Annex 3

Terms of Reference:

Infrastructure capacity and planning

Contents

Annex 3: Terms of Reference – Infrastructure capacity and planning:

THIS ANNEX COVERS THE FOLLOWING TERMS OF REFERENCE:

- Review unapproved capital expenditure requests, and current workforce and information initiatives and programmes, and
- Ensuring that planning is adequate to deliver the infrastructure capacity to meet the demands for improved service quality, especially improved timeliness.

Both parts of the above will be covered under the three headings of capital expenditure, workforce and IT.

1 Capital expenditure

A more effective national perspective of service delivery needs to drive the capital planning and budgeting process. That process also needs to have a longer-term focus, be better integrated with IT and workforce capacity development, and include the full scope of public health investment (i.e. the Ministry's capital programmes as well as those of the DHBs).

1.1 CURRENT SITUATION

1.1.1 DHB sector capital assets and investment

For the year ended June 2008 the DHB sector had an asset base of approximately $3.774 billion, incurred $634 million of additional capital expenditure of which $167 million was approved by the National Capital Committee (NCC), and received $108 million of additional government funding. Depreciation was approximately $330 million and $447 million was paid out in cashflow.

DHB capital expenditure above a certain threshold needs the approval of the Director General, Minister of Health, and Minister of Finance. Approvals for these requests go through three stages – Strategic Analysis, Options Analysis and Full Business Case. This process is managed by the NCC. The NCC members are largely drawn from DHB chairs and CEOs, chaired by the Ministry of Health Deputy Director General, DHB Funding and Performance, with the CEO of the Crown Health Funding Agency in attendance. The NCC is to provide advice on the whole of sector view of capital investment and to inform the Ministry's advice to the Minister.

For the 2009 capital year the strategic analysis funding requests from DHBs are $436 to $636 million. Historically over the last eight years the level of actual additional government funding approved averages out to $151 million.

1.1.2 Ministry of Health managed or led capital programmes

Capital expenditure managed by the Ministry of Health for its own departmental or for non -departmental programmes does not go through the NCC process but are subject to central agency review. Funding of these non- departmental capital programmes is separately allocated as non-departmental expenditure (NDE). Some NDE capital request can be significant: for example, the Oral Health business case ($116 million), the National System Development Programmes ($150 million), and Key Directions ($40 million).

1.2 ASSESSMENT OF CURRENT ARRANGEMENTS

In discussion with the sector and a review of existing documents a number of themes stand out:

- There needs to be better linkages between capital planning and health services planning. Although the NCC templates and processes require that linkage to be made the 'substance' of this linkage is variable. This is in large part because of the lack of a longer-term view of the desirable geographic service configuration and models of care sector-wide and, therefore, the asset base needed to support that future configuration. Health service planning needs to drive investment planning or we risk locking ourselves into replicating the current locally-driven and hospital-centric capacity, with that driving future service delivery.

- Capital planning needs to be longer term and continuous. This recognises that changes to geographic asset configuration and models of care are not a short-term or a stop-start process. Long-term capital plans should be reviewed each year as part of the process of putting together annual capital investment plans.
- Linkages between the capital planning process for facilities and equipment on the one hand and workforce and IT on the other are not clear and need to be strengthened. Although each of these investments has a template that examines these linkages, the substance of these linkages is debatable. These different aspects of productive capacity need to be properly synchronised to ensure high levels of capacity ultilisation (e.g. staffing of facilities). Moreover, changes in work practices and IT investments can help reduce avoidable hospital admissions and so delay the need for investment in hospital-based facilities. Stronger linkages between these three different aspects of 'capacity' are necessary because this interplay affects the timing, nature, and extent of investments required in each.
- The level of clinical leaders' involvement and support for these health plans is another area which warrants closer examination and improvement. At a local level secondary and primary clinical leaders need to drive and own any changes to models of care that underpin capital plans. Going forward it is equally important to get clinical leaders' support and ownership for regional health plans within the context of a national health plan. DHBs have long term 'asset management plans' but these tend to be the responsibility of corporate or financial executives of DHBs. Future asset management plans need to have the collective agreement of management and clinical leaders.
- Based on DHB published accounts, it is estimated that NCC approved capital expenditure only covers between 25% to 40% of DHB total capital expenditure. This raises the issue of where and who has an overview of the total capital expenditure programme of DHBs. Such an overview could look at competing priorities, possible duplication of capital resources, opportunities for joint procurement, and standardisation of equipment and devices.
- Also NDE-related capital projects need to be considered as part of the national capital planning process. The capital component of these projects can be significant and can affect the sector in terms of competing priorities on resources and timing. In the main these NDE-related capital projects tend to be driven by government priorities. Including them in the national capital planning process will ensure that these projects can be prioritised accordingly.
- The NCC role, function, membership and process all need to change. We recommend bringing this revamped process into a single Investment Committee (which would replace the NCC) reporting to the proposed National Health Board (NHB). It will then be driven by a longer-term view of service planning and be well integrated into decision-making around investments in IT and workforce training and development.

