⇒ meet individually with the Review Committee to discuss the report, consumer feedback and planning for future practice and professional development.

The review committee includes consumers and peers who have had an opportunity to review the practitioner’s report and evaluations prior to the review meeting. The practitioner appears for a 1-2 hour meeting with the Committee. Committees operate in all the 14 NZCOM regions and each MMPO member is expected to undertake an annual review regardless of the caseload.

- **Complaints Resolutions Committee.** Committees have been set up by the NZCOM in consultation and with support from the Health and Disability Commissioner (HDC), in all college regions. They are made up of a practitioner and a consumer. The result has been a reduction in complaints to the HDC.

- **Midwifery database.** This been developed by the MMPO based on requirements of Section 88 and the needs of a National Perinatal database. Data is collected from each midwife for every ‘case/woman’ and electronically entered. The system can identify outcomes by variables for analysis and review and is being used as a base for a National Perinatal database.

- **Information resource centre.** This is centred in Christchurch where the MMPO is located. It houses data and resources on maternity and midwifery issues, videos, books, electronic data searches etc. It is available to consumers, students and midwife members.

- **Midwifery Mentorship.** Specific midwives have been identified as mentors for midwives who are starting out in practice, returning to the workforce or require mentorship (this has to be identified by the practitioner themselves). The mentor develops a relationship with the practitioner as appropriate/necessary. Neither the MMPO nor the NZCOM mediates this.

- **Midwives Medicines Information Bulletin.** This is prepared in conjunction with the Preferred Medicines Centre in Wellington. Midwives prescribing activities are reviewed and disseminated to practitioners.

4. **The role of clinical leadership in the MMPO**

Midwifery members of the NZCOM were instrumental in the development and ongoing direction of the MMPO through the Board. The Midwifery Director of the NZCOM and the Midwifery Advisor actively participate in the functioning of the organisation through the Board and as requested by the Manager.

Members who have been identified as struggling with their role(s) or have experienced an adverse review of practice, seek and are given support facilitated through the Midwifery
Advisor, usually in the form of a mentor. The regional development of the NZCOM enables the practitioner to seek local support.

5. **This achievements of the MMPO in quality initiatives**

Outcomes of MMPO members appear to be superior to the national average for:

- normal birth outcomes
- lower intervention including induction, operative delivery
- home birth
- breast feeding rates
- home birth.

Key factors facilitating these achievements appear to be:

- the lower rate of shared care with medical practitioners among these midwives
- women/consumers committed to normal birth outcomes
- review processes enable midwives to consciously think before intervening
- women also taking an active part in care planning.

6. **Community and consumer participation in the MMPO**

Consumers are actively involved in both Board and practice monitoring and review processes. The MMPO has been actively sought for advice by community groups wanting to maintain their midwifery services.

Maori are represented at both practitioner and Board level.

7. **Promoting community health**

The MMPO is actively involved in promoting community health through:

- development of maternity services in rural and remote areas,
- supporting breast feeding initiatives including BFHI initiative
- smoking cessation activities
- pregnancy and parenting education
- education in schools and among community groups around childbearing.
- working in liaison with GP practices, Plunket and other community health providers to ensure access to health services for women and children
- follow up action to promote achievement of targets, including working with the MOH on data base development, recruitment of midwives into rural localities.
- evaluated/measured achievements in promoting community health through review of data base and increase in women opting for Midwifery LMC with MMPO members.
8. **Multidisciplinary developments in the MMPO**

The organisation is primarily aimed at supporting women and midwives, both of whom are involved in the organisation.

9. **Education and training within the MMPO**

Education and training programmes: available both regionally and nationally. Midwifery advisor and members of the Complaints and Review Committees visit regions to inform of activities and procedures. The standards review process is also educative. Regular practice updates available.