PROJECT CHARTER
Primary Care Programme

Organisation: Health Quality & Safety Commission
Date: June 2016
Version: 0.8

Document Purpose
The purpose of this internal document is to confirm the principles and mandate for the primary care programme of work. This document outlines the scope, methodology, team membership and roles and responsibilities, and expected benefits. It will be supported by a detailed programme plan refreshed annually or as required.

Context & Background
There is international and national agreement that successful primary care is the key to the future health of the population, reducing health inequities and the escalating costs and demand in secondary services and the wider health system. Most New Zealanders (95%) are enrolled with a primary health provider.¹ It has been estimated that 80% of adults (aged 15 years and over) and 75% of children will see their doctor at least annually.² Only a small proportion of these will go on to access secondary services and at a much later point in their health care journey. The opportunity for a significant impact on the health of New Zealanders exists in these multiple interactions with the complexity of primary health care, which is the largest part of the health system.

Under the 2015/16 Statement of Performance Expectations, the Health Quality & Safety Commission (Commission) intends to increase its focus on primary care and community services, aged residential care and disability services. In 2014 the Commission hosted a workshop with opinion leaders for primary care to identify the important quality and safety issues and how the Commission may best contribute. The Primary Care Expert Advisory Group (PCEAG) was established in 2015-16 to:

• Support Commission engagement with primary care
• Provide a primary care perspective to the current work and
• Advise on future initiatives.

With advice from the PCEAG it was agreed that a stronger focus in primary care will be accomplished by designing and implementing a small number of small-scale primary care initiated improvement

initiatives. These initiatives will act as a vehicle for engagement and provide a catalyst for future spread and scale up along a development pathway.

**Strategic Alignment**

The 2015/16 Statement of Performance Expectations states that the Commission intends to increase its focus on primary care. Through more purposeful work with the primary care sector, the Commission will be able to further extend its work from hospitals to the whole of the health and disability system.

The Commission wants to work in areas aligned to its own strategic priorities and capabilities, where it is best placed to add value and that are also aligned to government priorities. This work is aligned to the Commission core programme area of improving capability and leadership. Work in Primary Health Care also links to the 2016 Health Strategy theme of Closer to Home.

Explicit primary care initiatives will contribute to the Commission’s current strategic priority of assisting the sector to effect improvement. The programme has three priorities, which are to improve:

- **Equity**
  - Inequity is currently one of the key focus areas for the Commission and the government.

- **Integration**
  - Integration is a focus area from the theme of ‘One Team’ in the Health Strategy.

- **Consumer engagement.**
  - ‘Involving consumers’ is one of the core programmes of the Commission and a focus of the Health strategy theme ‘People Powered.’

**Problem statement**

The primary care sector is intrinsically motivated to undertake quality improvement activities. However, we recognise that there are limitations in both capacity (funding and time) and capability (knowledge and skills) to undertake such activities. Further, there is a lack of integration across primary care, for example between general practice and allied health professionals such as pharmacists, which creates artificial silos of health care.

The complexity of primary health care means that it is difficult to identify quality improvement needs. This is compounded by the lack of shared national data for improvement, such as consumer experience, adverse events and complaints.

The Commission does not currently have a high profile presence in primary care despite being responsible for health care improvement across the whole sector. The isolated and small scale initiatives that have been undertaken by the Commission in the sector have not benefitted from a co-ordinated approach. Further, the Commission has had limited knowledge of the primary health care sector. This has limited its ability to define where it is best placed to add value to primary health care improvement.
Aim

The aim of the programme is to increase quality improvement capability in primary care. This will:

- Contribute towards the long-term aim of improving health outcomes, equity, consumer engagement and integration in primary health care.
- Be demonstrated by a greater than 15% increase in quality improvement knowledge in the participating practices throughout the 18 month programme.

Goals

To increase quality improvement capability in primary care the objectives can be described as follows, they are:

- Collaborative partnerships between the Commission and primary care
- Training and education in quality improvement
- Sector led initiatives to build improvement expertise and capability
- Sector led initiatives to improve one or more health outcomes with associated improvements in equity, integration and consumer engagement as applicable.
- Identification of initiatives with validity and transferability suitable for spread at a national level
- Develop a base of primary health care improvement knowledge, both within primary care and the Commission, from which to develop wider improvement initiatives across the spectrum of primary health care, for example pharmacy, in a phased approach over time.