  This coordination could be achieved by having the Chairs of the Workforce and IT Boards of the NHB sit in the Investment Committee. In addition there should be consideration for an independent Chair, especially when the Ministry and the NDE-related capital projects are being considered. Just as the workforce and IT national planning and leadership group are part of and report to the NHB, the Investment Committee should be as well.

8 There needs to be a better pre-screening process before IT proposals enter the capital approval process. We are proposing that the NHB establish a National IT Board to provide a strategic leadership role for national health IT strategy and planning to advance the existing strategy (i.e. HISNZ 2005). That IT Board should ensure that IT capital proposals meet government priorities for advancing the IT strategy and are, therefore, part of the proposed national IT plan before submission for capital approval.

9 A number of financial indicators indicate the difficulty DHBs currently face in trying to break-even financially and sustain their current asset base:

- DHBs are currently running collective decits of about $150 million and have unfunded capital requests of $463 to $636 million.
- The capital expenditure spend to depreciation ratio of 150% indicates that, in general, replacement costs are exceeding the historical costs set aside for capital replacement, and
- The increasing proportion of total interest, depreciation and capital charge relative to total expenditure/ revenue indicates that DHBs in general are funding their capital expenditure by borrowings (interest) and/or equity injection (capital charge). The combined depreciation and capital charge cost of replacing depreciated assets with any major new capital project has a major 'profit and loss' impact on DHB bottom lines, often pushing them into deficit.

These indicators suggest that we cannot simply keep trying to replicate the current mix of assets. This is likely to be even harder in a more constrained fiscal environment. Service reconfiguration and new models of care that are relatively less reliant on hospital-based care are necessary to ensure a financially sustainable capital programme.

10 Further work: There are a number of financial issues that have been raised in our discussions that deserve further consideration:

- There is a concern that all revenue is typically used to meet operating costs, with little retained for asset replacement, so new capital builds create a short-term financial 'crisis' and the need for deficit support,
- While there is recognition of the need to reflect the true cost of capital, there are concerns around the expense of regular revaluations and the flow-on effects to the capital charge. Some question if the capital charge should act more like a return on shareholder funds than a fixed charge, and
- There is some support in the sector for the concept of nationalising the ownership of all DHB assets and so shifting the capital charge and depreciation costs away from DHBs. There is also some interest in private funding of some health assets. Neither approach will shift the cost of the assets away from DHBs: the eventual owners will still look to the eventual users of the assets to recover these costs (e.g. through lease agreements). To the extent that proposals for nationalisation are driven by the desire to see a stronger national perspective, then our proposals should help address these issues. While there are potential benefits from both proposals that are worth exploring, they should not distract from the more important issues canvassed above.

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

2.1 CURRENT ISSUES

In relation to the New Zealand health workforce there are many activities, initiatives, programmes and reviews in progress. The Ministry of Health, DHBNZ, the Ministerial Taskforce Group on Postgraduate Education and Training, the Medical Training Board, the Committee on Strategic Oversight for Nursing Education, the Senior Medical Officer Commission, and the RMO Commission are all either active or have just reported on some aspect of the workforce agenda.

The *Stocktake and Roadmap – Workforce Development and Training* report prepared by the Ministry of Health in early May 2009 is a useful summary of workforce activities and current roles. Since this summary was produced the Ministry and DHBs have developed a joint work plan.

Despite numerous and both uniformly and consistently critical health workforce reports, action and implementation to date has not resulted in any significant reform. There is uniform agreement that the health workforce status quo is not tenable in respect of current health needs, let alone those of an ageing New Zealand population. The failure to respond to these reports suggests that we need to change the way we manage the process if we are to make progress.

