Annex 6

Meeting the Challenge:

Report Recommendations

Contents

Report Recommendations

1 CLOSER TO HOME: NEW MODELS OF CARE

The MRG recommends that the Government:

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

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

(c) Reduce the management fees paid to PHOs with an enrolled population of less than 40,000 and use the resulting savings to help these PHOs to transition to a stronger management configuration (e.g. via amalgamation, confederation, or some other arrangement for sharing managerial support - see Annex 4 recommendations for more detail),

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

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

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

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

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

2 IMPROVING PATIENT SAFETY AND QUALITY OF CARE

(a) The quality programmes initiated by QIC are used as a foundation to develop the next phase of national quality and safety programmes that address patient safety and continuous quality improvement. Existing initiatives should become business as usual for DHBs, who should assume the funding for them as the existing QIC budget is worked through,

(b) The current PHO Performance Programme should be scaled back for a period and the resulting savings used to help accelerate the introduction of quality improvement for primary care using the Q14GP as a starting point, and

(c) An independent national quality agency is established to replace QIC and with responsibility for helping providers across the whole sector improve patient safety and service quality, with the following roles and characteristics:

(i) The agency is independent of the regulatory, funding and performance monitoring agencies of government, reporting directly to the Minister and with its own staff,

(ii) The agency's role should be to: develop a menu of 'certified' programmes for providers to choose from; develop safety and quality standards and guidelines; benchmark and gather comparative data on what works and why; run workshops aimed at helping clinicians and managers to make improvements; and publish national reports of quality indicators e.g. serious and sentinel events,

(iii) The agency should act to ensure sector buy-in to its programmes, recognising that programmes will not be sustained if they are mandated and forced on the sector,

(iv) Agency funding should be a mixture of top sliced PBFF (recognising the proportion of the agency's time devoted to DHBs), and charging private providers who want to use it for managing the implementation of agency-certified programmes, and

(v) At some point, this agency should become more independent of government and be funded by a mixture of fee-based quality programmes and financial subscriptions from public and private member organisations.

3 IDENTIFYING THE SERVICES PEOPLE NEED: FUNDING NEW SERVICES

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

(a) A reconfigured and strengthened NHC with the role of evaluating all new – and an ongoing selection of existing – health and disability services. This role to include:

(i) Assessing the extent to which new health and disability services are clinically safe and should attract public funding based on their effectiveness and cost,

(ii) Determining the conditions under which new publicly funded services should be made available, including the eligible patient group, restrictions on the provider (e.g. tertiary hospitals only) and/or the situations in which the new service should be used (e.g. trial only),

(iii) Selectively reviewing funding for existing interventions to identify which should no longer qualify for public funding based on their effectiveness and cost, and

(b) That when it is possible for Pharmac to assume responsibility for a nominal budget for medical devices from DHBs, then Pharmac should assume the same responsibilities and apply the same processes to these devices as it currently does for hospital pharmaceuticals,

(c) A new national procurement agency recommended in Section 12 below 'Shifting resources to the front-line' should establish a process for gradually assuming responsibility from DHBs for the collective procurement of, and managing the supply chain for, medical devices used in public hospitals that are not managed by Pharmac, and

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

4 THE RIGHT SERVICE IN THE RIGHT PLACE: CHANGING SERVICE CONFIGURATION

The MRG recommends that:

(a) The Minister establish a positive list of national services that will be planned and funded by the NHB and financed by top slicing the PBFF currently allocated to DHBs for that purpose. The NHB would then contract with a selection of DHBs to deliver these national services for the entire country,

(b) The NHB establish a transparent process for advising the Minister about which services currently planned, funded, and provided at the national, regional, and local levels should be organised at a different level in future,

(c) DHBs be required to produce RSPs across a wide range of services. The initial plans should focus on planning and funding for vulnerable services as well as those whose longer-term clinical and financial viability clearly depends on servicing a larger, regional population,

(d) DHBs be asked to delegate authority to their Chairs and CEOs to make decisions on their behalf at the regional level and who will become the regional service's governance body accountable for the development and implementation of the RSP,