The Driver Diagram depicting the system levers to achieve this is shown in Appendix 1.

Benefits

The expected benefits from the primary care programme across the stakeholder groups including consumers are shown fully in Appendix 2. Expected benefits for the participating practices and the Commission are to:

- Develop stronger connection between primary care and the Commission to improve primary health care quality.
- Increase primary care sector quality improvement leadership capability and knowledge
- Progress the equity, consumer engagement and integration agendas through work with primary care on initiatives to demonstrate quality improvement.
- Increase the capacity and capability within primary care in “Improvement Science” and collaborative improvement methodology.
- Improve patient outcomes related to specific improvement activities.
- Advance the Commission’s understanding of primary health care by working with the primary health care sector

Project Scope

The Commission will focus on areas aligned to Commission strategic priorities and areas of expertise and avoid duplication of effort in the areas of quality assurance (e.g. Cornerstone) and patient safety (e.g. Safety in Practice).

Initiatives will be selected using prioritisation criteria developed by the PCEAG and based on the draft Commission prioritisation criteria (Appendix 3) areas of:

- Strategic alignment
• Benefits Realisations
• Equity
• Value for money

Ideally, by starting with 3 to 4 small-scale initiatives within primary care, a quality improvement approach will be enabled. Innovative approaches can be tested at a small scale for their applicability for scale and spread. The aim will be to build knowledge and offer potential for transformational change across the wider primary health care sector.

We envisage initiatives would be led by general practice and supported through collaboration with the PHO to the level of that individual PHO capability. We will consider applications from other primary care providers which do not have a general practice focus, which might include Māori health providers that do not have a general practice component.

The Commission will provide reimbursement of staff time of up to $6000 excluding GST. In addition the Commission will fund travel and accommodation costs. This funding is to release staff to work on initiatives and attend learning sessions.

Applicants will be free to submit initiatives of their own choice that are important to them and their enrolled populations, but all must be aligned to one or more of the three priority areas:

1. Equity – all initiatives must be underpinned by consideration of equity in the design, implementation and evaluation phases.
2. Consumer engagement – consumer co-design will enable initiatives to move from ‘consumer experience’ to ideally reflect consumer journeys through health, including their impact on quality of life.
3. Integration – Integrated patient-centred care will be a key priority, targeting the vertical gap between primary care and secondary care or the horizontal gaps across primary care, for example with allied health professionals such as pharmacists and physiotherapists and with other social sector services from the consumer perspective to provide seamless transitions of care.

Phased approach:

The Commission has a long term commitment in partnering with primary care and building quality improvement capability. The future plans, beyond this first phase of proposals being sought, will depend on the number and suitability of the initiatives identified. We are confident that there will be future opportunities to be involved as we develop a phased approach to new initiatives identified, with a balance between those in development and refinement, and those that have progressed to “scale up” and broader implementation.

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 16/17</td>
<td>Year 17/18</td>
<td>Year 18/19</td>
</tr>
<tr>
<td>Identification of initiatives</td>
<td>Phase 1 initiatives evaluated</td>
<td>Revised initiatives spread</td>
</tr>
<tr>
<td>Initiatives tested through iterative cycles and collaboration</td>
<td>Successful initiatives revised for regional/national spread and call for new initiatives</td>
<td>Begin work on new initiatives</td>
</tr>
<tr>
<td>Build primary care network and improvement capability</td>
<td>Build primary care network and improvement capability</td>
<td>Build primary care network and improvement capability</td>
</tr>
</tbody>
</table>
This will be an adaptive process and will respond to feedback from the participating primary health care organisations in regard to phase 2 and 3 programme design.

**Sustainability:**

Sustainability of both the successful initiatives and the ability of the Commission to continue to support new primary health care initiatives is a key consideration and will be monitored throughout the programme. This will require the programme to move between a mix of quality improvement, initiative spread strategies and quality control activities without losing the ability to add value at all of these levels.

**Methodology – Phase 1**

To select the initial primary care quality improvement initiatives, we will run an expression of interest application process.