From reviewing all the activities a number of themes stand out:

- The sector realises that we need a simpler and more unified approach to workforce issues that better reflects the need for changing roles and practices to deliver improved models of care and service delivery. This will require a high-level governance group to bring the various stakeholders together to enable a more unified approach to health workforce education, training, recruitment, and development.
- There needs to be greater clarity in respect to the roles and responsibilities of the various stakeholders at the national, regional, and local level and for public and private employers, teaching and training organisations, registration and accreditation bodies, professional colleges, societies, and unions.
- There is a realisation that there has to be a much greater flexibility in the nature and deployability of the health workforce in respect to roles and scopes of practice, etc. The imperative to develop new roles and a more flexible health workforce has been recognised in a number of developed countries. While the Health Practitioners Competence Assurance Act 2003 allows for changes in scope of practice and for novel types of health roles, the innovations that have occurred in other countries have not been adopted here. This shortcoming needs urgent attention.
- The implementation of industrial relation agreements has concurrently increased remuneration for the public hospital sector and has put pressure on the private and NGO sector. This has seen a drift of workforce from the primary and NGO sector to the public hospital sector, particularly for nursing and support staff. The establishment of two separate Commissions following the last wage round highlights other employment-related issues that need resolution.

- The recent review by a number of taskforces has highlighted the need for the education and training sector to be more responsive to the employment models of the various employers in the health sector. Health services plans need to drive models of care and service configurations, which should in turn drive employment models, which in turn should drive consequential competencies and learning outcomes and the curriculum of education and training organisations.
- Recruitment, retention, and the distribution of the health workforce needs better coordination and a more integrated approach. New Zealand's reliance on an internationally mobile professional workforce in the context of worsening global health workforce shortages increases the worker-related vulnerability of local health services. For example, more than half of the doctors working in New Zealand and more than 40% of the medical specialists were born overseas. The training and retention of a New Zealand trained workforce is another major issue. For example, the evidence from Auckland University suggests that the medical students most inclined to stay in New Zealand, and to practice in high-utility disciplines such as general medical practice, were born in New Zealand . Yet more than 40% of New Zealand domestic medical students at that university were not born in New Zealand.

  A more cohesive and collective leadership of clinicians and managers will need to focus on developing the desirable behaviours and attitudes as well as skills in communication, conflict resolution, clinical and corporate governance, and management. The latter are agreed domains of professional leadership but are not taught at all or adequately in current undergraduate health professional curricula.
- There is a pressing need for good information on the workforce in terms of current quantitative realities, as well as modeling demand (linkages back to service requirements) and supply (linkages back to teaching and training capacity). While good progress has been made in the form of the Health Workforce Information Programme (HWIP), this needs to be supported further to become a national and across-sector resource. At present the HWIP has better information on the secondary sector and much less on the primary, aged care, and community sectors. In addition to the HWIP, relevant data is also accumulated and held (in silos) by the universities, the private sector, the PHOs, the professional colleges, and the various councils, boards, and accreditation and registration bodies.
- Funding needs to be better coordinated, both across programmes and providers. There are few across-sector and across-educational continuum views, either operationally or financially. For example, the undergraduate programmes for aspiring health workers are largely funded by the Tertiary Education Commission (which is not accountable to the health sector in any way other than for those programmes, such as medicine, which have capped numbers). The subsequent education and training is variously funded including by the learner, their employers, the Clinical Training Agency (CTA), and DHBs.

2.2 LOOKING FORWARD: A SIMPLER AND MORE UNIFIED APPROACH

It is clear that we need a simpler and more unified approach to workforce issues, including workforce recruitment, training, and development. This approach needs to be driven by the future needs of the sector and, in particular, the need for changing roles and practices to deliver improved models of care and service delivery. The proposed NHB will have responsibility for bringing together service planning and funding as well as the capital and IT investment needed to deliver the capacity required to deliver that service into the future. Workforce planning is integral to this process: it needs to be informed by future service delivery requirements and will, in turn, help define what can be delivered.

We propose that a National Heath Workforce Board (NHWB) be formed as part of the NHB structure, reporting to the NHB. The NHWB would be responsible for the planning, development and implementation of a national health workforce plan. In order to do that it would need to bring the various stakeholders together to enable a more unified approach to health workforce education, training, recruitment, and development. The NHWB would be responsible for assessing future workforce needs, for overseeing the planning and funding of postgraduate training (if the recommendations of the Ministerial Taskforce on the Funding of Heath Workforce Training are accepted), working with the various professional groups to influence work practices, and making recommendations to the Minister for changes in scope of practice and workforce innovations. It would also work with DHBs in developing an industrial relations strategy would help facilitate the changes in work practices to support the sector's wider objectives for workforce development.

