COUNTIES MANUKAU DHB

PRIMARY HEALTH CARE

WORKFORCE DEVELOPMENT

ACTION PLAN

November 2004

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1 INTRODUCTION

Primary health care is a key priority for Counties Manukau DHB (CMDHB). The DHB has acknowledged that its own success is dependent on the health improvement services delivered through the primary sector and public health[1]. For this reason CMDHB is heavily investing in primary health care and wishes to build on the constructive engagement to date which has resulted in a partnership approach between the DHB and its primary health care providers. This history of collaboration, along with a reputation for innovation and further investment by the DHB in primary care, should attract quality practitioners to work in the primary sector in Counties-Manukau. This is important as capacity of the workforce is one of the key barriers to realisation of our vision and in the short to medium term we will be competing with our neighbouring districts for this workforce.

This document describes the first phase of developing a workforce plan for the primary health sector in Counties Manukau. It is action oriented and takes a short to medium term view addressing specific priorities to be implemented over the next eighteen months. It is consistent with the longer term strategic direction and takes into account global trends but focuses on what is possible to influence locally in a relatively short time frame. Therefore, it is just the start of an ongoing process that will require further detailed work. The document attempts to scope the further work that is required and outlines a process how this can be achieved. The macro workforce issues can best be influenced nationally. It is therefore important that Counties Manukau District Health Board (CMDHB) gets involved in national processes through DHBNZ and the Health Workforce Advisory Committee (HWAC) in addition to any local workforce initiatives. This will allow input into the direction of education and curriculum development nationally as well as influencing these at a local level. It is through these mechanisms that impact can be made on longer-term workforce trends. This involvement and influence at a national level needs to parallel the implementation of this plan, rather than delay an immediate start on the priority workforce initiatives identified. Further scoping of this second phase, to influence the longer-term picture, is one of the recommendations of this action plan.

In order to be most effective in the delivery of healthcare it is important that the workforce mirrors the composition of the community that it serves. Given the dearth of Maori and Pacific workforce across the spectrum of health practitioners in Counties Manukau this has to be the first priority within each of the areas covered by this plan, even though this may not be explicitly stated each time in order to save repetition. Clearly we need to consider different ways of delivering services in order to impact on health disparities. The development of Maori and Pacific workforce is a key component in addressing health disparities. Therefore, the development of a Maori Health Workforce Plan and a Pacific Health Workforce Plan are top priorities that parallel the activity described in this plan. For this reason this plan does not deal with Maori and Pacific workforce issues in primary care, other than to acknowledge that this is a priority.

The DHB/DHBNZ Workforce Action Plan[2] proposes that DHBs identify three priority actions toward workforce development in each of the following areas: Maori Health, Pacific Health and Primary Health Care. This is the approach that this plan has taken in focusing on Primary Health Care to result in recommendations that are focused and already prioritised, thereby more likely to result in action.

1.1 Why develop this document

Counties Manukau DHB identified the need to produce a Workforce Development Plan as part of the Primary Health Care Plan published in 2003. This plan links to the CMDHB's Strategic Plan which outlines the following vision:

> To improve the health status of all our diverse communities, with particular emphasis on Maori and Pacific peoples and other communities with high health disparities.

It is widely acknowledged that the pathway to improving population health is highly dependent on a good primary health care system[3]. In South Auckland one of the key barriers to achieving this vision is the lack of capacity in the primary care sector. With future trends toward changing roles in the primary health sector, not only do we need more numbers of workers in primary care but significant workforce development is required to match the skill-mix desired in the future workforce. Such workforce development will assist with changing the current health system's focus on acute care to also meeting the ongoing needs of people with chronic disease.

Given:

- primary health care workforce issues are key barriers to realising this vision;
- the increased investment by the Government in primary health care and the expectation that primary care holds the key to better health outcomes for the population;
- the absolute dependence of successful implementation of the Counties Manukau Primary Health Care Plan on an effective and appropriate work force;

it is essential, that Counties Manukau District Health Board develop a primary health care workforce plan for the sector.

Furthermore, the Ministry of Health has asked District Health Boards (DHBs) to consider workforce plans and in particular to develop Primary Care, Maori Health and Pacific Health workforce plans that are consistent with the DHBNZ Workforce Action Plan. The Primary Care Workforce Plan must to be available by June 2005.

2 PURPOSE

The purpose of a primary health care workforce plan is to:

1 Identify the future workforce required to support achievement of the Counties Manukau Primary Health Care Plan (the 'desired future state')
2 Identify the current status of the primary care workforce in Counties Manukau (the 'current state')
3 Identify the key actions required of the DHB and other stakeholders to ensure appropriate workforce development initiatives are implemented and co-ordinated ('the transition')
4 Ensure stakeholder participation in development of the plan, and establishment of appropriate structure to support its implementation.
5 Integrate with wider sector workforce planning.

As explained above this Primary Health Care Workforce Development Action Plan has focused on immediate key priorities where the gaps and issues are well understood by those in the sector. These are deemed to be most important areas to start implementing while a more in-depth process is undertaken to complete the gap analysis and fully scope a longer term workforce development plan.

3 BACKGROUND

Planning for workforce development commenced early in the life of CMDHB and was assisted by the development of a scoping document produced by Dr Andrew Lindsay in 2002. It was initially intended that a workforce plan would be included as part of the CMDHB Primary Health Care Plan, however, given the need to engage the sector in planning for workforce development and the early development of PHOs this was not possible. The CMDHB Primary Health Care Plan set a goal to have a workforce plan completed by October 2003 in order to be included in the DHB's District Annual Plan. This time frame was later extended due to other priorities in PHO implementation including the workload, for all concerned, in addressing PHO enrolment issues.

CMDHB has decided to produce separate Maori Health and Pacific Health workforce plans as recommended by DHB/DHBNZ Workforce Action Plan and required by the Ministry of Health. Many of the issues in workforce development are generic (e.g. recruitment, retention and training etc), which apply across different professional groupings and are similar for Maori and Pacific workforce as much as they are for primary health care in general. However, there are issues specific to the Maori and Pacific health workforce and given there are separate plans covering these areas this, Primary Health Care Workforce Development Action Plan, does not consider these areas in detail.

It is recognised that addressing health inequalities is a top priority. In addressing health disparity, it is helpful to have a workforce composition that mirrors the local community where ever possible. In South Auckland this means we need many more Maori and Pacific people in the health workforce across all the roles and professions. It is acknowledged that, given the health inequalities that exist, development of a workforce to deliver competently to Maori, Pacific and other communities with health disparities is a priority that will require ongoing special training and cultural responsiveness. Once the make-up of the workforce reflects that of the community the need for this will diminish but will still be required. Clearly we need to consider different ways of delivering services in order to impact on health disparities. The future vehicle for delivering much of this care will be through PHOs and primary health care teams that focus on population health and not just individual care.

The Primary Health Care Strategy[4] emphasises health prevention and promotion, developing new ways of providing services, and working with non-health agencies. Ethnic mix, type and geographic distribution of primary care providers, will be important factors, which are likely to influence access to high quality primary health care. At the same time the workforce will need to be responsive to the changing needs of the population it serves. By addressing these factors it is more likely that we will see a positive impact on the health status of the people of Counties Manukau.

Issues that require consideration in developing the primary care workforce plan include:

1. Alignment with key high level health strategies – The New Zealand Health Strategy, The New Zealand Disability Strategy, The Maori Health Strategy (He Korowai Oranga), The Pacific Health & Disability Action Plan, and the Primary Health Care Strategy.
2. The recent and ongoing changes in the primary care sector including the establishment of PHOs.
3. Consistency with the health gain and service development priorities as identified in the Counties Manukau DHB Strategic Plan and Primary Health Care Plan.
4. Demographic patterns and changes, such as: a relatively young Maori and Pacific population compared to the aging European population; a large urban Maori population; the largest Pacific population in New Zealand; and an increasing number of Asian people.
5. Addressing the inequalities in health experienced by Maori, Pacific and, in particular, those who are socio-economically disadvantaged.
6. Maori and Pacific primary care workforce development issues.
7. A perceived shortfall in the existing general practitioner and primary health care nursing workforce in Counties Manukau.
8. National and international workforce trends, policies and initiatives.
9. Local, regional and national workforce training and education initiatives and policies including the work of the Health Workforce Advisory Committee (HWAC) and the DHB/DHBNZ Workforce Action Plan.

4 CONTEXT

4.1 Primary Health Care Strategy - Primary Health Organisations (PHOs)

DHBs are responsible for the implementation of the Primary Health Care Strategy. An important component of this strategy involves the establishment of Primary Health Organisations (PHOs). The strategy also states that in the future DHBs will be required to determine minimum standards for availability of primary care services.

The Primary Health Care Strategy[4] outlines six key directions for primary health care services. In future they will:

1. Work with local communities and enrolled populations;
2. Identify and remove health inequalities;
3. Offer access to comprehensive services to improve, maintain and restore people's health;
4. Co-ordinate care across service areas;
5. Develop the primary health care workforce; and
6. Continuously improve quality using good information.

Ideally primary health care in the 21st century will differ in the following ways:

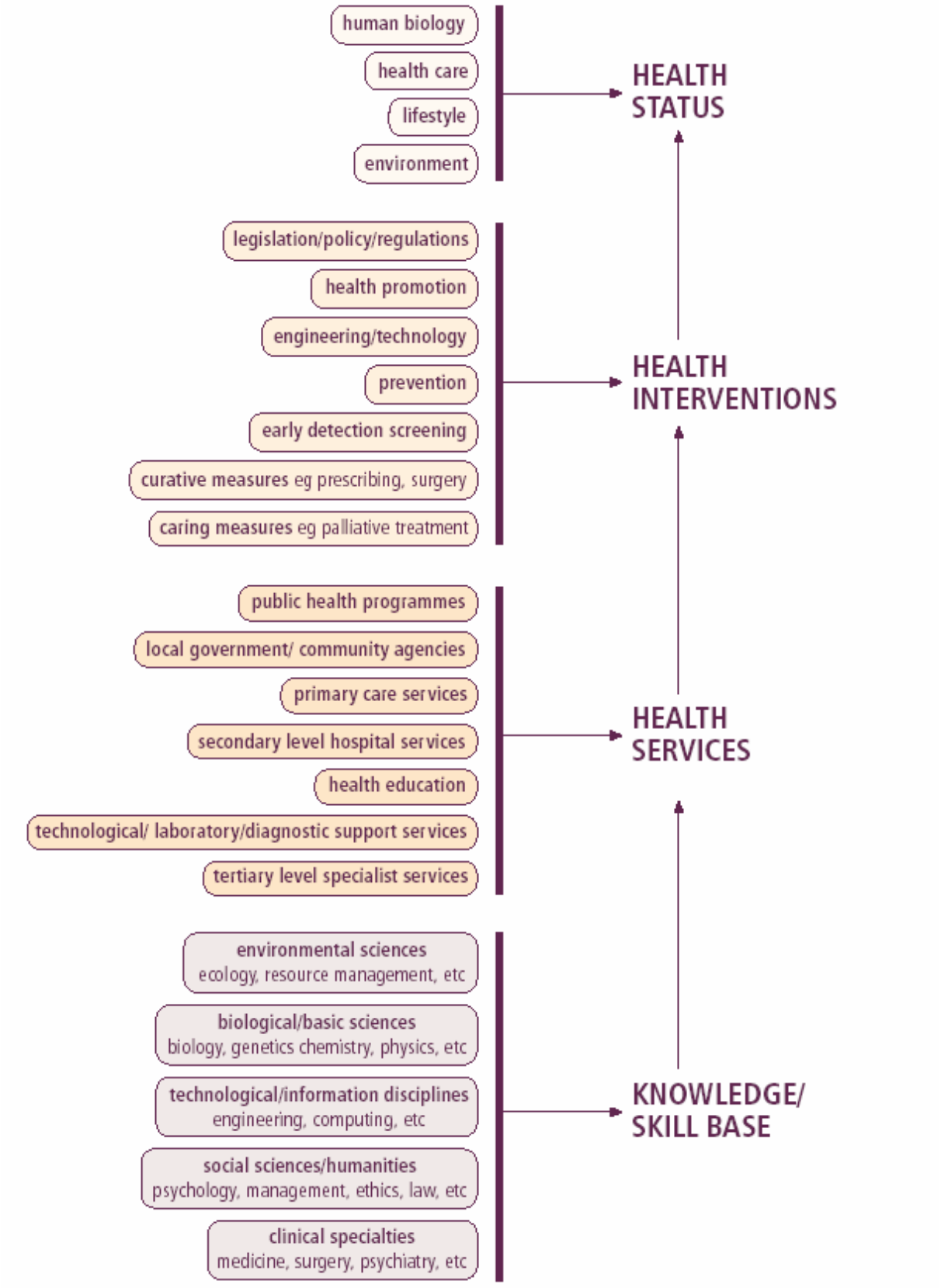
1. Be responsible for the health of populations as well as individuals
2. Be community rather than provider focused
3. Undergo a shift with more emphasis on health promotion and disease prevention than is seen currently
4. Consist of primary care teams
5. Be culturally competent

6. Consider the wider determinants of health and establish links with other health and non-health agencies
7. Reduce inequalities in health
8. Provide greater integration within the health sector as well as other sectors (housing, education, employment, local government, and NGOs).

The various health strategies have a strong emphasis on population health and a multi-disciplinary approach. This will require a reorientation in the delivery of primary care services, which have been traditionally focused on personal services directed at individuals, to one that that includes a range of activities that considers health from a population perspective. To do this a different set of skills will need to be developed within the primary care workforce of the future. For example, a workforce that understands the broader determinants of health will be necessary if we are to see a reduction in health inequalities. This workforce will need to be able to work not only within the primary care sector but also across sectors using a variety of strategies (see **Figure 1** below).

