

Dear colleague,

The first tranche of workforce service reviews have reported their findings and recommendations to the Health Workforce New Zealand (HWNZ) Board. These reviews, being overseen by HWNZ and driven and managed by clinicians across the country, have the potential to deliver some of the most significant shifts in how health services are delivered for decades. There is no alternative but for this series of reviews to achieve major change – with increased demand for health services expected to significantly outstrip projected increases in funding; the status quo is not an option.

The reviews, currently being undertaken in 12 service areas, were initiated when individual clinicians began to question the make up of the future workforce and to suggest some options for new ways of working. The leadership, commitment and trust shown by members of the review teams has fostered new and collaborative thinking about more effective delivery of patient-centred services.

HWNZ has provided the project support for the 12 review groups to describe their vision of the 2020 workforce. Operating as multi-disciplinary think tanks, over a 16-week period each group is preparing scenarios for how people will work and services will be delivered in an environment where resources are more limited but quality and outcomes are maintained or improved.

This work has required courageous and innovative thinking to construct options that can then be scoped further with colleagues and analysed, modelled and tested. The first five review groups – in eye health, palliative care, aged care, anaesthesia and muscular skeletal – are now setting out their thinking so that the projects can move to that next stage. A summary of their findings is attached.

The attached diagram outlines the review process, starting with small think-tanks generating scenarios which are then further developed and analysed by HWNZ, supported by clinicians and other sector experts. The scenarios are subject to financial modelling and scrutiny for alignment with health priorities and emerging models of care.

At this phase we are seeking the wider views of the sector as to how to progress the development and testing of the recommendations arising from the think tank stage. Contributions are invited from sector partners, such as those working in the specialties, professional bodies, regulators, education and consumers.

HWNZ is particularly interested in hearing from people in the sector who have experience in the types of innovations proposed by the reviews. Please contact us through innovations@healthworkforce.govt.nz.

The subsequent phase involves the establishment of demonstrations of new scopes, roles and ways of working emerging from the reviews in sites across the sector. The ideas and recommendations will influence HWNZ's investment strategy, leading on to longer term changes in workforce training, development and skill mix. Their insights also provide an opportunity to shape National Health Board service planning. Some of the work arising from this stage will be policy issues for the Ministry to consider as part of its work programme.

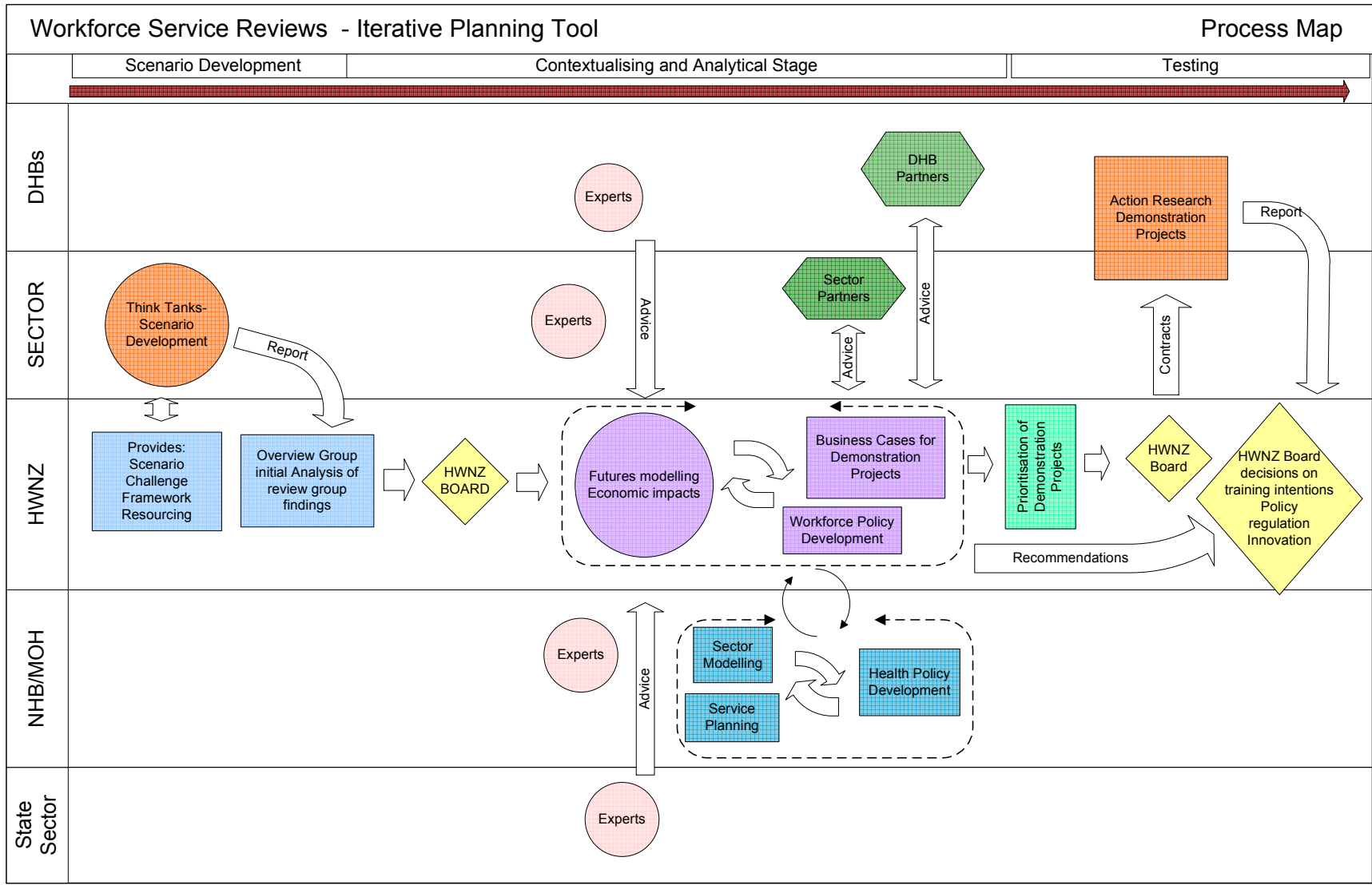
It is an iterative process and unlikely to be a straightforward or easy one. The projects are ambitious and the pace to date has been challenging. Each think tank has done a remarkable job to develop a vision for the future that can be put to the sector and can provide a platform for change.