(e) In those rare cases when DHBs cannot agree on the RSP, these disputes be escalated to the NHB for resolution and that it identifies the most clinically and financially viable option that delivers a quality service,

(f) The NHB contract on behalf of the Minister with DHBs for regional and local service and planning, and delivery, and monitor DHB performance, thus taking this function out of the Ministry,

(g) That over the next 12 months the Ministry be asked to work through the various policy and machinery of government issues associated with devolving all of the $2.5 billion of NDE currently managed by the Ministry to either the NHB (national level) or DHBs (regional and local level) and advise the Government accorgingly (Annex 4), and

(h) That the Ministry of Health's role focuses increasingly on providing policy advice, administration of regulations, monitoring the NHB, and servicing the Minister's office.

5 THE RIGHT CAPACITY FOR THE FUTURE: MAKING BETTER INVESTMENTS

The MRG recommends that:

(a) The roles and functions ascribed to the NHB in this report would be transferred to the CHFA, who would operate as the NHB. The Minister will need to reconsider the current membership of the CHFA Board in order to ensure that it is best placed to manage its new roles and functions. As part of the transition arrangements, a temporary establishment board might be appointed to manage the transition, and

(b) The proposed NHB is made responsible for capacity planning and funding, including workforce, capital, and IT. Detailed recommendations for addressing the capacity planning issues discussed in this section are found in Annex 3.

6 SHIFTING RESOURCES TO THE FRONT-LINE

The MRG recommends:

(a) The creation of a Pharmac-like national shared service agency with a mandate to manage the assessment, standardisation, management, purchasing, and/or supply chain management of any of the common back office functions of DHBs that are referred to it by the Minister of Health (Annex 4), and

(b) The NHB be required to:

(i) Establish a process for working through the entire range of common DHB back office services to identify a list of services that are best supplied by a single national provider, starting with non-pharmaceutical hospital procurement (Annex 4), and

(ii) Depending on how long it will take to establish the proposed national shared service agency, manage the existing three shared service functions that we propose be shifted out of the Ministry and into the national agency (i.e. Healthpac, Audit and Compliance, Health System Reporting Information).

7 GETTING MORE FROM OUR PUBLIC HOSPITALS: IMPROVING HOSPITAL PRODUCTIVITY

The MRG recommends that:

(a) DHBs be required to identify the top three or four productivity measures each year that are most important to them and report progress against the improvement targets they have set for themselves, and

(b) The NHB should ensure that:

(i) Productivity measures should be developed for use at system and hospital level. These should be developed by a credible, expert, and independent source, and

(ii) Clinical productivity measures should be developed at the appropriate level, with strong clinical input.

8 FURTHER WORK

The MRG recommends that the Ministry report on 14.1 and 14.3 and within its first year of operation the NHB:

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

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

9 CONCLUSION

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

(a) Seeks an assessment of the extent to which the public health and disability sector is likely to be able to continue lifting performance without requiring an ever larger share of GDP, and

(b) Identifies the changes in the New Zealand Public Health and Disability Act 2000, or replacement legislation, required to simultaneously secure the sustainability and lift the performance of the public health and disability system so it is ready to introduce these changes if a change in the legislative framework is deemed necessary following the assessment in (a) above.

Annex 2 Recommendations

1 ENHANCING CLINICAL LEADERSHIP

The MRG recommends that:

(a) The NHB should develop a cultural change programme aimed at enhancing:

(i) Recognition of and support for health care leaders, including via an annual leadership award programme celebrating and showcasing outstanding health care leaders from all parts of the sector, and

(ii) The ability of clinicians and managers to form productive partnerships, both within the hospital sector and across sectors.

The MRG recommends that:

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

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

The MRG recommends that:

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

The MRG recommends that:

(a) The Minister should seek advice on how best to encourage universities to:

(i) Further embed and develop the academic status of the discipline of clinical leadership, supporting research in multi-disciplinary models and further formalising academic achievement in this area, including via the establishment of relevant Chairs, and

(ii) Ensure undergraduate courses in all health disciplines to include formal attention to leadership development appropriate to each year of the curriculum, both in theory and in practice.