The application process will be run in 5 stages which consist of:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1:</td>
<td>Expression of interest applications to be received from the sector (template will be provided)</td>
</tr>
<tr>
<td>Stage 2:</td>
<td>A selection panel will review all the applications and construct a shortlist if required.</td>
</tr>
<tr>
<td>Stage 3:</td>
<td>The Commission will work closely with shortlisted applicants to submit full proposals (template to be provided)</td>
</tr>
<tr>
<td>Stage 4:</td>
<td>A selection panel will evaluate full proposals and select 3-4 applications.</td>
</tr>
<tr>
<td>Stage 5:</td>
<td>Negotiation of a memorandum of understanding will be undertaken between selected applicants and the Commission.</td>
</tr>
</tbody>
</table>

Once applications have been confirmed, we will work with the successful applicants to get initiatives established. A project manager and quality improvement advisor will work with the individual initiative teams to support as needed. This will include site visits, regular meetings, quality improvement advice and facilitation.

We will use methodology similar to the Institute for Healthcare Improvement Breakthrough Series (Collaborative) methodology and utilising the Model for Improvement (www.api.org). We will bring initiative teams together for three learning sessions to facilitate quality improvement capability building, sharing and of information, learning and the formation of natural networks. The location of the initiative teams will guide the location of the learning sessions and network building. In the action periods between the learning sessions on-site support will be provided by the Quality Improvement Advisor and the Project Manager.

**Milestones**

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1 start-up: Call for expressions of interest</td>
<td>1 July 2016</td>
</tr>
<tr>
<td>Final applicant and sector notification</td>
<td>20 December 2016</td>
</tr>
<tr>
<td>Commence initiatives work</td>
<td>1 February 2017</td>
</tr>
<tr>
<td>Phase 2 start-up</td>
<td>1 July 2018</td>
</tr>
<tr>
<td>Phase 3 start-up</td>
<td>1 July 2019</td>
</tr>
</tbody>
</table>
Measures

These measures are high level programme measures related to the programme aim and objectives. Each initiative will have an appropriate measurement plan to demonstrate improvement and change related to the topic of their choice and to include measures relating to equity, consumer experience and integration.

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Process Measure</th>
<th>Balancing Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increase in improvement knowledge from baseline measures by April 2018</td>
<td>• Number of initiative applications received</td>
<td>• Individual initiative project measures</td>
</tr>
<tr>
<td>(measured pre, mid and post initiative)</td>
<td>• Attendance at training/meetings</td>
<td>• Satisfaction of participants in training/meetings</td>
</tr>
<tr>
<td>• Outcome measures related to the specific primary health care improvement</td>
<td>• Number of onsite visits</td>
<td>• Primary health care personnel hours devoted to the initiative and training</td>
</tr>
<tr>
<td>initiatives. An improvement is demonstrated in:</td>
<td>• Webpage hits</td>
<td></td>
</tr>
<tr>
<td>■ Equity</td>
<td>• Number of changes tested at each participating site</td>
<td></td>
</tr>
<tr>
<td>■ Consumer experience</td>
<td>• Increase in primary care stakeholder contacts</td>
<td></td>
</tr>
<tr>
<td>■ Integration</td>
<td>• Distribution of submitted and selected initiatives by enrolled population decile</td>
<td></td>
</tr>
<tr>
<td>■ Health care outcomes, as demonstrated by improvement in System Level</td>
<td>and demographics</td>
<td></td>
</tr>
<tr>
<td>Measures (e.g. ASH rates) and local Contributory Measures which will be the</td>
<td>• Hours of QI coaching</td>
<td></td>
</tr>
<tr>
<td>project specific measures</td>
<td>• Number of personnel participating in each site</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of consumers participating</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Feedback from project team members on consumer engagement</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Programme Evaluation

An independent evaluation of this programme will be commissioned so that key learnings are captured and used to inform future improvement work by the Commission in the primary health care sector. The evaluation will be designed using the Commissions ‘Overarching Evaluation Framework: Quality Improvement Programme’ (2015). The design will aim to answer both process and outcome questions about the programme and will be informed by advice from the PCEAG. The measures collected as part of the programme and the specific initiatives will assist in this evaluation.