An independent evaluation by the Australian Health Workforce Institute is underway in parallel and will inform the process.



Professor Des Gorman
Executive Chairman
Health Workforce New Zealand





Anaesthesia Workforce Service Review

Lead: Dr Andrew Reid and Dr Nigel Waters

Anaesthesia is focused on maximising positive outcomes for the patient underpinned by a strong evidence base in science and advanced clinical skills. Anaesthetists are involved in patient care from initial pre-operative assessment of the patient through to post-operative care and pain management. They are involved in retrieval, trauma, emergency resuscitation work and intensive care.

This approach has informed the work of the Review Group, through a process of survey work and evaluation of a range of options looking to sustain the anaesthesia workforce into the 21st century and beyond.

The genesis of this review was the development of a Memorandum of Understanding (MOU) agreed between the NZ Society of Anaesthetists NZSA and HWNZ in July 2010, in recognition of the need to review and consider options for the future of a critical and potentially vulnerable workforce. Since that time, the Anaesthesia Resource Review Group (ARRG) has developed. The group incorporates representation from the New Zealand National Committee of the Australian and New Zealand College of Anaesthetists and from amongst the Vocational Trainees in Anaesthesia.

The review represents a major step forward as a profession led investigation and response to the issues facing the current workforce and those in training.

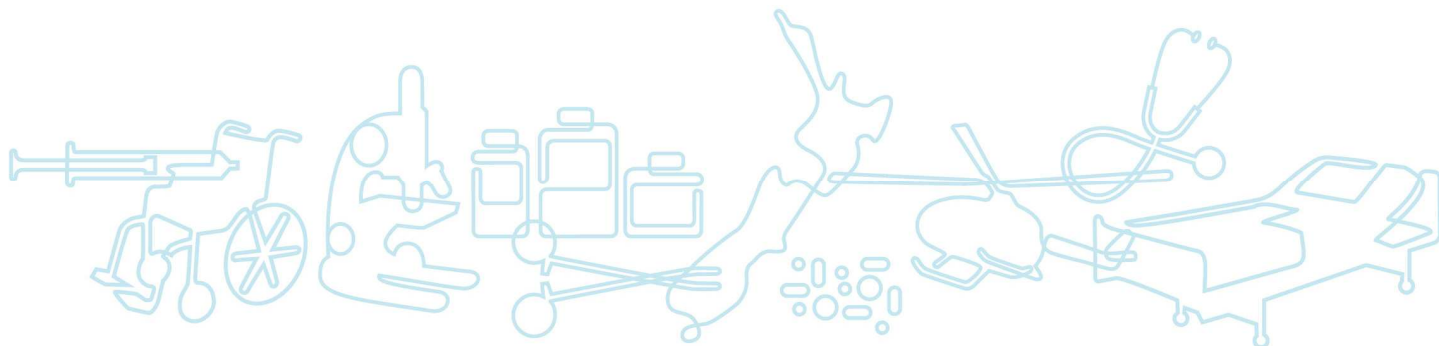
The brief of the ARRG has been:

“...to study, plan, implement and evaluate sustainable health workforce systems specifically for the anaesthesia workforce of New Zealand.”