Figure 1: The determinants of health.

Source: The Health Workforce Advisory Committee. The New Zealand Health Workforce. Framing future directions. Discussion document. October 2002[5]



4.2 He Korowai Oranga (Maori Health Strategy) [6]

This document highlights the government's recognition of the principles of the Treaty of Waitangi. The strategy emphasises a need for accessible and culturally appropriate services for Maori. This will require a trained Maori workforce including Maori managers, community workers and traditional Maori healers as well as Maori clinical staff. It will also be essential that consideration be given to the broader socio-economic determinants of health experienced by Maori and the necessary skills to influence these factors. The strategy also recognises the need to ensure a more effective mainstream service delivery.

4.3 Pacific Health and Disability Action Plan

This plan recognizes the lack of Pacific people in health occupations nationally[7] and undoubtedly also in Counties Manukau. Workforce development therefore is identified as a priority area in the Pacific health and disability action plan.[8] This plan outlines a number of objectives including:

1 Develop a Pacific workforce plan
2 Mainstream to support the development of a Pacific health workforce
3 Address mental health workforce issues
4 Develop the necessary workforce to support Pacific PHOs.

4.4 Health Workforce Advisory Committee & DHBNZ Workforce Action Plan

Health Workforce Advisory Committee (HWAC) has organised its work in the following seven key areas[9]:

1 Health workforce implications of the Primary Health Care Strategy;
2 The development of healthy workplace environments;
3 The evolution and further development of health workforce education;
4 Maori health workforce development;
5 Pacific health workforce development;
6 The evolution and development of the health and support workforce to better meet the needs of disabled people; and
7 Research & Evaluation

HWAC has developed an overall goal:

"*To recruit, train, employ and retain a health and disability workforce appropriate to meet the diverse needs of all New Zealanders in the short, medium and long term*";

and priorities for each of the seven areas above.

HWAC suggested the following key recommendations for early implementation, impacting DHBs that are relevant to this plan:

1 DHBs should include primary health care workforce in their workforce development plans by June 2005
2 DHBs include requirements for increasing the capacity of the Maori workforce in their workforce development plans for 2004/05
3 DHBs develop the capacity and capability of Pacific providers and their Pacific health workforce.

Generic issues highlighted by the committee, also affecting Primary Health Care, include the need to address:

1 Staff recruitment;
2 Staff retention;
3 Up-skilling and training; and
4 Promotion of a culture of learning.

The DHB/DHBNZ Workforce Action Plan referred to earlier[2], focuses on three key areas:

1 Development of workforce information;
2 Co-ordinated stakeholder relationships including:
    - Defining key stakeholder roles and responsibilities
    - Industrial relations
    - Education
3 Selected priority initiatives to build strategic workforce capability in the sector, including:
    - Maori Workforce Development
    - Pacific Workforce Development
    - Workforce Development Toolkit
    - Healthy work environments
    - Primary Health Care Workforce
    - Leadership Development
    - Industrial relations

5 METHODOLOGY IN DEVELOPING THIS DOCUMENT

CMDHB's Primary Health Care Plan emphasises the need for development of the Primary Health Care Team (PHCT) in order to achieve our vision of improved health status for all. Through its planning processes CMDHB decided to focus on four key areas as needing our initial attention: General Practitioner workforce; Primary Health Care Nursing workforce; Pharmacy issues; and Community Health Worker issues. Overarching all of these are the issues impacting on the Primary Health Care Team (PHCT). The Executive Management Team (EMT) endorsed this approach, as did the DHB's Workforce Development Committee. The decision to focus on these areas was endorsed by the PHO Workforce Development Group, a sub-committee formed by the DHB's PHO Group (GPHO). To be consistent with the recommendation in DHB/DHBNZ Workforce Action Plan it was decided, where possible, to limit objectives for each of these key areas to three or less, so that attention could be focused on action over the short to medium term to deliver on these top priority objectives.

5.1 PHO Workforce Development Group

Counties Manukau DHB engages the primary sector through the PHO Group, GPHO. GPHO formed a working party to consider Primary Health Care workforce matters called the PHO Workforce Development Group (see Appendix C for participants). The following groups were represented on this working party:

- Community Health Workers
- General Practitioners
- Intermediary Care & Allied Health
- Pharmacy
- PHO management

- Practice Nurses
- Primary Health Care Nursing Sector Reference Group

With the exception of the pharmacist representative all participants came from PHOs or their providers. This working party had a series of workshops and through brainstorming and further prioritisation identified the recommendations listed in this document.

The agreed focus, as outlined above, was on: General Practice; primary health care nursing; role of pharmacists; Community Health Workers; and the Primary Health Care Team. Minutes of the meetings and documents were also circulated to GPHO.

5.2 CMDHB Workforce Development Committee

The body within CMDHB that is responsible for coordinating the workforce development activity is the Workforce Development Committee, which is a sub-committee of the Executive Management Team (EMT) and Clinical Board. It oversees the development of the various workforce plans to ensure consistency and alignment. For membership of this committee refer to Appendix C. This alignment is particularly important given the development of separate workforce plans for Primary Health Care, Maori Health and Pacific Health.

This draft plan will be submitted to the CMDHB's Workforce Development Committee for further input and development and also be amended to reflect feedback from GPHO before being forwarded to CMDHB's board for approval.

6 SCOPE

The scope of this workforce plan will:

1. Be limited to the primary care workforce within Counties Manukau health district, but where feasible will link with regional and national work in this area.
2. Will address general primary care workforce requirements and will need to link to the Maori Health and Pacific Health Workforce Plans which consider the specific primary care workforce needs for Maori and Pacific people.
3. Concentrate on the general practice workforce in the first instance, with limited consideration given to other primary care workers[*]. This broader workforce will be considered in the second phase of the workforce plan as further work is required. Further work is required to analyse the wider primary health care workforce and future needs due to the lack of information about these providers. (HWAC, for example, could not find accurate data sources detailing the number and/or ethnicity profile of many of the non-general practice providers.) This plan (phase one) addresses urgent issues for the general practice workforce that we already know are priorities and commencing action on these should not be delayed while scoping further work.

Future work required in phase two of the plan's development will include:

1. A detailed stocktake of numbers and distribution of practitioners and some analysis of likely future requirements in terms of number of practitioners per thousand head of

[*] Pharmacists, primary care nurses (other than practice nurses), dentists, midwives, physiotherapists, chiropractors, community health workers, health promoters, traditional healers, dietitians, osteopaths, podiatrists, psychologists and so on

population. Currently some roles e.g. Community Health Workers are so new that it is difficult to determine the ideal ratios. Further work is needed with international comparison adjusted for the composition of our population.

2 Out of this work will come a clearer picture to make recommendations on the workforce requirements, such as the number, type and distribution of practitioners within the district (whereas phase one of this plan has concentrated on areas we know we currently lack key workforce).

3 It is likely that the primary care environment will need specific managerial, administrative and public health competencies to implement the primary health care strategy. Therefore, these competencies should be included for consideration in phase two of the workforce plan.

4 Even phase two of this plan will not include national training issues. For example, the workforce plan will not include issues relating to the basic and postgraduate training programmes for doctors, nurses or other health workers. However, where national training issues arise they will be noted for further consideration and input into the appropriate national process. Where the DHB can contribute to local training needs these should be included within the scope of the plan. For example, CMDHB may be in a position to facilitate and/or fund training for disease coding, or assist in Maori workforce development programmes. The DHB will also seek to influence training and curriculum issues through DHBNZ and other national forums and where possible with local education institutes [e.g. Manukau Institute of Technology (MIT), and University of Auckland].

While the agreed focus and priorities, as outlined above, were: general practice; primary health care nursing; role of pharmacists; community health workers (CHWs); and the Primary Health Care Team (PHCT). It is acknowledged that there are other areas that will also need action in time. These will be addressed with the ongoing work in developing phase two of CMDHB's Primary Health Care Workforce Plan, which, in addition to looking at education and curriculum development along with the national issues, will need to also consider the development of the other areas listed below:

- Health Promotion, community nutrition, dietetics and exercise (to be addressed with a working party as part of the Diabetes Strategy);
- Mental Health in Primary Care;
- Management and leadership in the primary health sector;
- Allied Health and Intermediary Care;
- Health of the Older Person (HOP) and linkage to Disability Support Services;
- Rural Health - the focus for which has been GP workforce retention and integrating HOP and Intermediary Care in the Franklin district. This pilot could lead to widespread change in configuration of these services across Counties Manukau.

7 KEY ISSUES

7.1 Future trends

It is well recognised internationally that not only is the population structure aging in developed countries, creating greater health need and demand, but also the health workforce is aging and generally for nurses and doctors this is of significant concern internationally.

Added to this is the burden of chronic disease, which quite aside from the aging effects contributing to greater illness, is contributed to by multiple lifestyle issues such as the burgeoning obesity epidemic in the population from nutritional excess and lack of exercise. This will lead to greater diabetes and cardiovascular risk, end stage renal failure, etc leading to a greater burden on the health system from chronic diseases. The role of public health may have a greater impact here than health care provided to individuals, hence why the six key directions for primary health care, as outlined above, are so important[4].

Responding to this increased burden of disease is the global trend toward developing the Nurse Practitioner role and other primary care nurse specialists' roles within primary care to deliver structured collaborative care such as chronic disease management programmes. In CMDHB we already have a well developed programme and model of care that will form the basis for ongoing development in the sector. This may mean that there need not be such a reliance, in future on general practitioner workforce as many of the tasks undertaken by GPs can be substituted by Nurse Practitioners. On the other hand GPs may up-skill and become more specialised leading to accreditation for procedures previously carried out by consultants. Actually delivering on this potential for freeing up doctor time has yet to be demonstrated and will need to be carefully managed. Similarly one needs to be cognisant of the need to substitute nursing tasks with less skilled health care assistants or nurse auxiliaries in order to free the nursing time needed to both train and work as a Nurse Practitioner.

Consumers will have a greater say in the running of their local health services in the future. This should result in a significant change to patient centred care from our current system, which often focuses around the needs of the providers. Provision of extended hours care will be the norm. For this and other reasons of economies of scale one would expect to see health providers coalescing in larger community health centres and one stop shops. These clinics will have multiple health providers from many disciplines depending on the needs and wants of the local community. Further more they will reflect the community in which they operate in terms of workforce and also family friendliness. Acute care will be provided on the same day where requested and systems will support active follow up of patients to ensure they are seen when they should be. But equally, the system will meet the ongoing needs of those with enduring illness and chronic conditions. Case management shall be commonplace for those with high health needs or chronic illness and information will be routinely available to ensure that patients get the care and social support they are entitled to.

Future trends in information management and access may see the health professionals of the future become information brokers to help interpret information for well-informed clients. Certainly there will be a shift towards greater self responsibility and self management as part of structured care and techniques like motivational interviewing and behaviour modification will be important in getting consumers to maximising their health. The ability for virtual consultations and telemedicine will provide some solutions for more remote practices and potentially change the face-to-face consultation, as we currently know it.

7.2 Recruitment, Training and Retention

In order to attract workforce to the primary sector in Counties Manukau, CMDHB should be actively marketing its unique features of having developed strong collaborative relationships with its PHC providers. The tradition of innovation in integrated care initiatives and also being the first DHB to implement PHOs has given the DHB a good head start in this respect. The DHB is proud of the quality and culture of its primary providers who have a history of engagement and partnering with secondary care to address the continuum of care across the primary/secondary interface. This development has resulted in the DHB in heavily investing new funding into primary care over and above that contributed by central government as tagged for implementing the PHC Strategy. In addition to PHOs and capitated funding streams most of this investment has occurred via the various integrated care initiatives including Chronic Care Management/FAMA and POAC.

Training, recruitment and retention are generic issues for the primary health care workforce across whatever discipline or professional group. HWAC identified retention of practitioners as a national issue. It will be important to determine the factors that may impact negatively on the DHBs ability to maintain an adequate primary care workforce in the future and to mitigate against these factors. Some of these are considered in the recommendations below.

Globally there is a shortage of doctors especially primary care physicians or general practitioners. We face stiff competition from Australia, the United Kingdom and the international recruitment of our medical graduates. Likewise nurses are paid more, and are keenly sort overseas. Furthermore, the impact of pay equity settlements in the secondary sector is likely to further erode the parity between the two sectors making it harder to recruit and retain primary care nurses. CMDHB will need to compete within the local market to attract health practitioners and needs to decide whether to market the area internationally as well. If the latter will, we compete on price or try and attract practitioners from under-developed countries where they are needed possibly more than in New Zealand? If we are to recruit from the local workforce then we need to consider what additional advantages can be offered to attract practitioners to Counties-Manukau. It is likely that both strategies will need to be employed in the short-medium term to attract quality workforce from elsewhere in NZ and off shore.

There is a need for input at undergraduate level to influence medical & nursing graduates to choose a career in primary health care. Similarly more can be done across the board for new graduates to be oriented toward primary care: e.g. rotation of new nurse graduates on general practice placements; consideration of RMO runs in general practice. A consistent framework and agreed standards are needed for Community Health Worker training. The future role of the health care assistant and training for personal carers also needs to be developed. Finally there needs to be a better system to support existing workers to train and up-skill including providing relief to free up time for study and continuing education, as well as on the job training.