A key early focus of the NHWB will need to be on the development of workforce innovations. Examples of such innovations include physician assistants in surgical and anaesthesia roles, nurse endoscopists, advanced roles for hospital and community pharmacists, and nurse practitioners in diabetes care. This board will need to get the various key stakeholders (e.g. DHBs, other employers, professional bodies, teaching and training organisations, and unions) together to outline the challenge and the opportunity going forward.

The membership of the NHWB would need to include leaders from the key stakeholders that can govern a process and structure that brings the sector together on this important issue. This board will also need experts and advisory panels that draw on and receive advice from the sector. As part of this process existing Ministerial and Ministry taskforces, advisory groups and expert groups that are tasked with any aspect of the health workforce should be reorganised (aggregated and rationalised) as part of the proposed NHWB. This board will also need to incorporate a national health workforce information collective and feature not only the current quantitative approach of the HWIP, but also a modeling function. These resources currently exist disparately in the Ministry of Health, as well as DHBNZ, and will need to be both aggregated and rationalised.

The Ministerial Taskforce Group on Postgraduate Education and Training has looked at and made recommendations on postgraduate education and training to the Minister. Likewise the SMO and RMO commissions have reported to the Director General of Health. The decisions the Government takes on the recommendations of these groups may well influence the roles and responsibilities of the proposed NHWB.

The MRG recommends that:

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

(b) The NHWB would be responsible for:

(i) The planning, development and implementation of a national health workforce plan,

(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 are accepted), and advising the Minister on changes in scope of practice and workforce innovations,

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

(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 explosion of information and technology available within health has both positive and negative impacts.

Information can be an enabler for better quality and safer health services delivery. Compared to most developed countries, New Zealand's use of IT in health care organisations is one of the highest in the world, especially by primary care providers. The next challenge is for information collected by these providers to be shared, communicated and made more easily accessible to other providers and patients.

However, the sector is currently inundated with too much information and too many IT projects. Literally each national health programme results in another 'national collection or database'. These current national collection and provider systems are not easily linked up to provide a 'patient or person-centred' view. This ignores the fact that for most people they will have more than one health issue that needs treatment and/or management.

The Health Information Strategy New Zealand (HISNZ) 2005 is a national strategy that paints the direction of travel and defines some essential building blocks. HISNZ recognises that information is collected by various providers for different purposes, and there is a need to have safe sharing and transfer of information amongst users. HISNZ is clear on its preference for a distributed approach for the safe sharing and transfer of patient electronic health information using interoperability standards set by the Health Information Standards Organisation (HISO). A distributed approach aims to enable the different systems of different providers to share information and differs from a single enterprise sector-wide approach that requires all providers to use the same system. HISNZ is currently missing a national IT architecture that clearly shows how a distributed patient-centred electronic health information system works for consumers and providers.

The current level of strategic leadership and governance of the information and technology agenda is inadequate and unlikely to significantly realise the potential of this enabler for the health sector. In most health organisations this important responsibility is left to their Chief Information Officer and a few enthusiastic clinicians and managers. There is a tendency to 'oversimplify' and look for IT solutions without getting the fundamentals right, like looking at standardising clinical process and assessing the readiness for changes in behaviour necessary to make new systems work effectively. The leadership roles of the Ministry of Health Information Directorate (ID) and the Ministerial committee HISAC is not clear to the sector.

To get greater benefits from the use of information and technology there needs to be:

- Clarity on who has a national strategic leadership role for national health IT strategy and planning,
- Confirmation on the preferred approach (interoperable and connected distributed systems or a single sector-wide enterprise system) and an architecture for a safe, shared and transferable patient electronic health record for the New Zealand health sector, and
- A higher level of 'strategic leadership and ownership' from clinicians, managers and governors of IT projects. This call recognises the significant and integral part this information plays in determining how health services are delivered.

The MRG has examined the above points by specifically focusing on the following areas – Key Directions (KD), National System Development Programme (NSDP), and the HSMC initiative, Primary care information system (PHO Performance Programme and Qi4GP), and MoH Information Directorate.