In order to gain the expertise and information needed to provide its report, the group undertook research into anaesthetic manpower and service delivery models in a number of other OECD countries; a survey of the current and projected status of all public hospital anaesthetic departments in NZ; a survey of anaesthetic vocational trainees on attitudes to alternative workforce models and ‘roadshow’ presentations to all anaesthetic departments in NZ.

The key findings of this review are:

1. The New Zealand Anaesthesia workforce is not in crisis but is currently severely stressed in some regions. It is likely to come under more stress as demand for anaesthetic resources increases over the next decade with a risk of service failure unless specific measures are taken to address this demand.
2. There are two separate issues regarding anaesthesia resource to consider. One is the potential difficulty in supplying anaesthesia and operating room (OR) resources to meet the increased demand for elective surgery and other procedures; the other is the potential difficulty in supplying sufficient anaesthesia resource to cover acute/urgent surgery (i.e. having adequate staff to maintain a good/safe on-call roster), which until now has received only limited examination. We have to be mindful of ‘not robbing Peter to pay Paul’ by ensuring sufficient resource is available in OR in all high demand acute areas.



3. To date the problem has been phrased generally as a mismatch of anaesthetic human resources to meet current and projected demand. The ARRГ believes that although measures to increase the anaesthesia workforce are relevant and important, so too are measures to increase OR productivity which do not rely on any increase in manpower.

The ARRГ identified many on-going systemic issues which significantly impede delivery of anaesthesia services now and will impede the implementation of any future measures taken to cope with potential shortages of anaesthesia resource. A nationally agreed approach to implement changes will need to be realised in order to address the rising demand for services within limited financial and human resources.

4. The high quality anaesthesia workforce we have at present cannot be placed at risk and de-stabilisation or disengagement of the current workforce must be avoided.
5. The SMO anaesthesia workforce suffers from maldistribution and mal-retention. Australia is currently our single biggest threat and the salary gap between the two countries in some sectors results in a loss of some of our most experienced senior doctors.
6. The use of allied health professionals to complement physician roles in anaesthesia is controversial. Any such proposal may have merit, provided it can be cost effective, provide achievable clinical gains without compromising quality of care or disengagement of the current anaesthesia SMO workforce, and is embedded in a doctor-led model.
7. As part of a mix of solutions to improve OR service productivity, consideration should be given to how to retain and capitalise on the skills of those SMOs who are older than 65 or nearing retirement. Many of these senior doctors remain clinically competent, are fit to practice and want to work in some capacity, be it part-time or in less onerous clinical roles with reduced on-call.
8. There is significant potential to create opportunities for those senior SMOs who no longer have young families at home to travel to other parts of New Zealand for work opportunities, either on a casual or semi-regular basis. The current DHB system works against this redeployment of personnel to hard-to-staff areas. Industrial limitations on migration across DHB boundaries have the effect of limiting staff movements to areas of need or shortage.

Recommendations:

The following statements are recommendations of the ARRГ.

1. We recommend that the anaesthesia technician workforce explore, together with input from Specialist Anaesthetists, ways in which their scopes of practice could be improved or expanded to ensure more productive delivery of OR services. This may entail the need for a higher level of tertiary study depending on the results of this process.
2. We recommend that regional oversight groups (ROG) are created to oversee the efficient deployment of anaesthesia SMOs across multiple worksites within a region. The oversight groups would have responsibility for recruitment and retention initiatives within their designated region, filling specialist vacancies as they arise and reducing dependency on expensive hospital locums.
3. We recommend that the issue of theatre productivity be given more urgency as this is a complex matter that is multi-factorial in origin.
4. We recommend that consideration be given as to the expansion of the Medical Officer grade of anaesthesia provider. This recruitment initiative could form a possible trial for Health Workforce New Zealand.