Factors that contribute to the trend for new graduates not wanting to enter primary health care include:

- large student loan debt
- better salaries and opportunities off-shore

- higher salaries and shorter working hours for RMOs
- a widening gap between specialist and GP income
- lifestyle and family factors

7.3 Quality Improvement

Workforce development is a key component of quality improvement and hence many of the key performance indicators (KPIs) in this year's CMDHB's Quality Improvement Action Plan relate to the primary care and impact on its workforce. In addition to the routine professional development that occurs day-to-day there is a need to develop a culture of learning and quality improvement. CMDHB's Quality Improvement Action Plan is designed to assist with development of this culture and lead to improved health outcomes as a result of improving the standard of delivery of health services. Development of this culture and the emerging model of care is greatly assisted by roll-out of CMDHB's Chronic Care Management (CCM) programme across the district. CCM provides evidence based structured care with electronic decision support in order to make a significant impact on health status but is dependent on sufficient workforce capacity to implement the programme particularly in nursing.

The clinical governance infrastructure of PHOs will need to be strengthened with the advent of the Referred Services Management and Clinical Performance Indictor framework. It is likely that further development of clinical governance infrastructure will be necessary with the development of utilisation review and feedback and a move to performance incentives. PHOs that are well organised and provide strong support in this area are more likely to be able to pay for the workforce they want as we move to a system of payments for results.

Increasingly electronic decision support will assist health practitioners to 'do the right thing' such systems of support may offer not only the workforce a competitive advantage (more income) but also help market the services provided by PHOs.

Cultural competency training is essential to address health inequalities and provide a patient's perspective to healthcare delivery. Proper communication skills will be increasingly important as the system incentivises better outcomes.

7.4 General Practitioners

It is estimated that Counties Manaukau district is approximately 55 GPs under resourced compared to the national average[10]. With an estimated 247 full time equivalent GPs that gives us a GP to population ratio of 1:1600 which is below the average for New Zealand of 1:1200. The problem is compounded by the distribution of GPs within our district leaving some areas like Mangere, Manurewa and rural areas severely under-doctored.

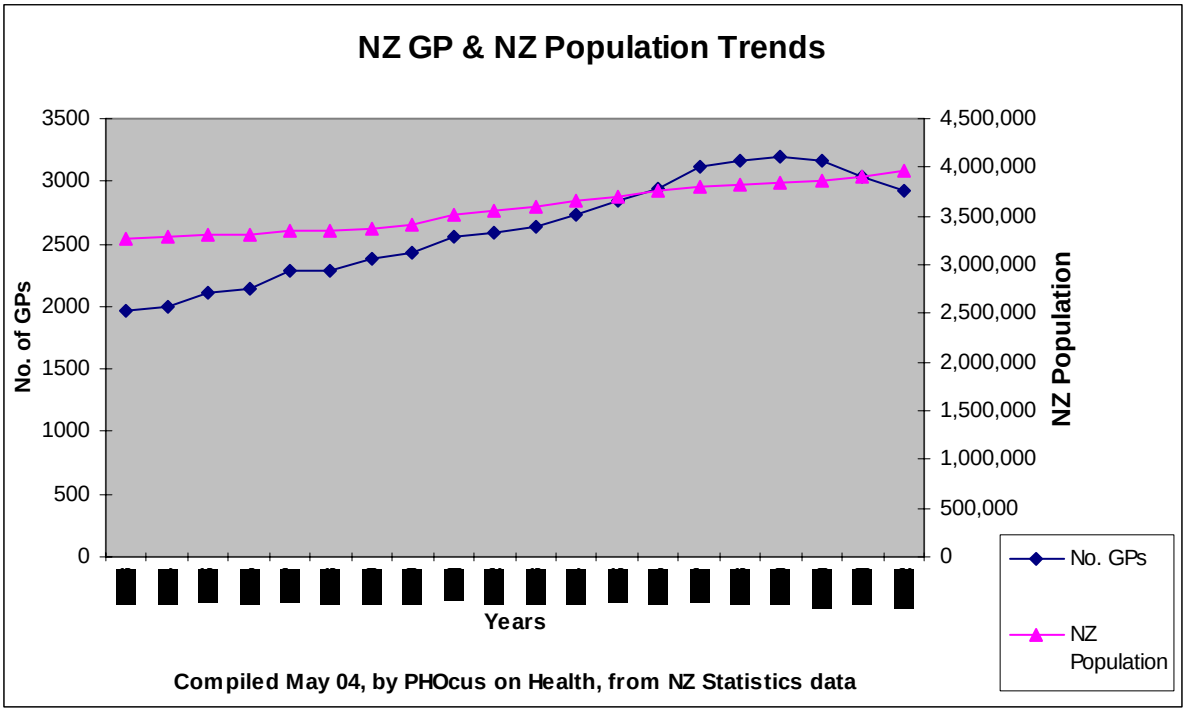
It is recognised that with the advent of capitation and the changing roles in the health system of the future that GPs may be supported by the Primary Health Care Team to provide care to a larger group of individuals. However, despite this, given the aging of the existing GP workforce and the reluctance of new graduates to enter general practice we are facing a crisis that is now starting to impact in urban areas as well as the longstanding problems we have had in the rural areas. Many younger doctors taking up

a career in the primary sector express a desire to be salaried rather than own their practice. Another factor is the reducing number of FTEs due to increasing proportion of female GPs, many of whom work part time. An NZHIS database demonstrates that over the past 5 years there has been the net loss of 5 FTE GPs from CMDHB's district; during that time there has been a growth in 50 Community Nurses, and significant growth in the population. This data is consistent with the Medical Council and Ministry of Health Nursing survey presented below (see **Figures 3 & 5**).

The graph below (**Figure 2**), compiled by PHOcus on Health, illustrates how GP numbers have been steadily dropping against population trends since the year 2000. Previously GP numbers had increased nationally greater than the population. We know that not to be the case in Counties Manukau. This just reinforces what is stated. A survey of medical students showed in 1998 >50% of medical graduates chose to do medical practice whereas last year <16% indicated a desire to work in general practice. A majority of those trainees completing the GP Vocational Training Programme indicate a wish to be salaried[11].

Figure 2: GP numbers relating to Population

Compiled from Statistics New Zealand data by PHOcus on Health Ltd



The Medical Council of New Zealand (MCNZ) Survey (2001)[12] showed that overall there had been a 25% increase in the number of registered medical practitioners describing themselves as GPs over the preceding ten years. However, of concern, was a net 4% reduction in the year the survey was conducted (2001) compared with the year prior. Also of concern was the reduction over three years of doctors in vocational training for general practice in 1999 these made up 50% of overall trainees whereas in 2001 this had reduced to only 34%. Females made up 38% of the GP workforce compared to only 24% ten years earlier and 13% a decade prior to that. Women on average worked 0.8 of an FTE compared to men working 1.2 FTE. Thirty-eight percent of the GP workforce in Counties-Manukau graduated from a foreign university.

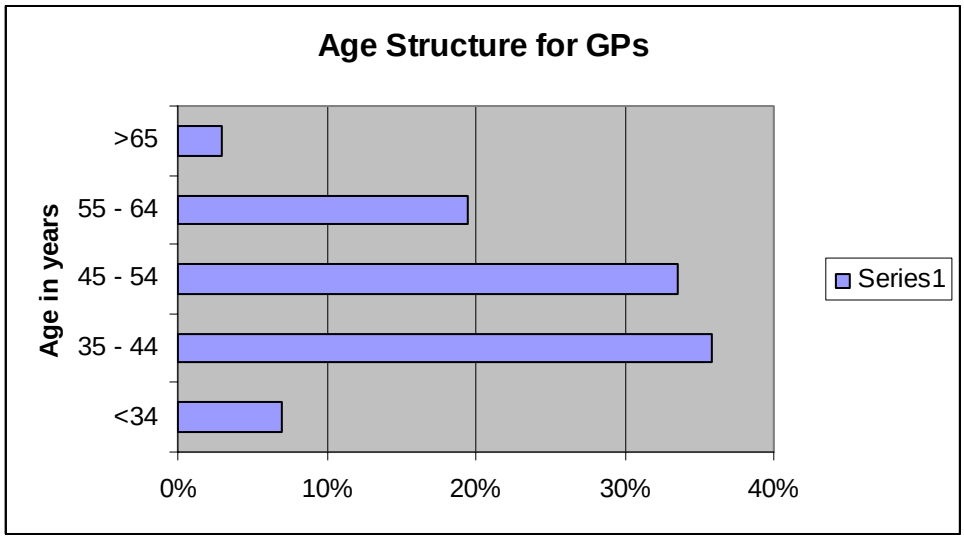
Figure 3: Active GPs working in Counties Manukau
Source: Medical Council of New Zealand

Active General Practitioners in the Counties Manukau DHB region by TLA and Year, 1998-2002

	1998	1999	2000	2001	2002
Manukau TLA	196	192	193	179	195
Papakura TLA	34	36	34	27	31
Franklin TLA	31	36	35	33	29
Total CMDHB	**261**	**264**	**262**	**239**	**255**

Unfortunately the age structure of CMDHB GPs cannot be ascertained from the MCNZ survey. However the average age of GPs in the country is 45 years for men and 39 years for women. The graphic below (*Figure four*) is derived from data from the RNZCGP Membership Survey (2003) [13] of 268 GPs chosen at random throughout the country. Females were over represented in respondents which may skew the age structure slightly toward the younger end.

Figure 4: Age Structure for GPs
Source: RNZCGP Membership Survey (2003) [13]



Local anecdotal knowledge would indicate that the Counties Manukau GP workforce is significantly older than this national sample but this cannot be confirmed until the stocktake of community workforce is completed.

The NZMC Survey data confirmed the 1:1600 GP:population ratio which apart from West Coast was the fewest number of GPs per head of population of any DHB in the country. Neither the MCNZ, New Zealand Medical Association, Independent Practitioner's Association Council nor the Ministry of Health, have a position statement on recommended or expected, GP to patient ratios. Coster and Gribben (1999)[14] demonstrated that utilisation rates in 1986-7 varied from 5.5 visits per year in Auckland, where the GP:population ratio was 1:1,353, to 3.0 visits per year in Invercargill where the ratio was 1:2,472. This trend was consistent with data obtained in 1979 indicating a higher pattern of utilisation in relatively "over-doctored" areas. They concluded that

given utilisation appears to be supply driven it is difficult to conclude what the correct ratio of GPs to population is.

The DHB continues to use the 1:1400 ratio determined by the Health Funding Authority for the purpose of issuing new Section 88 (then Section 51[15]) notices. These notices entitle doctors to claim public subsidies on behalf of their patients, however, with the advent of PHOs and capitated funding the DHB no longer controls doctors wanting to set up in practice provided that any prospective doctor has a contract for service with a PHO. Thus it is a PHO's responsibility to ensure that there is sufficient workforce to meet the needs of its enrolled population as it has the power to influence the distribution of the medical and nursing workforce.

The following summary contained in Appendix 3 of the RNZCGP Membership Survey (pg. 31)[13] is a useful list of factors to take into account when considering the 'ideal' GP to patient ratio (each of these points are referenced in the original document):

- "increasing demand for consultations with GPs due to, for example, the aging New Zealand population, the increasing prevalence of chronic diseases such as diabetes and the increasing devolution of hospital-based care to GPs
- increasing number of GPs working part-time because, for example, they prefer to have flexible working arrangements, or they are entering academic, management and non-clinical roles
- increasing number of GPs entering subspecialties and the expansion of general practitioners' roles into secondary care
- lack of GPs in rural and more deprived urban areas
- perception of comparatively low incomes in general practice compounded by student debt may be leading to avoidance of general practice as a career choice
- possibility that GPs might leave the profession due to, for example, stress, low morale, heavy workloads, concerns about litigation, and increasing compliance tasks and costs
- increasing number of women entering general practice (many of whom work part-time because of childcare commitments
- primary health care strategy's priorities (particularly in relation to removing health inequalities in Maori, Pacific, and lower socio-economic populations) and the additional time required for GPs to provide good quality patient services in the 'PHO environment'."

An additional factor to consider is the changing role of nursing and the emergence of the Nurse Practitioner role discussed in the section on PHC Nurses below.

Other issues identified by the RNZCGP Membership Survey were that:

- 72% of respondents indicated that aspects of their current working conditions were particularly stressful
- one third attributed the main stressor as administrative paperwork.

Interestingly over one third of respondents had no practice manager. It was unknown whether other people in these practices performed practice management tasks but it is interesting to surmise whether or not this contributed to the poor morale and perceived compliance burden noted by Dowell et al (2002)[16]. Only 27% of respondents intended to be working solely as full-time self-employed GPs in 2008. This was half of the existing full-time self-employed GPs at that time. Over one third indicated that personal annual income could influence their workforce intentions. It was poignant to note the following quote from one respondent:

> "*I know 'quality of practice' is important but if we are not able to survive economically this will not be an issue!*"[13]

7.5 PHC Nurses

Primary Care nursing has a lot to offer in acute and chronic disease management. Especially in structured care environments where it has been demonstrated that use of nurses results in better outcomes, better patient satisfaction with patients understanding more about their condition[17]. One of the barriers to implementation of new initiatives in primary care has been the lack of availability of practice nurses. The DHB's Chronic Care Management programme is consistent with the move to performance based incentives and structured care. However, a key barrier to successful implementation of this programme is nursing capacity within primary care. While there has been considerably increased funding provided to the primary sector this is yet to be reflected in investment in staff at a practice level. In time the increased funding will filter down to better wages and conditions for nurses as well as recruitment of more staff. The main barrier then will be availability of nurse graduates and appropriate training courses at post-graduated level.