3.1 KEY DIRECTIONS (KD)

Phase 1 of KD was approved in August 2008 with $10.9 million in project funding and $0.9 million per annum in ongoing costs to be spent over 2008/09 and 2009/10. In April 2009 a Health Report (AD86/37/9/5) recommends the total amount be revised downwards to $7.454 million and the balance transferred back to the Ministry of Health as part of the line by line review. This revised amount was to be earmarked for the following projects:

- Safe sharing of health information, community dialogue and education,
- Refresh HISNZ and develop an outline of a proposed investment pathway,
- Grants for scaleable sector information initiatives, and
- GP to GP Notes Transfer.

To avoid duplication and unnecessary expenditure the first project should be slimmed down and be implemented using the existing HISAC consumer forum. The second project should be deferred and the remaining projects should be repositioned to support the proposed primary care information system initiative (see sections below).

3.2 NATIONAL SYSTEM DEVELOPMENT PROGRAMME (NSDP)

This was originally a four-year national programme ending in 30 June 2010 with a budget of $151.5 million. There are six main components to this programme – Connected Health, Recipient and Provider Identity, Health Statistics and Reporting, Health Payment Systems, Capitation Payments and Information, and Access and Integration.

The Health Report for this programme up to 30 June 2008 indicated that deliverables were approximately one year behind schedule due to a variety of reasons, including a late start. The completion date for this overall programme is now estimated to be 2011 rather 2010, with costs incurred to date of $27.9 million compared to a budget of $69.5 million. This report notes that this programme's deliverables will still be delivered within the original envelope of $151.5 million. Central agencies noted that the focus up to 30 June 2008 had been on planning and design and that there is little benefit to show for the $27.9 million invested to date. Since this report the Ministry of Health has increased its programme management capacity and capability.

The governance of the programme involving key sector stakeholders have not met for some time and needs to be reinstated. The remaining work for the six components needs to be reprioritised to address two priority issues in particular:

- The high risk identified in the Ministry of Health Risk Register with regards to national payments and contract system, and
- Supporting the implementation of the distributed approach for a safe common, sharing and transfer of patient electronic health information using interoperability standards set by the HISO.

3.3 HMSC INITIATIVE

The Health Management System Collaborative (HMSC) is a collaboration amongst seven DHBs which aims to call for IT developments that will provide a complete and shared electronic patient record to health professionals. The objectives and vision of the HMSC proposal is consistent with that of HISNZ and has generated great interest in the sector. This initiative first started to look at options for replacing hospital patient administration systems (PAS), but has extended its scope to establish an individual-centric health service by 'wrapping The Health Management System around the individual', rather than the current state where the systems are provider focused.

The MRG has spoken to members of this project and others in the sector, including the chair of HISAC. As part of our brief to review unapproved capital requests, we also reviewed the Strategic Stage Analysis submission document dated 29 June 2009 sent to the Ministry of Health seeking funding support from the Crown. The MRG understands that the Ministry of Health is currently reviewing the HSMC proposal and has not made a decision on whether it will recommend it. The content of this strategic stage analysis has led the MRG to form a view that HMSC is synonymous with a single sector-wide enterprise solution. On 27 July 2009 the MRG received a revised strategic stage analysis from HMSC to clarify that this is not the intention of the initiative. Rather than a single sector-wide enterprise system, the MRG endorses the current HISNZ preference for an interoperable and connected distributed approach for the development of a safe sharing and transfer of patient electronic health information for the New Zealand health sector.

The scope of this initiative requires many stakeholders (primary care, pharmacies, rest homes, and NGOs) to agree to integrate or replace their current systems "if they so desire". Costs and timeframe estimates outlined in the Strategic Stage Analysis are very broad brush and need closer examining. For example if this initiative intends to fund replacement of stakeholder's systems, then it will cost more and take longer. This is especially so if an overseas solution needs customisation for the New Zealand context, which would also add significant implementation risks.

The MRG recognises the importance of implementing the safe sharing and transfer of patient electronic health information, so we agree with the information sharing aims of the HMSC. The HMSC steering group has pointed out the strong participation and leadership of clinicians including from a number of GPs. The MRG acknowledges their participation particularly on the vision for a safe sharing and transfer of patient electronic health information. The MRG notes that a decision for HMSC will have national implications and encourages better discussion at a national level. It has also been pointed out to the MRG that the participation of a number of GPs does not necessarily represent the views of general practice or primary care. The MRG notes that there is also a significant number of primary care IT projects in progress, such as the PHO Performance Programme, GP to GP Notes Transfer, QI4GP etc. Where there is great enthusiasm from primary care and general practice. We would, therefore, advise against proceeding with the current HMSC proposal and suggest it be refocused on replacing end-of-life hospital PASs with systems that meet HISO standards and allow easy sharing of electronic information with other providers (see more discussion below).