5. We recommend that there is an increase of training positions in those smaller hospitals already accredited by ANZCA for vocational training, and those smaller hospitals not accredited for training be supported to meet the criteria for accreditation.
6. We recommend that healthcare services are delivered in a “hub and spoke” model on a regional basis so as to introduce flexibility and efficiency in the way service provision is enabled. This would have the effect of preventing some of the duplication of healthcare services that has arisen in the current DHB model of care.

Next steps:

At a broad level the findings of the anaesthesia workforce service review are in line with key priority areas for HWNZ and the Minister of Health, including a focus on improving productivity in delivering elective surgical services, better use of the existing workforce and improved configuration of services at a regional level.

HWNZ is now analysing the findings for their financial, policy and social implications. HWNZ is also considering a proposal from the New Zealand Society of Anaesthesia to test a broader scope of practice for anaesthetic technicians. Two demonstration sites are expected to be established within the next three months.



Eye Health

Lead: Dr Mike O'Rourke

The review group's vision for the eye health service in New Zealand for 2020 is that 'eye health services in New Zealand will be based on need, place the consumer at the centre and be integrated at the primary, secondary and tertiary level'.

This vision incorporates a community model of eye health care and is focussed on improving the quality of eye health care services, efficiently utilising the different eye health workforces including the development of innovative roles.

The patient journey process was used to generate a number of clinical scenarios/pathways in eye health including:

- General referral pathway
- Cataract
- Glaucoma
- Diabetes
- Uveitis
- Macular Degeneration (MD).

A number of eye health service and workforce issues were identified from discussions on the clinical scenarios. Issues related to eye health services include:

- Eye health services in New Zealand are mainly hospital based and some hospital services could move into the community. The collaboration, communication and integration of eye health services between hospital and community could be improved, particularly in the referral and discharge processes and in prioritisation of hospital treatment
- Consumers often have to wait long periods for hospital appointments and in outpatient clinics waiting to be seen
- The quality (including access) of eye health services needs to improve including diabetic retinal screening, low vision assessments, child and vision screening.

Issues related to the eye health workforce include:

- There is currently a more than adequate supply of optometrists with 678 optometrists nationwide and 50 being trained each year
- Optometrists could be better utilised in the assessment, treatment and management of patients with eye health care issues
- There needs to be enhanced use of nurses and general practitioners in eye health services
- There is a need to develop training in eye health care particularly for nurses, GPs, and orthoptists
- Sufficient numbers of ophthalmologists need to be employed and trained to cater for population growth and the aging population.



Recommendations:

The review group therefore recommended that:

1. HWNZ supports and funds the establishment of pilot eye health managed clinical networks in three differently sized areas
 - a. That a requirement of the pilot clinical networks is to develop an eye health community model that includes an increase in the role of optometrists, including making six-month postgraduate fellowships available
2. HWNZ supports a change in the regulations under the Medicines Act to enable optometrists to prescribe glaucoma medications in accordance with developed guidelines
3. HWNZ supports and funds an increase of training places in ophthalmology, based on predicted need
4. HWNZ investigate the role and career pathway of ophthalmic nurse specialists within the hospital and other settings
5. HWNZ supports the development and establishment of a postgraduate diploma in ophthalmology that is tailored to the needs of the different professions e.g. GPs and nurses
6. HWNZ supports the investigation of the development of an undergraduate degree in orthoptics
7. HWNZ supports the rationalisation and standardisation of eye health child screening services and vision and hearing screening testers in New Zealand
8. The following service principles/recommendations made by the review team are passed on to the relevant Ministry policy section by HWNZ to incorporate into policy work with the DHBs:
 - Every community requires access to a diabetic retinal screening service that builds on local services
 - There should be at least 90% uptake from diabetic patients for the diabetic retinal screening service
 - The current diabetic guidelines that includes guidance on retinal screening should be implemented equitably throughout New Zealand
 - All people with macular degeneration and low vision need to be assessed by an eye health professional with low vision expertise
 - Every community needs access to low vision aids
 - A published network of low vision eye health services should be set up in New Zealand

Next steps:

The eye health review has developed a broad range of recommendations that HWNZ is currently analysing for their financial, policy and social implications.

As its first priority for this review HWNZ plans to establish a demonstration to test a community-based model of eye care which would include testing an increased role for optometrists in management of some eye health conditions and first specialist assessments.

The demonstration will look at providing better, sooner, more convenient care for patients closer to their homes. The demonstration would aim to significantly free up ophthalmologists' time in managing routine chronic conditions to focus on more complex cases and allow hospital services to better manage increased demand.