The MRG recommends that:

(a) DHBs should ensure that new appointments to clinical leadership positions receive a personalised assessment of leadership development needs, together with support and training to anticipate and understand environmental factors and their consequences and the opportunity for multi-disciplinary leadership skills development and mentoring,

(b) DHBs should ensure that a package of resources focusing on leadership skills and qualities is available to support clinicians in leadership positions as part of professional development programmes, to ensure leaders have the tools to work across contemporary boundaries to collaborate to achieve the best outcomes,

(c) DHBs should consider including a formal requirement for three to six months within a suitable mentoring partnership for all new appointments to leadership positions and all promotions. The mentoring partnership should be defined by formalised expectations of both partners and specified outcomes, and education and training made available to those new to offering mentoring support to new leaders, and

(d) DHBs should ensure that potential future leaders showing early promise are offered opportunities to develop their skills and competencies through involvement in performance improvement initiatives.

2 INITIATIVES TO INCREASE ELECTIVE SERVICES AND REDUCE PATIENT WAITING TIMES, IMPROVE ACCESS TO TIMELY PRIMARY AND HOSPITAL SERVICES AND IMPROVE PRODUCTIVITY AND QUALITY OF SERVICES FOR PATIENTS

The MRG recommends that:

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

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

The MRG recommends that:

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

The MRG recommends that:

(a) A national campaign (led from the highest level) be undertaken by the Ministry to explain and promote agreed national prioritisation tools.

The MRG recommends that:

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

The MRG recommends that:

(a) The NHB should ensure that:

(i) Productivity measures should be developed for use at system and hospital level. These should be developed by a credible, expert, and independent source, and

(ii) Clinical level productivity measures should be developed at a departmental and clinician level with strong clinical input.

3 WAYS TO ESTABLISH CLINICAL NETWORKS AND LEADERSHIP PROGRAMMES TO SUPPORT THESE GOALS

The MRG recommends that:

(a) Irrespective of their origin, clinical networks should:

(i) Have clear terms of reference and reporting arrangements,

(ii) Be led by clinicians with appropriate qualifications and a record of achievement in management – appointments to leadership positions should be for a fixed term and holders should maintain some clinical role,

(iii) Normally include representatives from across the breadth of health care and include an expectation of a holistic approach to recommendations,

(iv) Include regular measurement and reporting of outcomes and outputs in their terms of reference as well as assessment for impact in the local environment,

(v) Have a clear plan of how their quality and process outcomes will be given effect,

(vi) Expect to disband once they have fulfilled their objectives, and

(b) Dedicated project support should be available for those networks fulfilling the requirements above and with clear quality and process outcome targets, and

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

4 ESTABLISHING AND FOSTERING GREATER CLINICAL LEADERSHIP IN PRIMARY CARE AND ACROSS PRIMARY AND HOSPITAL CARE WITHIN DHBS – PRIMARY AND HOSPITAL INTEGRATION

The MRG recommends that:

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

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

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

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

The MRG recommends that:

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

5 THE ACCELERATION OF NATIONAL QUALITY AND SAFETY IMPROVEMENT PROGRAMMES

The MRG recommends that:

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

The MRG recommends that the national quality entity should:

(a) Establish formal linkages with one or more similar international bodies, but must concentrate on seeding and growing a local safety and quality culture, providing state of the art tools, skills and support and building New Zealand capability,

(b) Develop the next phase of a national quality and safety programme that addresses patient safety and continuous quality improvement, and

(c) Scale back the current PHO Performance Programme for a period and the resulting saving should be used to help accelerate the introduction of QI4GP.

The MRG recommends that the national quality entity should:

(a) Be governed by an appointed board and report to the Minister. Clinical appointments on this board must be drawn from the breadth of health care providers.

The MRG recommends that the national quality entity should:

(a) Expect to become partially self-funding by the end of its third year of operation through the development of resources, teaching and learning opportunities and other supports for workforce development and education, and

(b) Support prospective research and rigorous evaluation to demonstrate the transferability of real cash savings from improved safety and quality.