The other key risk is the pay equity settlement in the public sector which may see nurses in primary care disadvantaged compared to their hospital colleagues and add to the competitive lure of the secondary sector. Further work needs to be done to investigate the extent to which current funding streams and employment models are a barrier to better utilisation of teamwork.

Counties Manukau DHB was successful in securing $750,000 funding, over three years, from the Ministry of Health for Primary Health Care Nursing Innovations[18]. A key part of this funding is to develop the role of the primary care nurse and promote uptake of the Nurse Practitioner career pathway. The funding is also providing for the appointments of a Maori and a Pacific nurse to lead nursing developments in these areas and take a proactive approach to the nursing needs of the entire sector for Maori Health and Pacific Health. A role of Primary Health Care Nurse Leader will be appointed to assist the Director of Nursing with implementation of the innovations initiatives and link to Auckland University and MIT. This role is to take a proactive approach with curriculum development for post-graduate Primary Health Care Nurses and the assist nurses with the career pathway to Nurse Specialist and Nurse Practitioner status.

The DHB is also promoting new graduates to take up a career in primary care by offering positions in its Nurse Graduate Programme based in general practice. This year, ten nurses are sought to participate in this programme with the cost of their salary being met by he DHB and not by the primary providers concerned.

The information below gives the latest figures for nurses working in the primary sector in the Counties Manukau district. These may be community based nurses such as district nurses or public health nurses as well as practice nurses. At least this number is growing, unlike the number of GPs. A better picture of the make up of the primary healthcare nursing workforce is gained from the recently published survey, commissioned by the Ministry of Health in 2001[19]. (**Figures 8 & 9**)

Figure 5: Reg. Nurses working in PHC in Counties Manukau
Source: Nursing Council of New Zealand

Active registered nurses and midwives working in primary health care (including practice nursing) in the Counties Manukau DHB region by TLA and Year, 2000-2003

	2000	2001	2002	2003
Manukau TLA	163	162	195	201
Papakura TLA	30	37	31	35
Franklin TLA	28	29	28	33
Total CMDHB	**221**	**228**	**254**	**269**

Figure 6: Potential PHC Midwives in Counties-Manukau
Source: Nursing Council of New Zealand

Active nurses with midwifery qualifications working in primary health care (including practice nursing) in the Counties Manukau DHB region by TLA and Year, 2000-2003

	2000	2001	2002	2003
Manukau TLA	16	14	17	18
Papakura TLA	3	3	2	2
Franklin TLA	3	1	3	1
Total CMDHB	**22**	**18**	**22**	**21**

Nurses in this group are classified as midwives because of their qualifications, they need not be working as a midwife to be included. Nurses with midwifery qualifications are also included in the Registered Nurses and Midwives data.

Figure 7: Enrolled Nurses working in PHC in Counties Manukau
Source: Nursing Council of New Zealand

Active enrolled nurses working in primary health care (including practice nursing) in the Counties Manukau DHB region by TLA and Year, 2000-2003

	2000	2001	2002	2003
Manukau TLA	1	3	1	3
Papakura TLA	1	1	1	1
Franklin TLA	0	0	0	0
Total CMDHB	**2**	**4**	**2**	**4**

Figures 8 & 9 also demonstrate that general practice is the biggest employer of community based nurses. The majority of such nurses are not surprisingly Practice Nurses making up 23% of the workforce. Somewhat surprisingly, the second largest

group are school based nurses, followed by Plunket Nurses, with District Nurses and then Public Health Nurses trailing behind.

Figure 8: Work type of activity – PHC & Community Nurses in CMDHB district, 2001 *Source: MoH survey*[12].

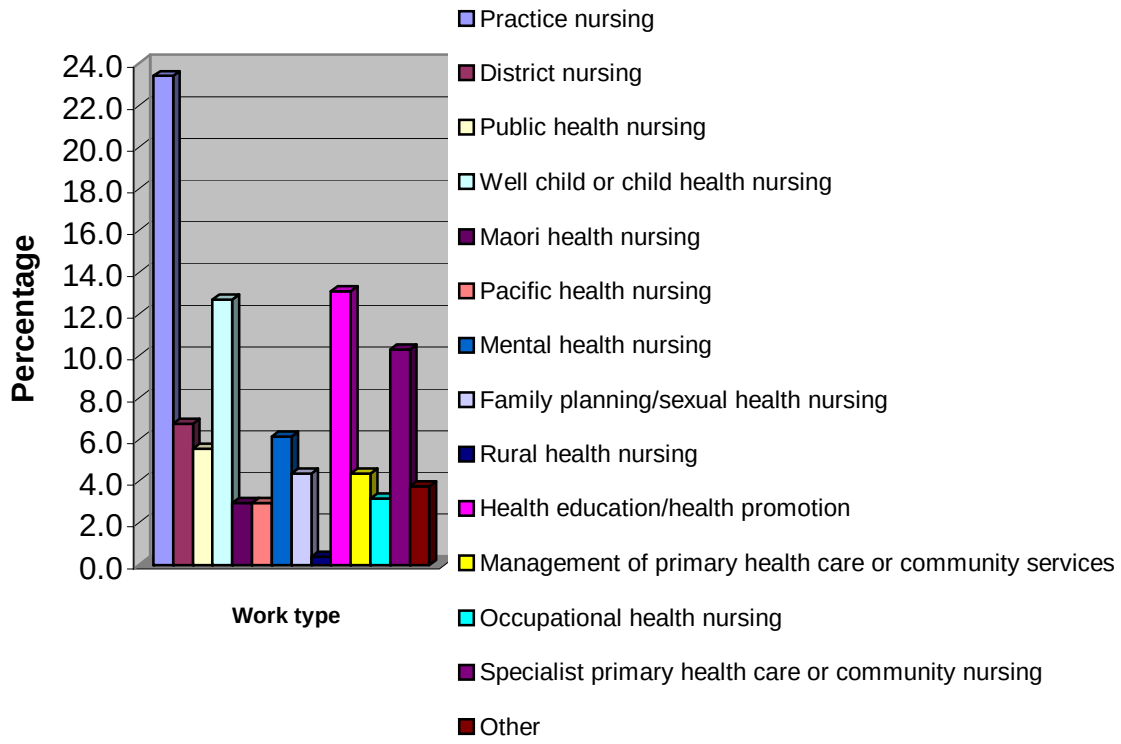
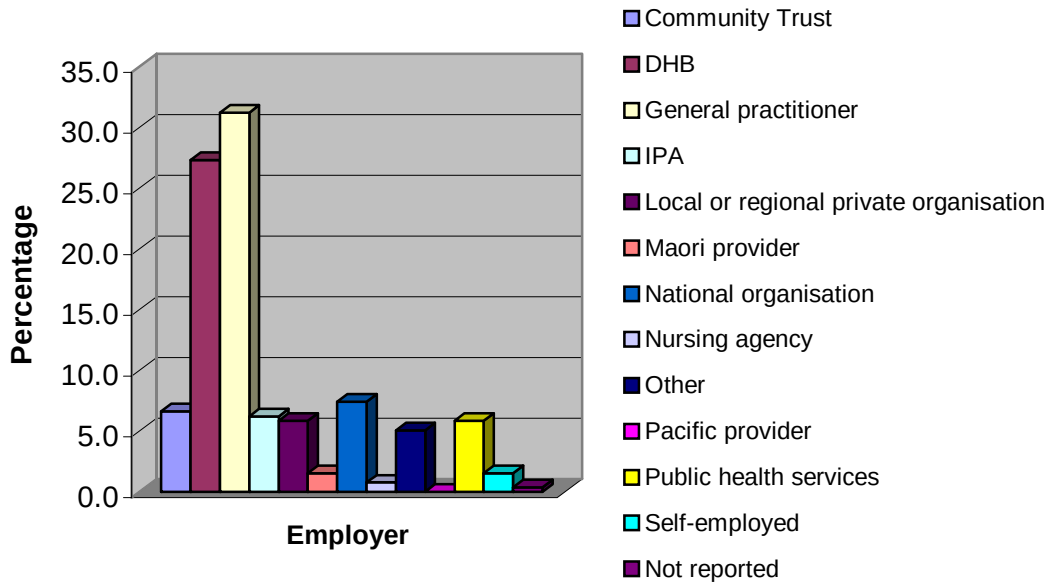


Figure 9: Employer of active PHC and Community Nurses in the CMDHB district, 2001 *Source: MoH survey*[12].



A wide and challenging variety of care settings are available for nurses to work in:

Figure 10: Service delivery settings for active PHC and Community Nurses in CMDHB district, 2001
Source: MoH survey[12].

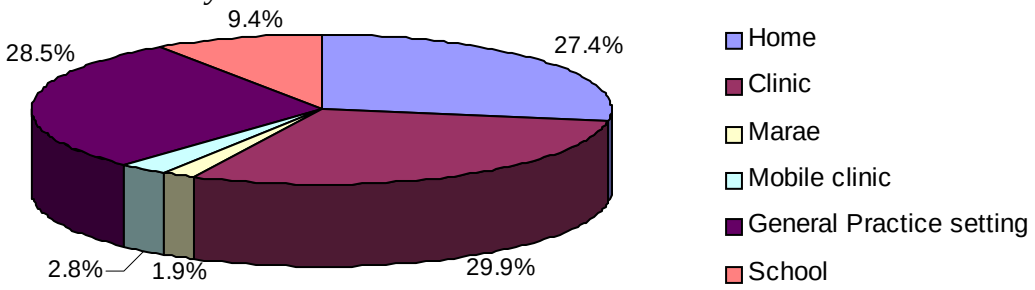
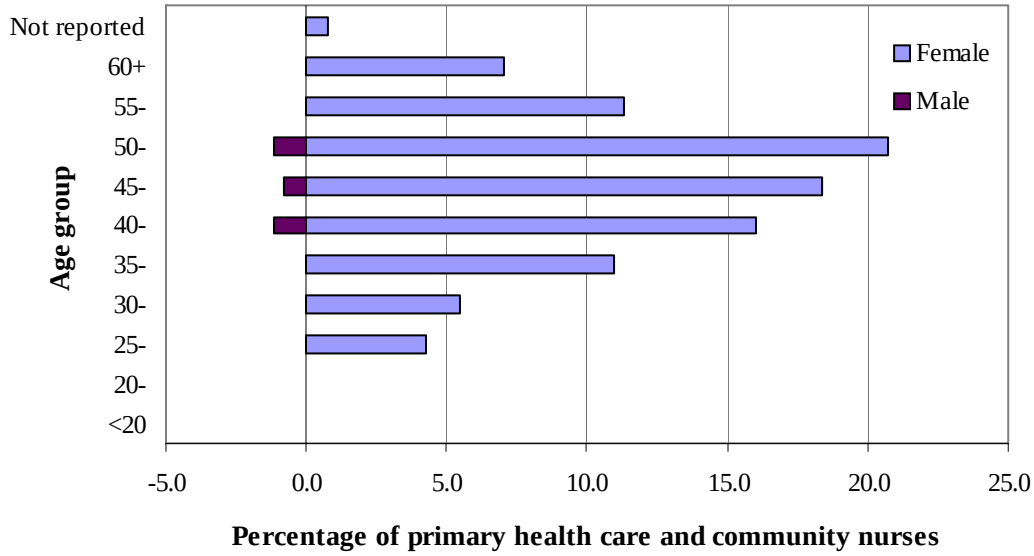
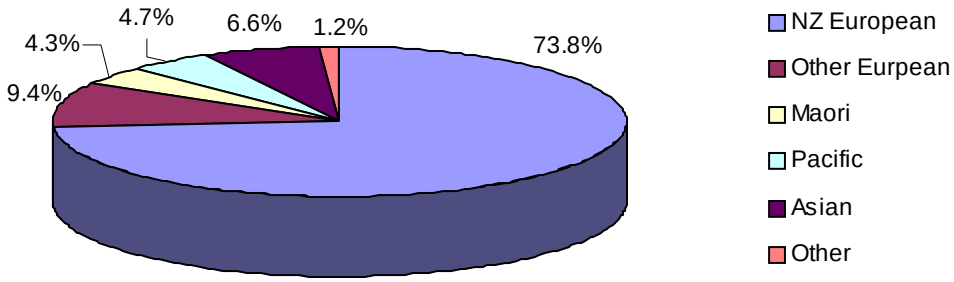


Figure 11: Age and sex distribution of active primary health care and community nurses working in CMDHB district, 2001.
Source: MoH survey[12].



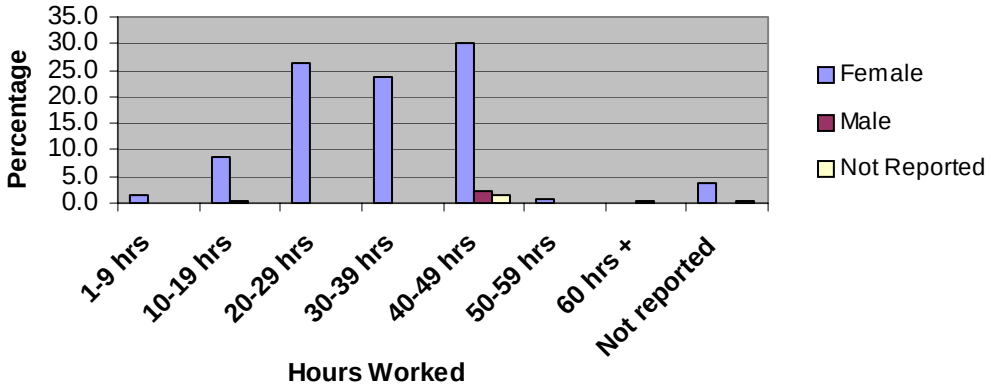
The above graph illustrates that the PHC nursing workforce is aging and recruitment of a younger workforce to primary care is urgently needed, even more so than for the medical workforce. There is also the need to build the Maori, Pacific and Asian workforce in nursing for this sector to match the makeup of the community:

Figure 11: Ethnicity of PHC and Community Nurses in CMDHB district, 2001
Source: MoH survey[12].