HWNZ will also support the establishment of a clinical network for eye health – this network will look across the entire eye health workforce in the area with a view to managing demand and referral more effectively.

HWNZ will be working with sector partners over the next few months to scope up the demonstration sites with a view to have two demonstration sites established within six months.



Aged Care Workforce Service Review

Lead: Dr Ray Naden

The review group adopted a 'whole of systems' approach to the health of older people, looking at the range of factors which impact on the health of older people and the relationships between them. These include the **needs** of older people themselves, the **services** which exist or are required to meet these needs, and the **workforce** which provides these services.

More of the same will not meet the challenge of increasing demand with finite services. It will be necessary to provide more of *some* existing services as *more* older people will require them. However, it will also be necessary to innovate to provide for some needs in ways that are significantly different to current services. The system of the future will have to be well-integrated, rather than a range of discrete or "siloe'd" services as they are currently.

A number of common themes were identified:

- It is vital to prevent or delay loss of function
- There needs to be more community-based responses to acute needs
- Rehabilitation for those people with significant potential for restoration of function must be active and rapid
- People should be supported in their homes where possible (through supporting self-care, informal carers, etc)
- Disruption of older people's normal routines and self-management should be avoided as far as possible (e.g., where possible bringing services to people rather than moving them to the service, and especially avoiding people being away from home overnight)

To have an aged care sector that is able to provide support services, to at least the current level and within a sustainable funding path, significant improvements will have to be made in preventive and rehabilitative care AND significant numbers of older adults will need to receive care in a community and primary care setting.

Shifts in the number of older people with acute care needs being treated in primary and community care settings can affect admissions to acute hospitals. Furthermore, when this scenario is combined with changing the nature and location of the service and/or the workforce providing the care, quite different future scenarios can be envisaged. However, this requires a large 'rethink' in what we currently consider to be community-based care facilities.

Shifts in the focus and deployment of skilled clinicians from DHBs to primary and community settings where they will support large numbers of formal and informal care providers will be a key strategy.

The funding and focus of residential care is currently on long-term care and support. Much more focus needs to be directed to preventative and rehabilitative care, with development of short-term service options.

Modelling indicates that it is possible to lower the rate of increase in older people accessing health services. For example, the improved preventative and rehabilitation care inherent within the 'healthier ageing' strategy could potentially reduce the number of older people needing long-term aged residential care.

The changes in the workforce required to support these changes include:



- More consistent focus on preventing and delaying loss of function and restoration of function where that potential exists (“caring for” cannot be simply “doing for”, which may be counter-productive if it leads to loss of potential capability).
- Focus on needs assessment and care planning (focusing on how to best meet the needs and optimise the potential of the individual rather than simply assessing their eligibility for available services)
- Co-ordination and active management of care plans with older people, so that the various and usually multiple components of their care plan are well-integrated (to be better sooner and more convenient for the consumer rather than for the provider). The role of care co-ordinator / health navigator needs to be developed.
- Building on the expertise of the small group of health practitioners (nurse practitioners, geriatricians, allied health professionals etc) with specialist expertise in care of older people, so that they focus increasingly on developing the capability of the wider health workforce, informal carers and older people themselves.

Several key enablers will be critical to the success of these models of care and workforce changes. They include:

- Enhanced information and communication technology (ICT) to ensure prompt and easy access to all of the information needed to provide quality care to older people. This includes access by older people themselves and anyone they choose to provide care for them.
- Flexible funding focused on supporting and promoting desired outcomes, models of care and innovations (for example, greater support for preservation and restoration of function rather than only long-term support for disability needs)