Annex 3 Recommendations

1 CAPITAL EXPENDITURE

The MRG recommends that:

(a) The NCC should be replaced by a single Investment Committee of the NHB,

(b) The Investment Committee should be independently chaired and its membership should include clinicians and the chairs of the NHB's workforce and IT boards,

(c) There should a long-term capital and asset management plan with an annual component that outlines total capital expenditure investment, and the level, nature, and source of the funding required,

(d) The plans in (c) above should be driven by service delivery models of care within local, regional, and national health plans,

(e) The plans in (c) above should have strong linkages with workforce and IT development and investment plans,

(f) The plans in (c) should include all proposals (including all non-departmental proposals by the Ministry) that exceed the existing central approval thresholds, with the NHB replacing the Ministry in the approval process, and

(g) The issues outlined in Further work above should be explored.

2 WORKFORCE

The MRG recommends that:

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

(b) The NHWB would be responsible for:

(i) The planning, development and implementation of a NHWB,

(ii) Assessing future workforce needs, overseeing the planning and funding of postgraduate training (if the recommendations of the Ministerial Taskforce on the Funding of Heath Workforce Training areaccepted), and advising the Minister on changes in scope of practice and workforce innovations,

(iii) Working with DHBs in developing an industrial relations strategy that helps facilitate the changes in work practices to support the sector's wider objectives for workforce development, and

(c) The NHWB be represented on the NHB Single Investment Committee to ensure there is strong alignment of the workforce with non-workforce investments such as IT and facilities, and

(d) The current HWIP be made a national resource under the governance of the NHWB and that the respective coverage be quickly increased to include the whole health sector workforce and to develop an effective modeling capability.

3 INFORMATION TECHNOLOGY

The MRG recommends that:

(a) An interim governance group be set up for both NSDP and KD to reprioritise and reduce the number of NSDP and KD projects with a focus on (a) addressing the risks in the payments system and (b) supporting the implementation of the distributed approach to a safe sharing and transfer of patient electronic information amongst providers,

(b) The Refresh HISNZ project of KD should cease and the Safe Sharing of Health Information Community Dialogue and Education project of KD should be slimmed down and utilise the existing HISAC consumer forum,

(c) All primary care related IT projects such as GP to GP Notes Transfer, PHO Performance Programme, Qi4GP, electronic referrals, electronic discharges, electronic medication, and electronic laboratory should be integrated and rationalised under a new primary care information system initiative,

(d) The Grants Scheme project of KD be reviewed to support projects related to the primary care information system initiatives,

(e) The PHO Performance Programme be scaled back and savings be redirected to support the development of QI4GP as part of a broader primary care information system initiative,

(f) That the interoperable and connected distributed approach rather than the single sector-wide enterprise system be confirmed as the preferred approach for the development of a safe sharing and transfer of patient electronic health information for the New Zealand health sector,

(g) The HMSC initiatives by seven DHBs revise their scope to concentrate on replacing the PAS for hospitals. This revised scope be implemented using a distributed approach for the development of a safe sharing and transfer of patient electronic health information, using interoperability standards set by HISO to ensure integration with primary care and other providers' systems,

(h) The roles and function of the Ministry of Health ID be reviewed and focused solely to support the IT needs of the Ministry,

(i) The national payments and contracts management systems provided by Sector Services (with a budget of 272 FTEs) should be moved out of ID to a national shared service agency. While work is being undertaken to establish the legislation to set up a national shared service agency, this function should be transferred to a single NHB subsidiary,

(j) All other current responsibilities of the Ministry ID be transferred to the NHB,

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

(l) The National Health IT Board will, on behalf of the NHB, work with the sector to develop a National IT Plan (including a national IT architecture framework) to advance HISNZ. This plan will be a rolling plan with local, regional, and national views, and a short, intermediate, and long-term perspective that it is aligned with the National Health Workforce Plan and National Health Capital Plan,

(m) The National Health IT Board will be represented on the NHB single Investment Committee responsible for planning and funding IT and facilities programmes,

(n) The National Health IT Board will ensure there is strong sector clinical manager and governance leadership of IT projects, and

(o) The National Health IT Board will work closely with the HSMC initiative and the proposed primary care information system initiative to advance:

(i) The implementation of a safe, shared and transferable patient electronic health record for New Zealand health sector, using a distributed approach based on interoperability standards set by the HISO, and

(ii) The implementation of a consumer portal.