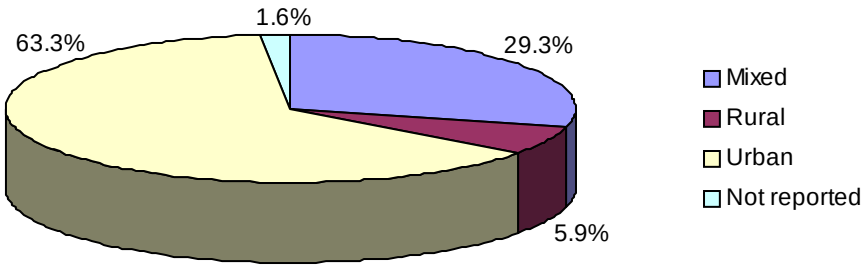
As for the medical workforce there is a large number (30%) of nurses who work overtime or more than an FTE. However, there is also a considerable number of part-time workers.

Figure 12: Hours worked by active PHC and Community Nurses in CMDHB district, 2001
Source: MoH survey[12]



Once can see from the graph below (**Figure 13**) that the rural sector does not get an equitable share of the workforce given that the population of Franklin District is approximately 40,000.

Figure 13: Urban/Rural split of active PHC and Community Nurses working in CMDHB district, 201
Source: MoH survey[12].



Finally, for the nursing graphics in this section, the following diagrams are designed to highlight educational issues. These are critical given the recognised need to up-skill the workforce and the move to competency based practising certificates from September under the HPCA Act. It would appear that very few PHC Nurses are studying toward a post-graduate qualification and hence Nurse Practitioner status may be out of the reach of many existing nurses. However, apart from perhaps financial considerations (25% GP employed vs. 19% all community nurses considered this was a barrier), the barriers to accessing education were no different between GP employed nurses and the total nurses employed in the primary sector.

Figure 14: Active PHC and Community Nurses currently studying toward a nursing qualification in CMDHB district, 2001
Source: MoH survey[12].

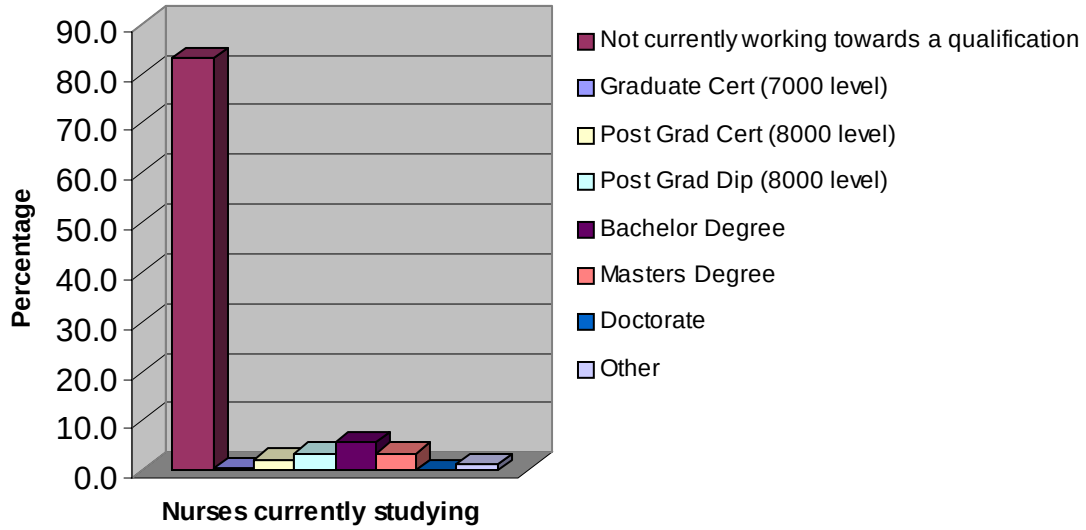
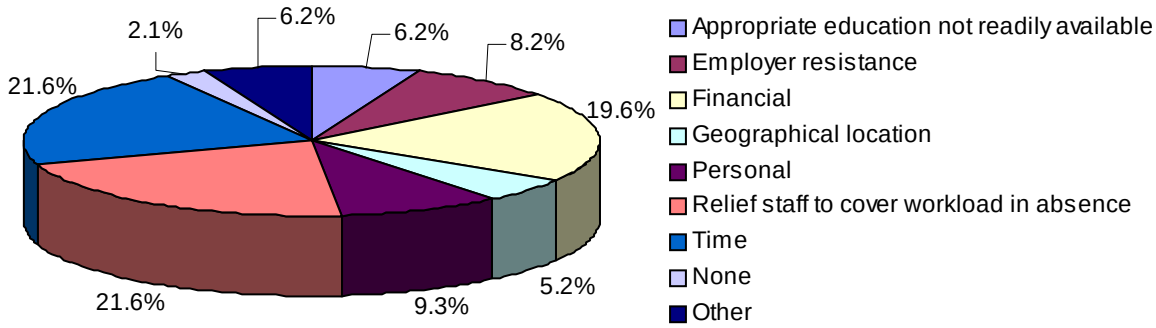


Figure 15: Barriers to accessing educational opportunities by active PHC and Community Nurses in CMDHB district (total), 2001.
Source: MoH survey[12].



It was interesting to note that availability of time was perceived as the biggest barrier and this was coupled with the availability of relief staff to fill-in. This is relevant to the recommendations made by the PHC Nursing Sector Reference Group to establish a central bureau to assist with a relieving roster for educational and other purposes. Having a pool of trained people available to relieve would significantly address this barrier and also enable better teamwork to occur the availability of relief staff would free up members for team meetings. This initiative could be selef funding.

Bronwyn Hedgecock (2003), Clinical Career Pathway Coordinator, undertook a survey of PHO nursing workforce last year[20], she summarises what is known about the Counties Manukau below:

- Primary health care and community nursing professions recruit and retain low numbers of Maori and Pacific peoples.
- Ageing primary health care nursing workforce
- Wairarapa, Counties Manukau & Waitemata District Health areas have significantly fewer primary health care and community nurses than the national average.
- Role fragmentation with a broad range of roles in 13 distinct work types
- Education al opportunities difficult to access due to lack of time, finance, and relief staff
- Clinical career pathways unavailable to over half the nurses who responded to the survey
- Management structure and/or leadership roles unavailable to many nurses
- Communication and collaboration nurses and employers could do more tin improve in these areas.

Further more she goes on to quote data provided by ProCare Health Ltd, "who conduct an annual survey of practice nurses, provide further insight. In 2002, half of the respondents (n=164) were employed part time (56%), had worked as a practice nurse for an average of 9.4 years and had been in their current role for an average of 5.6 years. Most of the respondents were registered general obstetric trained nurses (74%) with 13% holding other nursing qualifications, 1% with a master's degree and 13% currently engaged in study. Reasons for thinking about leaving practice nursing (31%) were reported as pay issues, lack of recognition, too much paper work. Attendance at meetings was reported as being less than twice a year by 55% of respondents".

Hedgecock made useful recommendations regarding up-skilling the existing practice nursing workforce and practical steps that the DHB could take to assist PHC nursing workforce development. Some of these have already been implemented and the rest are work in progress under the Primary Health Care Nurses Sector Reference Group including development of a Clinical Career Pathway for PHC nursing leading ultimately to Nurse Practitioner status.

Professor Bonnie Sibbald at the IPAC conference in Rotorua, in May 2004 gave a presentation on "Skill Mix in Primary Care"[17]. She highlighted the role changes that occur with the development of Nurse Practitioners as

- Enhancement of care
- Substitution of care
- Delegation of care

She presented an overview of the literature and concluded that nurses were highly competent and efficient in delivering components of primary health care but that there was negligible improvement in health gain for the patient, for enhancement of care to be cost effective. It is possible that better targeting of patients will result in greater health gain leading to greater cost effectiveness.

It has been recognised for many years that some nursing skills duplicate doctors' skills. Therefore, substitution of care is well established. When substituting care Prof. Sibbald concluded that structured care was better than unstructured care (Griffin & Kinmonth, Cochrane Database, 2000). However, it doesn't matter which health professional delivers structured care – as it is equally efficacious but more cost effective when delivered by a nurse. Structured nurse care was better than unstructured physician care. Using nurses helps to address the short supply of the medical workforce, results in the patient having a better understanding of their condition and also results in higher patient satisfaction.

Thus far 16 studies have failed to demonstrate a cost savings or reduction in GP time from this innovative care[21]. There was no difference in the quality of advice offered and no differences in most of the resources used including prescriptions and referrals (except investigations), but higher rates of recall, longer consultation times, and possibly higher hospitalisation. More investigations were ordered (labs & diagnostics, radiology etc).

It must be remembered that much of what general practice currently does is unstructured. This is not always bad, the structured care is certainly appropriate when dealing with chronic conditions but patients present with a wide range of issues and traditionally GPs have dealt with these as they arise even within routine consultations for chronic conditions. Hence, our model of care, while changing to allow nurse based clinics for people with chronic disease will need to allow enough flexibility for patients to get access to the right services to investigate and resolve other issues of concern and where appropriate, ensure correct diagnosis and management. We must not lose the holistic approach that primary health care currently espouses.

Delegation is where the doctor gives up doing something that is then performed by the nurse without supervision i.e. nurse skills duplicate doctor skills; Dr gives up doing what the nurse can do entirely. To prevent the nurses from getting overloaded it is important that the nurse also delegates to health care assistants/nursing auxiliaries. There is little evidence or studies covering the results of delegation. No studies have been done to investigate what doctors do with the time saved. The only published trial in this area by Laurant et al (BMJ 2004) – showed workload of doctors increased when nurse practitioners were added to the team[22], which implies that unless there is good strategic management to ensure that doctor time is reinvested wisely delegation may not free up time. Similar results apply to nurses and health care assistants or auxiliaries. It is likely that Nurse Practitioners will mostly develop in the New Zealand environment alongside GPs in PHC teams and this is preferable to independent or isolated practice but it will be essential that we manage implementation well to maximise the returns to the system and prevent duplication of workload and more complex team interactions.

In summary nurses enhance the quality of physician/general practice care. Substitution does not appear to reduce costs nor reduce GP workload. Careful management is required to ensure that efficiencies are realised and that coordination of care does not deteriorate. The challenge to health workers in Counties-Manukau will be to implement innovative approaches to substitution and delegation in such a way that we can maximise the efficiencies gained which may be possible if the process is well managed.

Added to the move to greater autonomy for nursing and the career pathway for Nurse Practitioner is the trend for more health care to be delivered in peoples homes. This is partly as a result of the aging population but also a general feature of a system more responsive to people's disability needs. This will be a challenge for all health practitioners including nurses and the evolving health care assistants and carers who will be needed to accommodate home-based care.

While there will always be a need for a 'generalist' (as opposed to a generic) PHC nurse in addition to PHC Nurse Specialists. Rationalisation between existing Practice Nurses and other community based nurses such as Public Health Nurses, District Nurses and even School-based Nurses needs to occur to lessen duplication and create closer collaboration with seamless care for the patient. Use of the Nurse Specialist/Nurse Consultant will be encouraged to optimise the expertise within the sector and assist with the Clinical Career Pathway. There will also be an evolving role of the nurse as a case manager especially for those with chronic illness or the frail elderly.

7.6 Community Health Workers

It has already been suggested that to provide effective healthcare the health workforce should reflect the community it is working in. The Community Health Worker (CHW) has a particular role to play here. Not only are Maori and Pacific workers more likely to be available for employment as CHWs but this may form lead to a career pathway towards to be a further health qualification as an adult student (e.g. Healthcare Assistant or Registered Nurse).

The CHW role is seen as a "generalist" role but that this should not prevent "specialisation" in different areas e.g. child health, sexual health etc. CHWs are usually a member of the local community where they work. They are more likely to relate to the service user and therefore communication is more effective. They have a significant part to play as interpreters (not for language alone) but to put medical jargon into simple language and also as "cultural interpreters" to ensure that the patient and practice staff are not talking past each other. A better informed patient will result in better adherence to treatment and better understanding of their condition will result in better outcomes. The CHW is a linking person between the practice and the community in which the health consumers live and is a valuable resource in their own right, as well as supporting other members of the PHC team to be more effective. This 'go-between between' function with other health providers and inter-sectoral agencies is pivotal to their role and also ensures that enrolled service users access services they are entitled to.

There is a strong recommendation for needing an NZQA accredited training framework. It was felt that each PHO should comply with minimum guidelines containing:

- Job Description.
- Clear reporting lines via Team leaders if relevant
- Processes for personal safety and debriefing
- Clear KPI's for CHW and the organisation
- Access to support e.g. Social worker / linking to other agencies.
- Training course to NZQA level 4 (to be completed over two years)

It is clear that enrolled nurses and other health care assistants require oversight by registered nurses but that there does not seem to be any legal requirement for CHWs to be supervised by RNs or clinical staff. There was no consensus as to who should administer the "framework" i.e. that CHWs should necessarily come under the auspices of the Nursing Council. The Public Health sector was thought to be another possibility.

It was the view of the PHO Workforce Development Group that eventually CHWs should seek to be "registered health professionals" and therefore, eventually, be recognised under the HPCA Act.