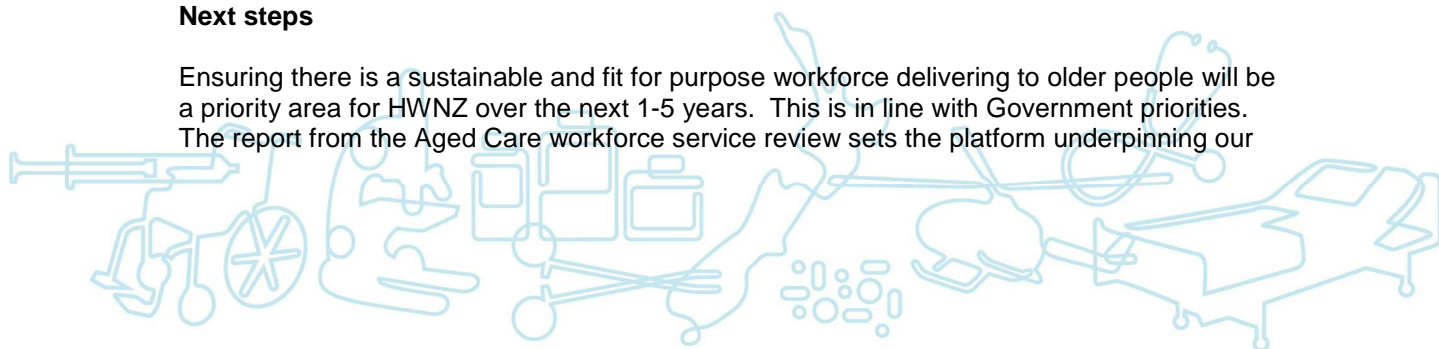
Recommendations

It is recommended that:

- An increased focus is directed to home and community-based prevention and rehabilitative service options for older people, emphasising short-term interventions focused on maximising the potential for independence.
- More work is done to support formal and informal caregivers, especially in helping older people to maximise their own potential. It is recommended that specific training and development be provided to these groups with a ‘career path’ for formal caregivers who make up the bulk of the aged-care workforce.
- Clinical specialists in the needs of older people be seen as one of the major resources available and they need to focus on supporting increased knowledge and skills of other health and support workers in community and primary care. (“leveraging”) To do this the constraints that ‘tie’ people to a facility such as an acute hospital need to be looked at to facilitate the ‘transfer of expertise’ across different service locations.
- Service and facility design within acute care to be geared up to the needs of their major patient group i.e. people over the age of 65.
- Older people, because of their multiple needs, cut across many specialities and service locations. A key to enabling integrated care for older people will be to design and pilot a ‘network information strategy’ based on ensuring ready access to all data relevant to the individual person by anyone who needs this to provide optimal care.

Next steps

Ensuring there is a sustainable and fit for purpose workforce delivering to older people will be a priority area for HWNZ over the next 1-5 years. This is in line with Government priorities. The report from the Aged Care workforce service review sets the platform underpinning our



next steps in this area. The strength of this report is its broad view of services provided to older people and the need to ensure these are working effectively to keep older people at a high level of functioning for as long as possible.

The next step for this review is to set up an internal HWNZ group with external advisors involved to assess what are our immediate and medium term priorities for action. This will involve working with other parts of the Ministry and with the DHBs to ensure we have joined up work programmes that deliver maximum benefit for the sector.

A report will be submitted to the HWNZ Board for consideration at its June meeting. Details on the aged care components of HWNZ's work programme will be released shortly after this.



Palliative Care Workforce Service Review

Lead: Dr Simon Allan

Palliative care in New Zealand is provided in a variety of settings including community, hospitals, residential care and hospices. The majority of people with cancer will require palliative care but an increasing number of people with chronic diseases also require and benefit from palliative care. These people often require palliative care for a longer duration than people with cancer.

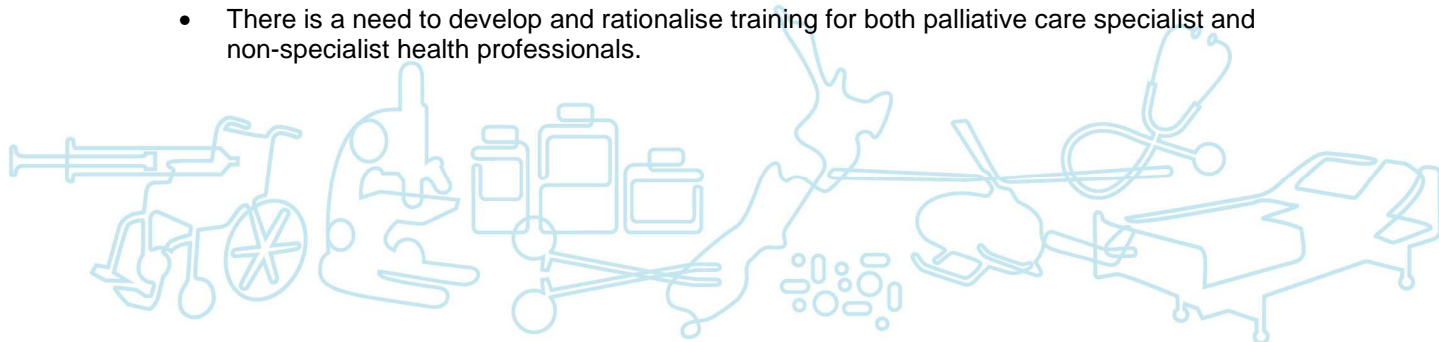
Specialist palliative care services are essential in providing expert clinical care and advice for people with complex symptoms requiring palliation. Non-specialist services particularly primary care, community health nursing and residential care are also essential in the provision of palliative care.