Annex 4 Recommendations

1 TESTING THE LINE-BY-LINE SPENDING REVIEW WITH THE MINISTRY TO IDENTIFY ANY ADDITIONAL IN-DEPTH REVIEWS OR LONGER-TERM WORK THAT WILL NEED TO BE ADDRESSED

With respect to NDE managed by the Ministry, in addition to the recommendations in the main paper, the MRG recommends that:

(a) All new expenditure proposals should be accompanied by a three-year forecast of the most likely full future cost of the proposal, an assessment of the proposal's cost-effectiveness, and an indication of savings that could be released from low priority expenditure elsewhere in Vote Health to fund the proposal, and

(b) The results of the ongoing programme that the Director General has for seeking savings in key areas in both departmental expenditure and NDE be subject to independent expert review for relatively large areas of expenditure and be completed before the associated funding function is shifted out of the Ministry.

2 CONSIDERATION OF THE MINISTRY'S ROLE AS A MANAGER OF A RANGE OF NATIONAL OPERATIONAL FUNCTIONS

With respect to the longer-term management of the $2.5 billion of NDE managed by the Ministry, the MRG recommends that:

(a) Over the next 12 months the Ministry be asked to work through the various policy and machinery of government issues associated with devolving all of the $2.5 billion of NDE currently managed by the Ministry to either the NHB (national level) or DHBs (regional and local level),

(b) The funding streams that are relatively straightforward to move out of the Ministry before the 12 month period should be moved, and

(c) Unless unanticipated issues arise, all of this funding and the associated budget to manage that funding should have been shifted out of the Ministry at the end of this period.

The MRG recommends that:

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

The MRG recommends that:

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

The MRG recommends that:

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

The MRG recommends that, with respect to the NRL:

(a) The NRL remain as an independent unit within the Ministry of Health in the first instance,

(b) The Ministry of Health acts to increase the commercial flexibility of the NRL, within the constraints of operating within the Ministry, and

(c) The Minister of Health considers the opportunity provided by the new Radiation Safety Bill to investigate the 'one stop shop' option for scientific services underpinning the public health service.

The MRG recommends that:

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

The MRG recommends that:

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

3 SELECTIVELY REVIEWING THE REST-OF-SECTOR EXPENDITURE, INCLUDING DHBS, TO REDUCE WASTE AND BUREAUCRACY AND IMPROVE SPENDING QUALITY AND PATIENT SERVICE

The MRG recommends that:

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

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

(c) DHBs be advised that new PHOs should be permitted, on condition that:

(i) establishment funding is not provided

(ii) that it is the preference of health care providers, and

(iii) sound corporate governance, sound clinical governance, and effective community participation is demonstrated.

The MRG recommends:

(a) The creation of a Pharmac-like national shared service agency with a mandate to manage the assessment, standardisation, management, purchasing, and/or supply chain management of any of the common back office functions of DHBs that are referred to it by the Minister of Health,

(b) The operational budget of this agency be funded by top-slicing the DHB funding formula,

(c) That this agency will act as an agent for DHBs and will agree with them a notional (or actual) budget for the management, purchasing, and/or supply chain management tasks it undertakes on their behalf,

(d) As long as a budget can be identified, then the board of this agency will make the final decision on what is purchased and the terms, conditions, and prices of procured items and the management of shared services (like payroll and supply chain), and

(e) That the NHB be required to establish a process for working through the entire range of common DHB back office services to identify a list of services that are best supplied by a single national provider, starting with non-pharmaceutical hospital procurement.

4 REVIEW THE REPORTING AND ACCOUNTABILITY PROCESSES BETWEEN THE MINISTRY, DHBs AND PHOs TO IMPROVE FOCUS AND REDUCE UNNECESSARY BUREAUCRACY

The MRG recommends that:

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

The MRG recommends that:

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

The MRG recommends that a:

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

5 SELECTIVELY REVIEW THE PLETHORA OF EXISTING MINISTERIAL AND MINISTRY COMMITTEES AND FUNCTIONS.

The MRG recommends that:

(a) Four committees have their terms of reference and membership refocused to fulfil the new mandate outlined in the MRG report,

(b) 16 committees be disbanded,

(c) 16 committees be disbanded and their functions transferred to the NHB,

(d) Seven committees be merged,

(e) Five committees be reconfigured into Expert Panels as outlined in the Framework in Section 3, and

(f) 54 committees are retained. Of these 10 are Statutory Committees, four are Ministerial Committees, and 40 are Ministry of Health Committees (including 10 NSU and eight Ethics Committees).