The core **competencies** of a CHW are considered to be:

- Ability to listen
- Good communication skills
- Wide life experiences
- Maturity / but need young CHWs to link to youth, in specific areas e.g. STD, teenage pregnancy, substance abuse etc.
- Need knowledge of how to access social agencies e.g. benefits
- Knowledge of how to deal with threatening behaviours (personal safety issue – violence).
- Ability to link - wide social network
- "Social workers"
- Cultural competence – Understanding of Treaty of Waitangi

The following issues were identified by the PHO Workforce Development Group as relevant for Community Health Workers:

- Need to define a scope of practice. This was required to provide consistency of training and the care delivered
- Supervision, accountability and legal issues
- Need to reduce variation in practice– framework would assist with this. Standardisation of job descriptions but need to allow specialised or "niche" roles
- Advocacy - "Walking alongside patients" and enabling. Also improving GP/team awareness of cultural issues
- Providing interpreting services Language Interpreting – Pacific, Te Reo
- The use of community volunteers for health promotion & education and the training required
- Health Eduction role:
    - Prevention and promotion
    - Role in screening
    - Linking to family & feedback
    - Nutrition/Cooking methods
    - Exercise
    - Immunisation
    - Smoking cessation
    - Hygiene/housekeeping
- Needs assessment processes e.g. screening for violence, depression, alcohol etc
    - Possibility of using an assessment questionnaire (e.g. Intensive Home visiting)
- Provider of information

- Holistic – care for total household
- CHW role in development of the care plan. It was felt they had an important part to play – particularly for the social component and "inter-sectoral" needs of the patient
- DNA management - getting patients to their appointment and making sure they attend follow ups etc
- Plunket used CHWs as community support and to co-ordinate roles
- Role in supporting breast feeding rates
- Role in increasing immunisation rates and referrals to hard-to-reach providers
- Relationship management - understanding family dynamics - TRUST
- Understanding social issues and assisting with personal priorities & obligations e.g. personal, family, church.
- Assistance with other agencies e.g. ACC, CYFS etc
- Personal assistance to build relationship of trust that leads to therapeutic intervention e.g. budgeting, housing, benefits, clothing, food, childcare, transport, legal issues
- Strengths based approach
- Liaison between hospital and discharged patients for foolow-up
- Issue of safety and security when attending home visits and isolated sites
- Need to develop indicators or outcome measures:
    - Evidence that patients have care plans
    - Action plans and clear outcomes expected
    - Review of progress to plan & social issues
    - Metabolic markers e.g. HBA1C & adherence
    - Attendance at WINZ
    - Reduced DNAs
    - Reduced GP visits
    - Smoking rates
    - Breast feeding rates
    - Immunisation rates
    - Number of referrals ...etc

It was felt that processes for referrals were important (vs. acting autonomously). Referral of cases must be documented and the reason for the referral clearly stated. Other features of the role within the PHC Team were the need for careful:

- Administration
- Documentation
- Reporting
- Referring
- Linking to practice/clinic
- Recording in Patient's clinical notes

The group reflected on the recent introduction of capitation and made the comment that we appeared to be trying to fit the patient behaviour to the system rather than design the system to fit the patient, for example, with transient populations and fee-for-service deductions. The expectation is for patients to develop a relationship with one particular health provider i.e. continuity of care, but many have long standing patterns of utilisation of accessing multiple health providers, for a variety of reasons. CHWs can

assist in building the relationship with patients to break down this type of behaviour by building on the concept of a "medical home". CHW represent a new skill set, needed in this new environment that focuses on population based heath rather than one-to-one, face-to-face consultations.

Current workforce indications are that we have over 40 CHWs in Counties-Manukau. These are predominantly in high needs PHOs with one having a ratio of one CHW for every 460 patients. While three PHOs have none. The projected need is difficult to determine and further work needs to be done to scope any international comparisons but the PHC Workforce Development Group looking at workforce needs for the Diabetes Strategy has suggested that we will probably need 100 CHWs by the year 2020 which would require a recruitment rate of at least 4/year. The recommendations in the objectives in section 8 below were a unanimous view of the PHO Workforce Development Group.

7.7 Role of the Pharmacist

The following is an extract from a letter sent to DHBNZ from the Pharmacy Guild dated 19 Mach 2004[23]. This helps to set the scene as to the role of pharmacy in the future health environment.

"Over the next five years we anticipate the strategic directions for pharmacy will include:

- Continuing the evolution of quality pharmacy services towards more effective use of pharmacy skills, competence and capacity.
- Pharmacists operating as an integral part of integrated primary health care teams, sharing a joint focus with GPs and nurses in maintaining and improving overall health care for their enrolled patients.
- Pharmacy will continue to hold a major position as a first stop for minor ailments and health conditions.
- Pharmacists working with local communities and alongside PHOs to address health inequalities.
- Reinforcing the role of community pharmacy in a nationwide network of readily accessible care where pharmacists continue to be the main source of safe primary medicine management services and medicine advice services.
- Alignment of financial and service incentives for health service delivery and sustainable performance across the primary health care sector to remove the perverse influences that presently exist in order to promote smarter more efficient patient management practices and as a result better health outcomes.
- Pharmacists demonstrating the value they add to improving patient care and health outcomes in maximising the effectiveness of available health funding through economic analysis and research.
- Pharmacy generated health information will be used to facilitate better health outcomes and smaller health management including the development of reports on medicine utilisation trends and patterns, impact of disease state programmes, and compliance with policy.
- Removing unnecessary bureaucracy which hinders teamwork and adds costs to services thus assisting PHOs to deliver on improved teamwork, professional satisfaction and efficiency goals.
- Service initiatives aligned to DHB and PHO service priorities include potential for:

- Medicine management programmes to support independent living strategies.
- A range of patient-focussed services in medicine review particularly for those with enduring illness.
- Enhanced patient compliance programmes.
- Enhanced disease state management for high needs patients.
- Provision of joint health promotion and screening services.
- Facilitating better medicine management through support to the prescribing process, and provision of advice to improve medicine utilisation.
- Widening the scope for pharmacists to provide services that improve access to medication and reduce the load on general practitioners.
- Complex patient medicine reviews.
- Reducing wastage and promoting value for money.

There is evidence for benefit of medication reviews resulting in improved health outcomes for patients. The cost effectiveness has not been extensively investigated and depends on local salaries and conditions (Sibbald[10]). Further work is needed in this area and CMDHB will be piloting the use of medication reviews as part of its Frequent Adult Medical Admission (FAMA) Project this year. This part of the programme will be subject to a separate evaluation that could also consider cost effectiveness.

There is a need for pharmacists to consider where they can add value in the PHO environment and this may mean a change in roles from dispensing to working more closely with the practice teams to offer advice and medicines management and prevent adverse events. This change from dispensing focus to an advisory role will extend to the relationship with their patients as well, with playing a greater part in assessing patient adherence and assisting the patient with any medication queries or concerns, especially for those with chronic illness. If we were to focus on diabetes alone the additional workforce needs would be at least an extra 10 specialist clinical pharmacists over the next fifteen years. These pharmacists would need post graduate qualifications in facilitating utilisation feedback and performing pharmaceutical reviews of individual patients. Then there are all the issues relating to the existing community based pharmacists.

7.8 Primary Health Care Teams

The importance of effective teamwork has been recognised by CMDHB in its Primary Health Care Plan[24]. It is therefore essential that health workers have the necessary skills to work as part of an integrated team to address the current health needs of their enrolled population and to plan services in anticipation of future need. This requires careful role definition and a clear understanding of the function each member has within the team. Teamwork will not just happen, the right environment for trust and a culture of joint responsibility needs to be fostered. This is not possible if individual members of the team or professional groups feel threatened or unsupported. Employment structures may be a barrier to teamwork and this needs further exploration in a PHO environment, in particular, the relationship of practice nurses and GPs.

Teamwork will need to be funded with time being made for teams to develop relationships and trust. This may require dedicated time away from the coalface and this has to be resourced. Leadership training and development will be a key component of developing the PHC team.

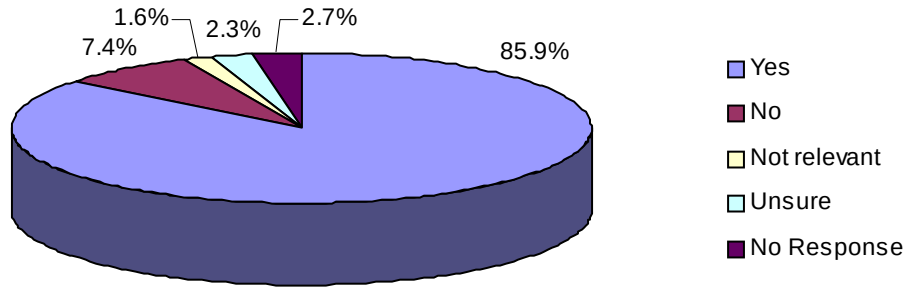
As we have seen above good management of the PHC team will be all important to actually realising the potential gains from changing roles in the sector. The PHC team of the future is likely to have Nurse Practitioners as the first point of contact for patients. The PHC team will become more diverse with the addition of a pharmacist playing a more central role in medicines management and advice; Community Health Workers for high needs communities, Mental Health workers and perhaps in time social workers and health promoters in addition to the medical and nursing skills required by clinical case managers.

We will see the advent of more Clinical Nurse Specialists in PHC as well as Care Assistants (or nursing auxiliaries). GPs will specialise in more complex health care problems. However, if workload is not carefully managed with defined tasks and clearly delineated roles then what will result is work intensification and duplication. If not giving up other work then nurses and doctors will end up working harder and more intensely! Hence, a change management programme is needed to ensure that the workforce give up what was done before in their previous traditional roles. It is said that the PHC team is less well performing than many other teams therefore the need for good management is greater. The management of the team may be more important than who makes up the Team (Sibbald[17]). This highlights the need for the further development of management and leadership in the primary sector.

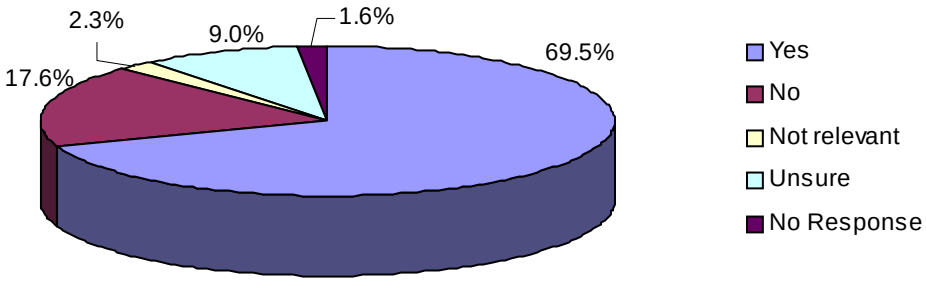
Figure 18 explores demonstrates that collaborative work processes already occur between community nurses in Counties Manukau in 2001. So it can be seen that the vast majority of nurses feel that collaboration is already occurring between different nurses and other providers as well as within existing teams, however it also explores the negatives.

Figure 18: Opportunities for working collaboratively
Source: MoH survey[12].

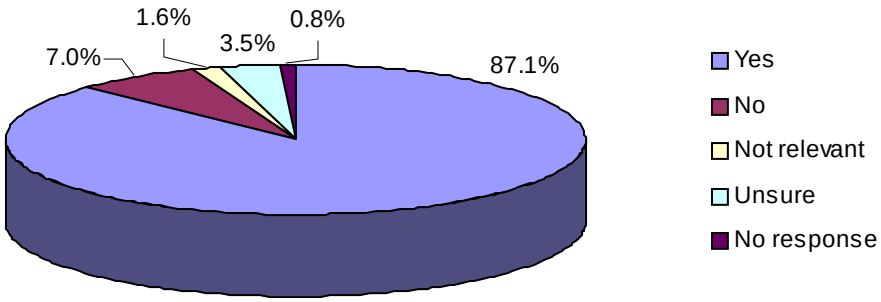
a) Nurses within their own organisation:



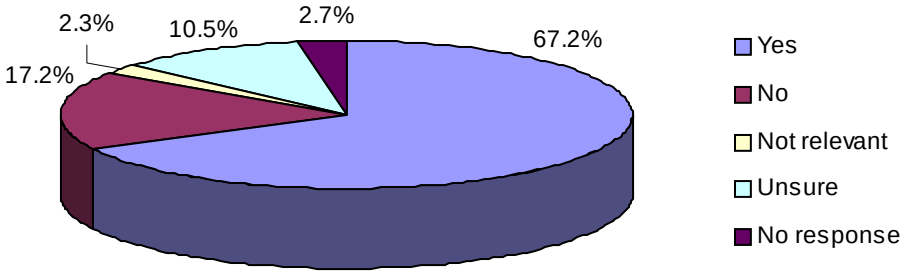
b) With Nurses in other organisations



c) With other community health professionals within organisation



d) With other community health professionals outside their organisation



The Counties Manukau Primary Health Care Plan[24] identifies several key features that team-based care relies on:

- All members of the team share a common purpose
- Every member of the team has a clear understanding of his or her own functions and recognises common interests
- The team works by pooling knowledge, skills and resources, and all members share responsibility for outcomes
- The effectiveness of a team is reflected in its capability to complete its work and to manage itself as an independent group of people

Every PHC team would need the following competencies in order to be successful:

- Clinical
- Community
- Cultural
- Business/management competencies

The DHB is keen to explore innovative models of care based around the primary health care team and two opportunities present themselves in this respect. Firstly the

availability of GP beds in Franklin County, the age structure of the local community and the workload on the existing providers makes Franklin a logical place for trying something new that could deliver better integrated, more accessible and more comprehensive care to the community. This model would include intermediary care, community nursing and practice nursing workforce alignment. Secondly, the green fields development of a city of some 40,000 people over the next ten years in Flatbush, offers the opportunity for the DHB to take a planned approach to the provision of primary care services in a community without impacting adversely on existing providers. This could prove a useful test site for innovative models of care, training and developing primary care workforce and configuring the ideal team. Such a clinic would aim to be a centre of excellence by demonstrating a new model of care in order to influence change elsewhere and implement best practice. It would model shared management systems between providers to minimise administration costs, and would enable the DHB to explore to what extent existing employment and governance structures are barriers to good teamwork.