The aim of the Palliative Care Workforce Service Review was to develop a vision and model of palliative care service and workforce for 2020 in a context of increasing demand and limited funding.

The review was informed by literature; palliative care service and workforce data; population and forecasting data; patient experience in palliative care and also innovations that are occurring in palliative care services in New Zealand.

The review identified the following:

- The demand for palliative care services, and thus workforce, will increase slowly over the next ten years but thereafter will increase more rapidly in line with the ageing population
- The bulk of the ageing population will be European
- The number of deaths and proportion of palliative patients will nearly double by 2061
- The number of people requiring palliative care will increase by nearly 25% over the next 15 years and will nearly double by 2061.
- There are gaps in palliative care service provision particularly in 24 hour care in the home, bereavement counselling, community and primary care and rural palliative care
- There are a variety of palliative care models utilised by services and differing levels of regional governance
- There is a large variation in workforce numbers amongst regions. The number of FTEs (medical and nursing) per 1,000 patients varies between 20.7 per 1,000 patients (Upper South Island) to 42.2 per 1,000 (Central region) with the average being 27.9 per 1,000 patients
- There are a number of palliative care workforce issues that need to be addressed including an ageing workforce; recruitment and retention of palliative care medicine specialists; a shortage of general practitioners with an interest in palliative care; a shortage of nurses with specialist palliative care skills; confusion over advanced nursing practice in specialist palliative care across clinical settings; and a need to define and develop the role of allied health professionals within the multidisciplinary team
- There is a need to develop and rationalise training for both palliative care specialist and non-specialist health professionals.



The vision for this review is to ensure that all people receive effective palliative care from a qualified and competent interdisciplinary team. The next ten years will provide time to plan for palliative care services and workforce to ensure that vision is achieved.

The group believes that this vision would be achieved through development of eight regional palliative care managed clinical networks that would link locally, regionally and nationally to deliver more effective and efficient palliative care services. These regional networks would use an integrated model of palliative care that enables most people with palliative care needs to be cared for in the community by primary care and district nursing professionals but with access to effective specialist palliative care services when needed.

Networks would enable regional planning, development and management of palliative care services and workforce and ensure that all people within the network would receive effective palliative care services in a timely manner no matter where they live.

The funding of leadership positions in each network and development and funding of the primary care sector over and above current levels would be essential.

A demonstration project could inform the development of the managed clinical networks. It would be important to ensure that this pilot is set up in a region where there is support from a palliative care clinical champion.

A useful complement to the palliative care regional networks would be the development of an Interdisciplinary Education/Training Board that links with Health Workforce New Zealand (HWNZ) whose task would be to prioritise and progress palliative care education and training needs.

Recommendations:

1. That HWNZ funds a demonstration pilot managed clinical network in palliative care that is evaluated through action research to inform the development of palliative care managed clinical networks nationwide. This pilot should include funding for the director of palliative care, primary care lead and administration.
2. That the demonstration pilot is piloted in regions order of priority: MidCentral, Lower South Island and Counties Manukau.
3. That HWNZ requests that the Ministry's Cancer Programme Team consider the development of eight managed clinical networks that are linked nationally to manage palliative care in New Zealand as part of their work on palliative care models of service delivery.
4. That the palliative care managed clinical network develops a funding model for primary care services to provide community palliative care.
5. That HWNZ work with the Ministry's nursing team to undertake a national project outlining the service definition and utilisation of advanced nursing roles (nurse practitioner and clinical nurse specialist) within palliative care including the development of accredited training programmes within palliative care managed clinical network regions.
6. That HWNZ requests the Ministry cancer team to develop the role of allied health professionals within the multidisciplinary team within their national work programme on models of palliative care, the role delineation model and the specialist palliative care service provisions.
7. That HWNZ sets up an Interdisciplinary Education/Training Board that links with HWNZ to prioritise and progress the palliative care workforce requirements.



Next steps:

The Palliative care review findings link well with work underway within the Ministry and wider sector. HWNZ is currently analysing these findings for their financial, policy and social implications.