The MRG recommends the following principles govern all committees, including Statutory, Ministerial Advisory, Ministry of Health, and NHB:

(a) Formal Ministry of Health Committees (Programme/Project Advisor Groups) should only be established on approval of the Senior Leadership Team,

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

(c) All committees and Expert Panels should have a robust terms of reference, a workplan, and reporting requirements,

(d) All committees should have an independently appointed skilled Chair, whose role is not to represent an opinion but to ensure the committee fulfils its responsibilities,

(e) All committees and Expert Panels should consider how they include consumer voices in their processes,

(f) All committees and Expert Panels to use teleconference as the preferred method of meeting whenever possible,

(g) All committees to have an independent review of their terms of reference, delivery against the workplan, and membership to ensure they continue to add value and/or benefit to the sector, and

(h) All Ministry of Health committees to have an end-of-life date.

The MRG recommends that:

(a) The structure below is endorsed for the future.

PHOs stratified by population size	Statutory Committees	Ministerial Advisory Committees	MoH and NHB Programme/ Project Advisory Groups	MoH and NHB Expert Panel
Rationale for existence	Established by an Act of Parliament	To provide advice to the Minister of Health on specific issues	The expertise required is not employed within the Ministry of Health; and/or Existing networks do not have the full required expertise; and/or There is a requirement for long-term expert advice	When expertise and input is required for a specific topic or piece of work Drawn from the service panel of experts (see below)
Term of office	Three years or less	Three years or less	One year or more	Short-term focused work then disbanded; or called together as required to fulfil a specific agenda
Renewal	As Minister of Health directs after the three-year review	As Minister of Health directs after the three-year review	As approved by the MoH Senior Leadership Team	

The MRG recommends that:

(a) The Ministry of Health establish a common terms of reference template, and

(b) That the Ministry of Health develop a set of guidelines for the regulation and monitoring of committees and Expert Panels.

The MRG recommends that:

(a) That the Ministry of Health implement a full cost process for every committee and Expert Panel.

The MRG recommends that:

(a) The National Health Committee be refocused with a broader mandate to advise the Minister on services that should be publically funded,

(b) The Public Health Advisory Committee be refocused with a broader mandate to advise the Minister on the configuration and provision of public health services,

(c) The National Health Epidemiology and Quality Assurance Advisory Committee, known as the Quality Improvement Committee (QIC), be replaced by an independent quality entity with responsibility for helping providers across the whole sector improve patient safety and service quality,

(d) The four Mortality Review Committees are merged into two committees,

(e) The Drinking Water Implementation Advisory Committee is not established,

(f) The Health Information Strategy Advisory Committee be disbanded and becomes part of the NHB IT capacity planning mechanism, and

(g) 10 Statutory Committees are retained, each to have a process established for three-yearly review of their terms of reference and membership to ensure they continue to add value and/or benefit for the Minister.

The MRG recommends that:

(a) The Cancer Control Council of New Zealand be retained and the recommendations of the review of the terms of reference and membership are implemented,

(b) The Sanitary Works Technical Advisory Committee be retained and is refocused on the Drinking Water Assistance Programme only and meets once per annum,

(c) The Health of Older People Forum is disbanded in its current form, and

(d) The three other committees are retained, each to have a process established for three-yearly review of their terms of reference and membership to ensure they continue to add value and/or benefit for the Minister.

The MRG notes that 12 committees have already been reformulated into Expert Panels and recommends that:

(a) The NSU committees, including the Joint Ministries Committee and the Expert Panels, continue to be reviewed annually to ensure they are adding value to the NSU programmes.