Programme Constraints

Key constraints include:

- The sectors capability and/or capacity to undertake quality improvement initiatives.
- Other competing priorities (i.e. Cornerstone Accreditation and Foundation Standards Certification).
- Funding to meet ongoing programme expectations.
# Roles and Responsibilities

<table>
<thead>
<tr>
<th>Roles</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| **Primary Care Expert Advisory Group**     | • Provide independent sector-wide advice to the Commission  
• Proactively support effective relationships between primary care and the Commission  
• Make recommendations to the Commission on strategies to improve the quality and safety of health and disability services with a focus on primary care services that are informed by evidence and national and local knowledge  
• Share information that supports a national approach to quality and safety improvements  
• Foster an integrated approach to improving the quality and safety of health and disability services with other Commission programmes.  
See Appendix 5 for Terms of Reference |
| **Clinical lead/Chair**                    | • Spokesperson for the EAG and the programme.  
• Publicise and promote the initiatives and programme in general  
• Help the project manager and quality improvement advisor to develop a charter, topic content, and measurement strategy  
• Support teams during the ‘action periods’ e.g. answering subject matter questions, providing examples of success or challenging teams  
• Attend expert advisory and PHO quality Improvement Network meetings  
• Provide feedback to the expert advisory group regarding progress |
| **Clinical Advisor**                       | • Publicise and promote the initiatives and programme in general  
• Help the project manager and quality improvement advisor to develop a charter, topic content, and measurement strategy  
• Support teams during the ‘action periods’ e.g. answering subject matter questions, providing examples of success or challenging teams  
• Attend expert advisory group meetings  
• Support team by answering subject matter questions |
| **Project manager**                        | • Oversee all aspects of the programme  
• Risk escalation  
• Secretariat support for EAG  
• Co-ordinate learning sessions, and action period activities  
• Set up meetings, webinars and learning sessions  
• Co-ordinate learning sessions and conference calls |
| **Project sponsor**                        | • Provide oversight, guidance and advice to the national team  
• Approve the budget and oversee expenditure  
• Attend steering group meetings  
• Regularly assess collaborative progress against agreed timelines and reviews risks and mitigation strategies |
| **Quality improvement advisor**            | • Develop the measurement system with the assistance of the project manager  
• Teach and coach teams on process improvement  
• Assess progress in the collaborative and identify necessary changes in key technical content, measurement, and use of improvement methods  
• Support collaborative learning throughout the action periods |
Appendix 1: Primary Care Programme Driver Diagram

Increase Quality Improvement capability in Primary Care

Training & education in quality improvement

Collaborative partnerships between the Commission & primary care

Grow and maintain sector relationships

Connect with internal programmes

Learning sessions

Onsite support

Measurement and Evaluation

Initiative development

Sector led initiatives

Sector communication

Consumer engagement

EAG

Meetings

Cross chair representation at meetings and shared workspace

PHOQIN

Presentations/booth at Primary based conferences e.g. RNZCGP Quality Symposium & Goodfellow Symposium

Collaborate with and seek endorsement from RNZCGP

Identify and use all opportunities for relationship building

Connect with Let's P.L.A.N

Connect/promote consumer experience survey

Stay Independent

Serious Adverse Events

Atlas of Healthcare Variation

Site and initiative specific meetings and sharing of learning

PHO/Practice visits

Teleconference/webinars

Data tools

Programme evaluation

Plan for spread and sustainability

EOI process

Primary health teams supported by Commission

Develop communication approaches

Involve/inform DHB and PHO

Consumer on initiative teams

Consumer advisor on Commission steering group
### Appendix 2: Expected Stakeholder Benefits

<table>
<thead>
<tr>
<th>Consumers</th>
<th>Primary Health Care</th>
<th>PHO</th>
<th>DHB</th>
<th>Health Quality &amp; Safety Commission</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improved health outcomes.</td>
<td>• Develop stronger connection between primary care and the Commission to improve primary health care quality.</td>
<td>• Increase primary care sector quality improvement leadership capability and knowledge</td>
<td>• Develop the mechanisms and relationships to improve primary-secondary health care integration and health care outcomes</td>
<td>• Advance the Commission’s understanding of primary health care by working with the primary health care sector.</td>
</tr>
<tr>
<td>• Improved consumer experience.</td>
<td></td>
<td>• Increase the capacity and capability within primary care in “Improvement Science” and collaborative improvement methodology.</td>
<td>• Increase performance against key metrics such as Health Targets and System Level Measures</td>
<td>• Work with primary care on initiatives to demonstrate quality improvement while progressing equity, consumer engagement and integration agendas.</td>
</tr>
<tr>
<td>• Increase in consumer engagement.</td>
<td></td>
<td>• Improve patient outcomes related to specific improvement activities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Co-design and/or participation in improvements.</td>
<td></td>
<td>• Improve patient experience of care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Improved primary care sector experience and knowledge in engaging and working with consumers.</td>
<td></td>
<td>• Improved primary care sector knowledge in engaging and working with consumers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Health care designed to delivers ‘what matters’ to consumers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Collaborate with and learn from other primary health care improvement teams nationally.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 3: Draft Primary Care Initiative Prioritisation Template