The PHO Workforce Development Group identified the following as likely barriers to implementation of good teamwork:

- the need for co-location or better I.T. to enable virtual teams
- time to build relationships
- cultural competence
- costs to the practice - funding mechanisms should not be a barrier
- no time for meetings
- seen as PHO responsibility (lack of practice staff buy-in to PHO initiatives)
- insufficient funding for management of the PHO
- support needs to be a routine part of the job (all members of the team need support structures and mechanisms)

Certainly the PHC team of the future will have wider competencies than the current team and is likely to be better supported given the level of investment occurring in primary health care and the move to a model that includes health promotion and prevention at one end of the spectrum and case management at the other.

7.9 Allied Health & Other

A detailed discussion on allied health and other health professionals is beyond the scope of this document but shall be considered in phase tow of the plan. Certainly with the aging population as pointed out previously there will be a need for far greater support from allied health professionals. This needs to be scoped as part of phase two and the assumptions in the model may then be tested with implementation in Franklin which presents an ideal environment to explore the integration between primary care and current intermediary care services and what the structure might look like in years to come.

Clearly there will be a growing need for home based support and care assistants. With this, will come the need for better training programmes in disability support services generally but especially in the frail elderly. Health of Older Person's strategy and the concept of a seamless continuum of care are really important here in order to deliver patient centred services. In addition to the supervision required to ensure that best

practice care is being complied with, a member of the PHC will take on the case manager role for the frail elderly.

The DHB has already funded as part of the 2004/05 District Annual Plan priority initiatives a project whereby a community dietitian will be recruited to train the trainers based on the 'Counterweight' model in the U.K. If this is found to be successful then this model could also be replicated to support health promotion and lifestyle intervention based on good advice on nutrition and exercise.

7.10 Public Health

An important feature of the new primary care environment will be the focus of PHOs on the health and well being of their enrolled *population*. This will require the acquisition and application of public health skills not usually seen in primary care with its personal health focus. PHO funding will allow for innovative approaches to addressing health issues under the umbrella of health promotion. This will be an opportunity to address the underlying determinants of health by applying the full range of health promotion strategies as defined by the Ottawa charter (1986)[†]. While education is important it does not adequately cover the range of strategies described in the Charter. It will be necessary for PHOs to develop the skills to implement and evaluate modern health promotion programmes.

7.11 Information

Workforce planning is dependent on accurate and up-to-date workforce information. To track our needs and progress to fulfilling these, a database is required covering a wide range of professional groups. This would enable the collection of a minimum dataset which would include practice location, contact details, hours of work, client contact time, competencies and skills, ethnicity, training needs, and so on. Reporting such information is not currently a requirement in the PHO contract and it is likely this will require a regional approach to set up and maintain the database. This is a role that the NDSA could contribute to. Work on a community stocktake of the health workforce has begun.

8 OBJECTIVES/DELIVERABLES

In addition to the objectives listed below addressing the five key areas previously identified. There is a need to:

8.1 Complete phase two of the Workforce Development Plan including:

a) Developing a primary care database, and options to maintain the database over time including strategies to address information gaps;
b) Further analysis of the supply and demand side workforce issues including issues relating to recruitment, training requirements, and retention and modelling of the workforce needs and how to address the deficit;

[†] The Ottawa Charter developed by the World Health Organisation (WHO) at the 1986 health promotion conference describes five strategies to improve population health. These include, encourage community action, develop personal skills, create supportive environments, reorient health services and build healthy public policy.

c) Setting up a PHC Workforce Development Group with the appropriate expertise to consider the broader primary health care needs including allied health and mental health needs in primary care.
d) The group will provide recommendations:
    i) For ongoing development of the primary care workforce based on health need analysis and the required competencies
    ii) To provide information to assist decision makers on the appropriate/recommended ethnic mix and geographic distribution of the workforce within Counties Manukau, where possible including ratios of practitioners to population for different types of health workers and populations sub-groups.

8.2 GENERAL PRACTICE

8.2.1 Objective: Retention of existing workforce

Proposed Strategies	Steps	By Whom	By When
Improved job satisfaction	• Locum Doctor Scheme • Better access to diagnostics • Offer up-skilling in EC or OPC • Better use of Information Technology • More practice support (Shared services model) • Explore possibility of PHOs (or in special circumstances DHB) providing salaries for GPs to reduce the administration of running the business	Mar 05 Jun 05 & ongoing	Work up Business Case only Work with services to develop plan Links to CCM Discussion with PHOs Model to work with is Waiuku
Improved Morale	• Publicity Campaign promoting positive role of general practice • Good News stories & better utilisation of media • Leadership development (LAMP)	Mar 05 Ongoing Ongoing	In association with Lauren Young. Development of Video in conjunction with WFDC oversight. Schedule of articles for local paper First candidates already done
Improve viability of existing practices	• Improved income through PHC strategy and investment in CCM/FAMA and such programmes • Review of funding model and sustainable pricing •	Ongoing	Further modelling to understand cost structure and encourage efficient models

8.2.2 Objective: Attract more GPs to the needy areas of Counties Manukau

Proposed Strategy/Outcome	Steps	By Whom	By When
More Maori GPs	• Maori Health Plan (Recruitment & training strategies) • Promote in local schools • Link to undergraduates • Scholarships • Marae based recruitment and strategies • Additional support for new Maori graduates and GPs	Jun 05 Jun 05 Dec 05 May 05 Dec 05	In conjunction with "model of innovative care" Work with Educator to Design programme Work with Medical Schools Design Programme in conjunction with local marae Work with MMH Clinical School
More Pacific GPs	• Pacific Health Plan (Recrtuitment & training strategies) • Promote in local schools • Link to undergraduates • Scholarships • Use of church based model for recruitment across all workforce • Additional support for new Pacific graduates and GPs	Jun 05 Jun 05 Dec 05 May 05 Dec 05	In conjunction with "model of innovative care" Work with Educator to Design programme Work with Medical Schools Design Programme in conjunction with local churches Work with MMH Clinical School

Distribution of GPs	• Discussion with PHOs re ratios and planning • Not allow new GPs into well covered areas • Making PHO accountable for practices with patient ratios > 1:2000	Jun 05 Feb 05 Mar 05	Already started Review S88 & PHO processes Underway – expect PHOs to report on action – prioritise use of SIA etc
General Recruitment strategies	• Promote General Practice amongst RMOs • Consider requirement for RMOs to spend at least 6 months in Primary Care (pool of locum doctors or RMO rotation through General Practice) • Possible New Graduate Programme • Training for overseas doctors • Explore possibility of DHB employing GPs in needy areas or sponsoring the set-up of PHO clinics or other incentives • Promotion of CMDHB as good area to work • Overseas recruitment campaign	Jun 05 Nov 05 Oct 05 Jun 05 Jun 05	 d/w MCNZ Link to GPVTP Link to MCNZ & RNZCGP Link to "Innovative Models" work & ongoing work with WFDC Explore practicality and how to ensure ongoing employment

8.3 PRIMARY HEALTH CARE NURSING

8.3.1 Objective: Development of a career pathway

Proposed Strategy/Outcome	Steps	By Whom	By When
Professional development of CCP	• Assist nurses with portfolios (Advice and assistance with compliance to HPCA Act requirements in September) •	Ongoing	Underway
Development of Nurse Practitioners	• Innovations funding initiatives	Feb 05	First NP by Dec 04? Framework developed
Support for formal post-grad	• Consider central nurses bureau for	Jun 05	

education	"locum" relief cover to enable 'time-out' for education • Scholarships (?)	 May 05	

8.3.2 Objective: Retention strategies

Proposed Strategy/Outcome	Steps	By Whom	By When
Increased Job Satisfaction	• Training and development as part of CCM programme • Promote model of nurse consultations within PHOs	Jun 05 & ongoing Jun 05	Underway needs development with educational institutions Develop up models & work programme, then promote it
Greater role in Governance	• CMDHB review of governance structures and Leadership in PHOs • Survey nurses re their views	Feb 05 Apr 05	Underway
Pay/employment issues	• Address pay equity issue nationally • Discussion with PHOs re Practice Nurse Employment with pilot of nurses being employed by one PHO	?Apr 05 Jun 05	Underway Project Manager to develop/scope pilot

8.3.3 Objective: Recruitment strategies

Proposed Strategy/Outcome	Steps	By Whom	By When
More Maori Nurses	• Access to local schools to promote nursing • Scholarship Scheme • New Graduate scheme – target Maori nurses • Marae based recruitment and strategies • Support for new worker once in the role	Jun 05 Oct 05 Nov 05 Dec 05	Dolly Rewha (DR)
More Pacific Nurses	• Access to local schools to promote nursing • Scholarship Scheme • MIT Pacific Nurses Scheme (Foundation	Jun 05 Oct 05	Pacific Nurse Leader (PNL)

	studies?) • New Graduate scheme – target Maori nurses • Use of church based model for recruitment across all workforce • Support for new worker once in the role	Nov 05 Dec 05	
General Recruitment strategies	• Return to Nursing initiative • Placements of new graduates in Primary Care • Local and international recruitment campaigns	Apr 05 Jun 05	New Graduate programme underway - 5 new grads recruited for New Year for placement PHC

8.3.4 Objective: Up-skill the current workforce

Proposed Strategy/Outcome	Steps	By Whom	By When
Access to Hospital run training courses	• Offer invites to existing CNE • Specialised courses e.g. plastering; wound management; aural toilet etc	Oct 04 Mar 05	Actioned Underway
Practice Nurse orientation Courses	• Work with MIT to change focus from overseas trained nurses to N.Z. nurses and more appropriate for practice needs including CCM and collaborative structured care.	Jun 05	

8.4 COMMUNITY HEALTH WORKERS

8.4.1 Objective: Formal training for Community Health Workers

Proposed Strategy/Outcome	Steps	By Whom	By When
Availability of local Training Course	• Discussion with MIT • Expect course in 2005	Mar 05	Discussion underway course unlikely til 2006

	• Input into curriculum development • Resolve issues of what level NZQA course is required	Jun 05 Oct 05	
Define core competencies	• Mostly done by working group • Wider consultation on this	Jun 05 Oct 05	Jun 05 Oct 05

8.4.2 Objective: Ensure Workforce Reflects the Community it Serves

Proposed Strategy/Outcome	Steps	By Whom	By When
Maori Recruitment & Retention	• Marae based recruitment and strategies as for other Maori health workers above • Support in new role	Oct 05	Framework sorted
Pacific or Recruitment & Retention	• Church based recruitment and strategies as for other Pacific health workers above • Support worker in new role	Oct 05	Framework sorted

8.5 ROLE OF THE PHARMACIST

8.5.1 Objective: Threatened viability

Proposed Strategy/Outcome	Steps	By Whom	By When
Funding framework	• Consider alternative funding streams to Dispensing. e.g. PRS; medicines management and role in adherence (scope service spec see 8.5.3 below) • Resolve current contract issues with clarity re funding and what services the DHB is purchasing	Feb 05	Underway Contract issues now largely resolved
Certainty of role and funding streams	• See 8.5.3 below	Feb 05	See Dunlop Report
Morale	• Joint session of Pharmacists with PHOs on various DHB programmes and Primary Care resources available to patients (CHWs, SIA, HP, FAMA, CCM, POAC etc)	Mar 05	

8.5.2 Objective: Jobs for Interns

Proposed Strategy/Outcome	Steps	By Whom	By When
Concern re availability of jobs for interns given funding situation	• Concerns do not appear to have materialised with all interns having been placed but needs monitoring and if problematic consider scholarships etc	Ongoing	Watching brief – does not appear to need further action at this point

8.5.3 Objective: Defining role – change from dispensing to advisor

Proposed Strategy/Outcome	Steps	By Whom	By When
Define role and possible service specifications	• Convene local/regional pharmacy group to consider options • Include PHO representation • Consider future options re medicines management; and role in adherence; Pharmaceutical Reviews etc • Promote Pharmacist prescribing for some minor ailments - & OTC drugs • Appoint Pharmacist to CAG for input into DHB processes	Feb 05 Jun 05	

8.6 PRIMARY HEALTH CARE TEAMS

8.6.1 Objective: Role definition different team members

Proposed Strategy/Outcome	Steps	By Whom	By When
Working Parties	• Use of existing forums such as GPHO; PHCNSRG; Pharmacy Group etc; Diabetes Strategy; HOP Continuum of Care; • Workshop of health workers and practitioners	Ongoing	
Promulgation of conclusions	• Widespread consultation • Formalising in a publication	Dec 05	Promote new innovative 'model of care'

8.6.2 Objective: Encourage team meetings

Proposed Strategy/Outcome	Steps	By Whom	By When
Provide relief/funding for release of time	• Encourage PHOs to set up relief for staff time to enable participation in team building • Smaller PHOs may need CMDHB support • Consider central bureau for pool of relief staff	Jun 05	
Governance	• Review of governance structures and minimum requirements	Mar 05	Await outcome of Governance review
Communication	• Ensure that communication channels are agreed and functional • Promote use of I.T. solutions for case management and service coordination and communication.	Feb 05 Dec 05	In association with LY