The MRG recommends that:

(a) The National Systems Development Programme Sector Advisory Group and the National Systems Development Programme Connected Health Community Steering Group are disbanded, and

(b) The Health Information Standards Governance Group be disbanded and becomes part of the NHB IT capacity planning mechanism.

The MRG recommends that:

(a) Six of the current workforce committees' roles and functions become a standing feature of either the Nursing Reference Group or the Medical Reference Group in the health workforce capacity and planning capability of the NHB, and

(b) The Specification Review of Midwifery First Year of Practice Advisory Group and the Midwifery Post Graduate Education Expert Advisory Group be disbanded and their functions left to the Midwifery Registration Board.

The MRG recommends that:

(a) The operational and committee functions of the National Influenza Strategy Group be separated and the structure and function of the committee be reviewed once 2009 influenza vaccination programmes are completed,

(b) An overarching Immunisation Technical Forum and an Immunisation Coverage Forum be formed to incorporate the current roles of the Immunisation Technical Working Group, the MenzB Effectiveness Group, and the Immunisation Programme Advisory Committee, and

(c) The need for one further committee (the National Immunisation Register Advisory Group) be reviewed as part of a review of the internal arrangements required to meet research, privacy, and ethical needs.

Of the remaining six, the MRG recommends that:

(a) Five committees (the Hepatitis C Treatment Advisory Group, the AIDS Medical and Technical Advisory Committee, the Antibiotic Resistance Advisory Committee, the National Certification Committee for the Eradication of Polio, and the Tuberculosis Advisory Group) be retained, and

(b) The terms of reference and membership of the Pneumococcal Surveillance Advisory Group be reviewed with a view to a broader role in vaccine preventable disease surveillance.

The MRG recommends that:

(a) Those recommendations from the review of the Ethics System pertaining to committee structure and role are implemented in a timely manner.

The MRG recommends that:

(a) The three Core Cancer Control Committees are retained and reviewed annually to ensure they continue to add value to the Cancer Control Strategy.

The MRG recommends that:

(a) Before the two-year term is complete the Primary Health Care Advisory Council has an independent review of their terms of reference, delivery against workplan, and membership to evaluate the value and/or benefit to the sector from the committee structure and process, and

(b) The functions of the Primary Health Care Nursing Expert Advisory Group be assumed by the Nursing Reference Group of the HWTB.

The MRG recommends that:

(a) The three common Finance Related Committees are disbanded and the functions move into the NHB role, and

(b) The National Capital Committee be disbanded and become part of the NHB capital capacity planning mechanism.

The MRG recommends that:

(a) The Te Taumata Roopu – Maori Public Health Reference Group be retained and that its membership and terms of reference be reviewed annually to ensure it adds maximum value for public health services.

Of the other three, the MRG recommends one is retained and that:

(a) The Food and Beverage Classification System Technical Advisory Group and the National Breastfeeding Committee are reconfigured as Expert Panels and called together as required for specific issues.

The MRG recommends that:

(a) The Ministry of Health work with the Cancer Control Council and the Health Sponsorship Council to remove any duplication of workplan, and

(b) The Ministry of Health reviews the requirement for the Tobacco Control Research Steering Group prior to the next contract being let.

The MRG recommends that:

(a) The National Diabetes Retinal Screening Advisory Group is disbanded.

The MRG recommends that:

(a) The third is currently retained.

The MRG recommends that:

(a) The workforce development component of the Health Protection Advisory Group is transferred to the NHB Health Workforce capacity planning function and that the committee meets up to twice yearly to fulfil its assessment process.

The MRG recommends that:

(a) The Joint Ministry of Health/Department of Internal Affairs Stakeholder Reference Group on Preventing and Minimising Gambling Harm be reviewed and/or disbanded at the end of its term.

The MRG recommends that:

(a) The Sexual Health Advisory Group be disbanded.

The MRG recommends that:

(a) Both the Nationwide Service Framework Co-ordinating Group and the Health Impact Assessment Support Unit Reference Group be reformulated into Expert Panels,

(b) The DHB Information Liaison Group be disbanded and the monitoring functions become the responsibility of the NHB, and

(c) The National Service and Technology Review (NSTR) Committee's role becomes a function of the reformulated National Health Committee.