### Overview of the proposed initiative

<table>
<thead>
<tr>
<th>Project title</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Project purpose</td>
<td></td>
</tr>
<tr>
<td>Key contact within practice (name, email and phone number)</td>
<td></td>
</tr>
<tr>
<td>Key contact within PHO (name, email and phone number)</td>
<td></td>
</tr>
</tbody>
</table>

### A. Strategic Fit

Which HQSC strategic priorities is this initiative aligned with?
- Consumer engagement
- Building leadership & capability for improvement
- Measurement

Which primary health sector focus areas does this initiative align with?
- Integration between primary and secondary care
- Equity

To what extent does the proposal align with other agencies’ and health sector priorities?

### B. Proposed Initiative

Is the project new, or does it relate to an existing programme?

What is the problem to be addressed?
- Does the proposal relate to a known and explicit problem?
- What is the size and impact of the problem?
- Describe the population of focus (e.g. Māori)

Brief description of project’s key activities

What is the evidence for the proposed initiative in practice or interventions? Or if this is a new innovation, please outline the theoretical basis.

How are consumers factored into the design of the initiative?

Are Māori consumers involved?

Outline proposed timeframes for implementation.

Is this initiative suitable for testing on a small scale and then scale up and spread nationally?

What resources do you currently have in place that could contribute to this initiative?

### C. Benefits Realisation

What are the intended benefits of the initiative?

What will be measured and how will you measure it? Please provide draft definitions of intended measures.

How will the change be sustained over time?

What are major risks for this initiative, and what mitigation strategies do you have in place for each risk?

### D. Equity

Does the problem affect some population groups more than others? Does it contribute to equity of health outcomes?

How will the proposal seek to promote health equity? How will this initiative aim to decrease existing inequity?

How will inequity be measured?

What are the potential impacts on Māori health?

### E. Value For Money

What are the costs of the change – HQSC and sector?

To what extent is the proposal good value for money?

### Any Other Information

Do you have any other information you wish to provide in relation to this proposed initiative?
### Co-design

From Boyd et al NZMJ 2012

“...co-design projects incorporate six main elements or phases. The first three elements are primarily about capturing and understanding the patient experience. While the latter three focus on improving the patient experience.

- **Engage:** proactively establishing and maintaining meaningful relationships with patients (and staff) to understand and improve health services.
- **Plan:** working with patients and staff to come up with ideas about the goals of the improvement work and how to go about doing it.
- **Explore:** learning about and understanding patient and staff experiences of services, and identifying things that can be improved.
- **Develop:** turning the ideas into specific improvements.
- **Decide:** choosing what improvements to make and how to make them.
- **Change:** turning improvement ideas into action. While described as a series of steps, in reality each element may overlap and the order, and even the omission, of some elements is not necessarily important. The common element is the active engagement of patients and their families in each activity undertaken.”

### Consumer Engagement

Consumer engagement is a process where consumers of health and disability services are encouraged and empowered to actively participate in decisions about the treatment, services and care they need and receive. It is most successful when consumers and clinicians demonstrate mutual respect, active listening and have confidence to participate in full and frank conversation. Systems that support consumer engagement actively seek input from consumers and staff at all levels of an organisation (taken from Engaging with consumers guide – HQSC 2015).

### Equity

Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. Health inequities therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms.

### Integration

Integration is:

- The extent to which patient care services are coordinated across people, functions, activities and sites over time so as to maximize the value of services delivered to patients. (Shortell et al. 2000)
- Patient care that is coordinated across professionals, facilities, and support systems; continuous over time and between visits; tailored to the patients’ needs and preferences; and based on shared responsibility between patient and caregivers for optimizing health. (Singer et al. 2011)

### Primary Care

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology.
made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process (taken from Primary Health Care strategy - February 2001)
Appendix 5: Terms of Reference

Primary Care Expert Advisory Group

Terms of Reference

February 2015

1) Purpose

The purpose of the Primary Care Expert Advisory Group (PCEAG) is to provide independent sector-wide advice to the Commission, and the Commission’s other expert advisory groups. This advice will inform the Commission’s engagement with primary care and help identify activities to improve the quality of primary care services, and health and disability services more broadly. This advice is to contribute to achieving the Commission’s vision, namely:

New Zealand will have a sustainable, world-class, patient-centered health care and disability support system, which will attract and retain its workforce through its commitment to continually improve health quality, and deliver equitable and sustainable care.