3.4 PRIMARY CARE INFORMATION SYSTEM (PHO PERFORMANCE PROGRAMME AND QI4GP)

Not so long ago New Zealand's primary care provider's (general practice, laboratory, and pharmacies) information systems led the world. However, in recent years other countries have overtaken New Zealand and have shown the way for the next phase of investment in primary care information systems. The next step for these various primary care providers is to accelerate the safe and easy sharing and transfer of information between providers and patients using interoperability standards set by the HISO.

Primary care needs a system to measure quality of primary care interventions. This 'quality-driven' system needs to be underpinned by what happens between a clinician, the patient and his/her family. Information gathered at this level can then be summarised to measure the quality improvements generated by primary care interventions on the enrolled population. To be most effective in helping primary care clinicians meet the needs of their patients, this information has to be available to them as they work with patients.

This need for reinvestment can best be illustrated in the current sector feedback on the current PHO Performance Programme. This programme collects and reports a number of performance indicators at PHO as well as general practice level. The method of collection of data from general practice and delay in reporting these indicators out to the sector greatly undermines their usefulness.

The current PHO Performance Programme has an annual budget of $30 million and in recent years has only paid out around 80% of its budgeted funds. This programme needs to be slimmed down and reshaped to address concerns over the timeliness and usefulness of reporting and to reduce the overhead in data collection and in the reporting on and changes to future indicators. Such an initiative to reshape the PHO Performance Programme is not possible unless we address the underlying GP Practice Management System that collects the information on which measurement is based.

The next generation of high-performing GP Practice Management Systems will need to have timely access to comprehensive information of patients and their families, decision support tools for individuals and population groups, and better interface with other primary providers such as pharmacy information systems. The management of patients with long-term conditions will require information systems, processes, and relationships that links all the providers involved.

The Royal College of General Practitioners and IPAC has a joint initiative, Quality Information for General Practice or Qi4GP. This programme is a combination of a quality agenda underpinned by a new generation of GP Practice Management Systems. A significant number of the PHO Performance Programme governance group is of the view that Qi4GP provides the solution for resolving the current challenges faced by the PHO Performance Programme. While the initial focus is on general practice, this initiative will need to be extended and cover other primary care providers.

There are also other primary care related information projects such as the GP to GP Notes transfer project, electronic referrals, electronic discharges, electronic medication, and electronic laboratory projects. Rationalising and integrating all these various primary care information projects will reduce duplication and provide greater cohesion that can accelerate progress.

It is important that all primary care provider information systems look at how information can be captured, shared and transferred using common standards amongst all the different providers (including pharmacies, NGOs, rest homes, laboratory, etc). In addition this new generation primary care information system initiative must collaborate with the suggested rescoped HMSC initiative to support the implementation of a safe, shared and transferable patient electronic health record between primary and secondary providers. Such collaboration also needs to extend to the development of a consumer portal along similar lines as the Danish model. The development of such a portal needs to be driven by consumers rather than from a provider's perspective.

3.5 MOH INFORMATION DIRECTORATE (ID)

The ID has broad roles and responsibilities, an annual operating budget of $64 million and 596 Full Time Equivalents (FTEs). These roles and responsibilities include servicing Ministry of Health IT needs through to running national systems and managing national projects. There are over 100 IT related projects in various stages of progress. In recent times processes have been put in place to help prioritise and manage them. Nevertheless these projects still far exceed the resource capacity of the ID and need to be reduced further, particularly the large number of projects driven by two national programmes, NSDP and Key Directions.

Another key driver of IT related projects is the work programme from other Ministry of Health directorates. A plethora of national databases has evolved from the myriad of national programmes implemented by various directorates e.g. the National Immunisation Register, Before School Checks, and national screening programmes. There is an opportunity to reduce overheads related to maintaining these separate national databases and at the same time to provide a more integrated 'person/patient' view from these national databases.

A number of the roles of ID need to be reconsidered. For example, there are significant resources and FTEs budgeted for "relationship management with the sector and vendors". In addition as the number of projects is reduced the number of resources and FTEs for the ID should also be reassessed.

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,

(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.