8.6.3 Objective: Leadership			
Proposed Strategy/Outcome	**Steps**	**By Whom**	**By When**
Using existing forums	• GPHO - for multidisciplinary and interdisciplinary discussion • Working parties on specific issues • LAMP programme scholarships • Internal Leadership & Development courses	Ongoing	Already had two candidates in LAMP fully subsidised by DHB

8.6.4 Objective: Innovative Models of Care			
Proposed Strategy/Outcome	**Steps**	**By Whom**	**By When**
Develop a Model for Franklin	• Initial scoping • Engagement of local providers • If decision to proceed develop Project Plan	Feb 05 Ongoing	Underway
Develop a Model for Flatbush	• Initial Scoping • Decision to proceed or not • Form Steering Group • Scoping phase two and development of formal business plan	Nov 05 Dec 05 Mar 05	

8.7 RURAL HEALTH

8.7.1 Objective: Retain existing Rural Workforce			
Proposed Strategy/Outcome	**Steps**	**By Whom**	**By When**
Use of Rural Workforce	• Ensure ProCare Network for Manukau	Feb 05	

Retention Funding	has plan in place • Monitor – act if not working • Facilitate solution for less after-hours call • Support local GPs and encourage joint Franklin solutions • Align with HOP Strategy and use of GP beds and local hospital and community nursing services • Develop innovative model for PHC services in Franklin • Encourage greater autonomy and use of nurses • Consider nurse practitioner training for local nurse	Ongoing Dec 05 Ongoing Apr 05 Ongoing	
Help to reduce (social) isolation	• Assist with schooling • Use of information technology for staff, family and patients (e.g. web based solutions)	?? Ongoing	?Need for this given current age of Workforce Further analysis needed to see what would attract ad keep younger workforce

9 NEXT STEPS

1 Establish a primary care workforce steering committee to oversee the development of phase two and implementation of the CMDHB Primary Health Care Workforce Development Plan, define a detailed project plan (including budget), and gain DHB approval of this prior to commencement

2 Consideration of the following,
   a) Supply side issues
      i) Workforce supply and productivity
      ii) Geographic distribution
      iii) Ethnic mix
      iv) Gender
      v) Competencies required to implement the primary health care strategy
      vi) Local training requirements
      vii) Demand side issues
      viii) Population requirements for services
      ix) Health status
      x) Health needs

3 Decide from the various tools available the appropriate ones to use. These include, for example,
   a) Workforce to population ratios
   b) Student admissions
   c) Needs-based planning
   d) Demand-based planning
   e) Benchmarking
   f) Models of care approach

4 General practice data collections. Develop and test data collection tools including:
   a) Questionnaire development
   b) Timing
   c) Resources required

5 Consultation with providers and community.

6 Scope and implement IT requirements for,
   a) Primary care database of providers
      i) Phase one: GPs and practice nurse
         - Set up and maintenance of the database – consider NDSA involvement.
      ii) Phase two: include other primary care providers in the same or separate but linked database.

9.1 Project structure

The following project structure is suggested:

1 **Project sponsor:** Allan Moffitt (Clinical Advisor Primary Care)
2 **Project Manager:** tba

3 **Steering committee:**

Project Sponsor
Project Manager
PHO Management representative (GPHO)
Maori PHC representation
Pacific PHC representation
Allied Health/Intermediary Care
PHC Nurse Leader or representative from PHCNSRG
Community Pharmacist

Depending on competencies of the above additional members will be selected from the following:

General Practitioner
CHW/Team leader/Manager
Public Health
Educational Institution representation (as required)

4 **Project team:**

Project Manager
DHB Programme manager
PHO +/- other primary care representatives,
Others, to be advised

5 **Reference Groups:**

Existing PHO Workforce Development Group
PHC Diabetes Workforce Group
Community Health Workers
Pharmacy Group with PHO representation
Emergency Care Workstream (with links to Civil Emergency & Disaster Management Plan)

6 **Primary care database:**

a) Proposed Survey (stocktake has been commissioned).
   Input into development of questionnaire/tool (previous draft available).
b) IT – database development, maintenance and ongoing support.
   Consult with PHOs over maintenance of information on database.
   Potential hand over to NDSA (or Health Alliance, Trudy Whimp) to keep updated.

9.2 Linkages / Stakeholders

1 PHOs
2 Other Primary sector worker groups:
   a) Pharmacist Group
   b) Primary Health Care Nursing Sector Reference Group
   c) Community Health Workers
3 CMDHB – internal clients including:
   a) Workforce Development Committee
   b) Programme Managers: Primary Care; Maori Health; Pacific Health; CCM
   c) Community Liaison Manager
   d) Security re the Database for CEDM & Disaster Response Plan
4 CMDHB Maori Health Workforce Plan
5 CMDHB Pacific Health Workforce Plan
6 Counties Manukau Diabetes Strategy

7 CMDHB Quality Action Plan
8 NDSA – regional workforce work.
9 DHBNZ
10 HWAC
11 HPCA Act; & Health & disability Sector (Safety) Act
12 Professional bodies:
   a) RNZCGP
   b) MCNZ
   c) NZNC
   d) Pharmaceutical Society/College
   e) Pharmacy Guild
13 Educational Institutions
   a) Manukau Institute of Technology (MIT)
   b) University of Auckland

9.3 Future Milestones

To be developed by steering committee, once established, for phase two of the plan.
Accountability for the above objectives can then be populated and signed off by the DHB.

9.4 Timeframe

Finalisation of this plan including scoping of phase two is to be completed by May 2005. Where possible, implementation of phase one to proceed but where additional resources are required these are to be applied for as part of the 2005/06 business planning round.
Work is about to commence on the community stocktake of primary care workforce personnel.

9.5 Budget

Further scoping is required before a detailed budget can be drawn up. It is expected this will be completed sufficiently in time for the 2005/06 planning process.

Workforce stocktake has been commissioned in 2003-04 year.

A project manager will be required, either from existing staff or externally sourced and resourced.

APPENDIX A – PHO SERVICE SPECIFICATIONS

The PHO service specifications are include the following key areas,

1 Service objectives
   a) General
      i) Essential primary health care services will be evidence and best practice based (where possible) and will aim to improve, maintain and restore health and ensure access to care.
      ii) They should be provided for individuals across their life span, for families, whänau and communities taking a broad view of health, including physical, mental, cultural, social and spiritual dimensions.
      iii) Services should be co-ordinated with other health care services and will aim to reduce health inequalities.
   b) Maori health
      i) PHOs will work with iwi, Mäori communities and providers to develop and implement a Mäori Health Plan that outlines how it will contribute to improving outcomes for Mäori.
   c) Pacific health
      i) PHOs providing services for Pacific communities will, be expected to work with Pacific communities and providers in planning and delivering services to contribute to the reduction in Pacific peoples' health inequalities.
2 Service components
   a) Improve health through,
      i) Health promotion, linking to public health programmes at national, regional and local levels.
      ii) Health education, counselling, and information provision on how to improve health and prevent disease and interventions or treatments which treat risk factors.
      iii) Intersectoral linkages and relationships to improve health
   b) Maintain health through,
      i) Ongoing assessment and advice
      ii) Appropriate evidence based screening, risk assessment and early detection of disease
      iii) Use recall and reminder systems and referral to national programmes
      iv) Interventions to reduce or change harmful lifestyle behaviour
      v) Family planning
      vi) Immunisation
      vii) Working with public health providers in the prevention and notification of disease
      viii) Ongoing care and support for people with chronic and terminal conditions
   c) Restore health through,
      i) Health information for self care
      ii) Urgent medical and nursing services
      iii) Assessing urgency and severity of presenting problems
      iv) Recommending and providing where appropriate necessary treatment
      v) Referring to appropriate diagnostic, therapeutic and support services
   d) Co-ordinating care,
      i) Co-ordinating rehabilitation services
      ii) Developing collaborative working relationships with a range of community health services and public health providers
      iii) Establishing links with a range of primary and secondary health care providers.
   e) Population awareness

i) Plan and delivery services which are appropriate for the demographic make-up and health needs of its population.

f) Provide access to services for populations with high need

g) Develop health promotion services. Programmes must be consistent with population health objectives and public health programmes at national, regional and local levels

h) PHOs will be responsible for managing referred services for their enrolled population.

APPENDIX B – COUNTIES MANUKAU PRIMARY HEALTH CARE PLAN (EXCERPT – OCTOBER 2002)

THE FOLLOWING SERVICES GIVE AN INDICATION OF THE EXPECTATIONS OF THE WORKFORCE IN PRIMARY CARE

Primary care services provided

Primary health care services will undertake the following tasks:

- Improving health through promotion:
  - Screening and early detection
  - Prevention (e.g. immunisation)
  - Education and health promotion
  - Information about how to maintain wellness
  - Developing the capacity for self-management
  - Developing people's ability to make decisions about their own health
  - Linking with public health programmes and intersectoral relationships and advice
- Maintaining health:
  - Ongoing health and development assessment and advice
  - Risk assessment and lifestyle advice
  - Use of recall systems
  - Family planning and sexual health services
  - Chronic care management
  - Palliative care
- Restoring health:
  - Assessment, investigation and diagnosis services
  - Emergency care
  - Treatment options including minor procedures
  - Rehabilitation
  - Therapeutic and support services including counselling
  - Co-ordination of care
  - Referral to appropriate services
- Improving community health:
  - Increased community awareness of healthy lifestyles
  - Total community collaboration in respect of housing, employment and schooling.

APPENDIX C – MEMBERSHIP OF WORKFOCE GROUPS

CMDHB WORKFORCE DEVELOPMENT COMMITTEE:

Deputy Medical Officer	Wendy Walker
GM Maori	Bernard Te Paa
GM Pacific	Margie Fepulea'i **(Chair)**
Clinical Advisor Primary Care	Allan Moffitt
Director of Nursing	Dale Oliff
Allied Health	Jenni Coles
Finance	Tony Hickmott
Two operational GMs	Chris Fleming (Surg & Ambulatory Care)
	Ian McKenzie (Mental Health & Intermediary Care)
GM HR	Andrew Norton
Director of Midwifery Practice	Thelma Thompson
Service Manager (s)	Debbie Keys (Medicine)
HR representative	Wayne Sissing
Leadership & Development	Greg McBain
Secretarial Support	Anna-Maree Harris

CMDHB'S PHO WORKFORCE DEVELOPMENT GROUP:

Brenda Berryman, Executive Officer, ProCare Network for Manukau (PCNM)
Eleanor Browne, Manager Home Health Care, Intermediary Care, CMDHB
Michael Chan, Manager - Community Health Workers, South Seas Health Care,
Dr Elizabeth Finn, Pharmacist, Pharmaceutical Society of NZ
Loretta Hansen, Practice Nurse Coordinator, East Health Service Ltd
(Representative from PHC Nurses Sector Reference Group)
Dr Aumea Herman, Public Health Registrar, Ta Pasefika
Dr Tim Hou, General Practitioner, Mangere Health Centre (Middlemore PHO)
Olivia James, Manager, Otara Health Inc.
Dr Allan Moffitt, Clinical Advisor Primary Care, CMDHB(Chair)
Jenny Prince, Regional Manager, Plunket Society
Dr Eileen Sables, General Practitioner, East Health Trust PHO
Te Kaanga Skipper, Community Health Worker Team Leader, ProCare Network for Manukau,

The following also contributed to the work of the committee:
Dr Michael Wilson, Mangere Family Doctors (Middlemore PHO)
Mr Michael Lamont, Chairman, Mangere Community Health Trust

APPENDIX D – GLOSSARY

CAG	Clinical Advisory Group of CMDHB
CCM	Chronic Care Management (programme)
CEDM	Civil Emergency & Disaster Management
CHW	Community Health Worker
CMDHB	Counties Manukau District Health Board
CME	Continuing Medical Education
CNE	Continuing Nursing Education
CTA	Clinical Training Agency
DHB	District Health Board
DHBNZ	District Health Boards of New Zealand Inc.
DNA	Did not attend (management of patients failing to arrive for appointments)
EC	Emergency Care (department of)
EMT	Executive Management Team
FAMA	Frequent Adult Medical Admission programme
FTE	Full time equivalent
GPHO	PHO Group (a management advisory committee consisting of PHOs and other primary care representatives, along with representation from CMDHB)
HOP	Health of Older Persons
HP	Health Promotion
HPCA	Health Practitioner Competency Assurance (Act)
HRC	Health Research Council
HWAC	Health Workforce Advisory Committee
KPI	Key Performance Indicator
LAMP	Leadership & Management Programme of DHBNZ
MCNZ	Medical Council of New Zealand
MIT	Manukau Institute of Technology
OTC	Over The Counter (pharmaceuticals)
POAC	Primary Options for Acute Care (Programme supporting GPs to keep people out of hospital)
NCNZ	Nursing Council of New Zealand
NDSA	Northern DHB Support Agency
NZMA	New Zealand Medical Association
PCNM	ProCare Network for Manukau
PHC	Primary Health Care
PHCT	Primary Health Care Team
PHCNSRG	PHC Nurse Sector Reference Group
PHO	Primary Health Organisation
PRS	Pharmaceutical Review Service
RMO	Resident Medical Officers
RNZCGP	Royal New Zealand College of General Practitioners
SIA	Services for Increased Access (PHO services to improve access to primary care)
TEC	Tertiary Education Commission
THO	Total Healthcare Otara PHO

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