The key purpose of this expert advisory group is to:

a) Proactively support effective relationships between primary care and the Commission
b) Make recommendations to the Commission on strategies to improve the quality and safety of health and disability services with a focus on primary care services that are informed by evidence and national and local knowledge
c) Share information that supports a national approach to quality and safety improvements
d) Foster an integrated approach to improving the quality and safety of health and disability services with other Commission programmes.

The expert advisory group will provide advice on a primary care work programme that is in the first instance focused on the current work of the Commission, and evolve to include new initiatives.

The PCEAG initial priorities are to:

a) Take an overview of current Commission work to improve the quality of primary care services and provide advice on how this could be strengthened.
b) Support sector engagement
c) Inform the completion of the initial scoping and prioritization of possible new primary care initiatives
d) Provide advice on the development of a work programme

2) Accountability and Governance

e) The Chief Executive of the Commission has key accountability of the PCEAG on behalf of the Commission. The PCEAG will provide advice and recommendations to the CEO and Senior Leadership team and will work in partnership with the Commission’s other expert advisory groups and mortality review committees.
3) Membership

f) The PCEAG will comprise 8-10 members. The Chair will be appointed by the Commission.

g) The membership will comprise well respected leaders, who are experts in their respective fields, and/or who are actively engaged in the community or group/s they seek to represent. Membership will include, but not necessarily all of or limited to, representatives of:

i) Clinicians from primary care settings, from across professional disciplines.
ii) People with expertise and experience in quality and safety improvement in primary care.
iii) Consumers who can demonstrate their links to consumer groups and will engage widely with other consumers of primary care services
iv) Additional members who may be co-opted to provide specialist advice as and when required.
v) College of GPs, GPNZ and professional bodies
vi) PHOs and District Health Boards

4) Responsibilities

The PCEAG has an obligation to conduct its activities in an open and ethical manner.

Members are expected to:

h) Work strategically so that the Commissions actions contribute to sustainable system improvement.
 i) Work co-operatively, respecting the views of others with a focus on improving health outcomes and overall system performance as well as improving the experience for health care consumers, whanau and family.
 j) Act, as a collective group, in the best interests of the Commission’s quality and safety initiatives locally, regionally and nationally.
 k) Make every effort to attend all meetings and devote sufficient time to become familiar with the priorities of the group and the wider environment within which it operates.
 l) Identify and declare any conflicts of interests and proactively manage any conflicts.
m) Refer requests for media comments to the Chair or the Commission Chief Executive

5) Meetings and Decision-making

Recommendations to the Commission will be made at the PCEAG meetings and ratified through the Chair. Decisions will be made by consensus.

n) The PCEAG will meet a minimum of quarterly, either by tele/videoconference of face to face
o) A quorum will be a minimum of five members

6) Secretariat

The Group will have a secretariat provided by the Commission.

The responsibilities of the secretariat include:

p) preparing and distributing the agenda and associated papers at least five days prior to meetings
q) recording and circulating the minutes no later than a fortnight following the meeting date
r) managing the organisational arrangements for meetings, including flight bookings, the provision of rooms and audiovisual equipment
s) managing the membership appointment process.

7) Reporting and Communication

Progress of the PCEAG will be reported quarterly via a report prepared by the secretariat with overview and approval by the Chair of the EAG.

Key messages from the PCEAG will be communicated via the Commissions communication networks and mechanisms such as website, newsletters.

8) Terms and Conditions of Appointment

 t) Members will either be invited to join the Group and / or appointed following a “call for applicants” and review of credentials by a selection panel.

u) Any member may at any time resign as a member by advising the Chair in writing.

9) Fees

Members who are staff of a New Zealand public sector organisation including public service departments, state-owned enterprises or crown entities are not permitted to claim a fee to attend the PCEAG meetings.

The Commission has a Fees Framework that applies to members who are not included in the above groupings.

10) The terms of reference for the group will be reviewed after two years.