HWNZ intends to support the testing and development of palliative care networks in the sector through demonstration sites. There are also a number of policy issues such as the development of a funding model for primary care services to provide community palliative care that HWNZ will take up with the relevant parts of the Ministry. This is part of wider discussions with other parts of the Ministry of Health and sector partners to ensure work plans are well integrated and support each other.

HWNZ will be able to release more detail on our work plan after the June meeting of the HWNZ Board.



Musculoskeletal Workforce Service Review

Lead: Associate Professor Sue Stott

The review group noted that better, sooner more convenient services will be enabled by using the following overarching principles, to improve efficiency and effectiveness in musculoskeletal care:

- Conservative management of musculoskeletal disorders, including chronic musculoskeletal pain, should be a *core competency* for all general practitioners and physiotherapists.
- Effective triaging of secondary level DHB referrals by virtual means should be done by the most experienced clinicians including practising orthopaedic surgeons.
- Physiotherapists and GPs with a special interest should be up-skilled so they are able to examine and conservatively treat many musculoskeletal disorders.
- Telemedicine, video-conferencing and other electronic modalities have potential to enhance virtual assessment of patients referred for tertiary level services.
- There should be an increased emphasis placed on rehabilitation.

The over arching concept is that the most appropriate person should examine and assess the patient *in the most appropriate way* when they are first referred. Clinic-based assessment of a patient by a surgical specialist should only occur when there is a realistic expectation that that patient could require surgery.

Paper (virtual) triage of secondary level DHB referrals should be done by the most experienced clinicians (which should include an orthopaedic surgeon, rheumatologists, a GP Liaison officer and advanced physiotherapy practitioners). This triage with expert input would determine whether the patient needs to see an orthopaedic surgeon or rheumatologist or should be first assessed by another member of the team e.g. advanced physiotherapy practitioner or GP with advanced scope of practice in musculoskeletal medicine or if referral should be declined as inappropriate for the service.

Recommendations: medical workforce:

- Conservative management of musculoskeletal disorders, including chronic musculoskeletal pain, should be a *core competency* for all general practitioners, with increased CPD opportunities for all GPs in relation to musculoskeletal medicine and the development of a GP workforce with expertise in musculoskeletal medicine.
- There should be increased emphasis on musculoskeletal teaching at undergraduate level, including aspects of rehabilitation and occupational health.
- There is benefit in the development of a workforce of non-operative paediatricians/GPs/physicians expert in conservative management of minor musculoskeletal disorders but with skills to refer appropriately for expert surgical or rheumatological advice.
- Career paths for senior clinicians in the musculoskeletal field, i.e. orthopaedic surgeons and rheumatologists, should be more distinct for example the current DHB roles are “set in stone” with senior clinicians performing much the same duties as junior consultants. Active career planning and up-skilling for consultant specialists is needed with mentoring of junior consultant into the expert clinician and clinical leader over time.



- Investigation of the advantages and disadvantages of pain management becoming a Medical Council scope of practice, (currently it is within the anaesthesia scope).
- We support an increase in the number of staff with expertise in geriatric management for post-operative medical care within the orthopaedic setting
- We support an increase in the number of doctors trained with expertise in rehabilitation across the sector, including tertiary level rehabilitation specialists and GPs with rehabilitation medicine as a special interest.

Recommendations: physiotherapy/nursing:

An advanced physiotherapy practitioner model in NZ could provide a first tier level of assessment for many patients currently referred for specialist musculoskeletal medical/surgical review. Advanced physiotherapy practitioners would have the ability to examine, provide initial conservative management and reassurance for many patients with musculoskeletal disorders currently referred to orthopaedic surgeons or rheumatologists.

To enable physiotherapists and nurse specialists to undertake first assessments and early treatments of many patients with musculoskeletal conditions requires:

- Development and consolidation of advanced scopes of practice for physiotherapists by the Physiotherapy Board and recognized by ACC.
- Better integration between DHB-funded community physiotherapy services and DHB clinicians.
- A funding model that incentivises virtual FSAs and use of allied personnel to assess secondary level referrals rather than current model which drives use of consultant specialists to carry out FSAs for patients with minor complaints.
- Extending musculoskeletal training to clinical nurse specialists, ensuring there is an appropriate career path into this area, developing qualifications with financial and other incentives to undertake this extra work would improve and up skill the musculoskeletal workforce.

Nurse specialist and physiotherapy specialists could do post-operative assessments and follow-ups, either in person, leading clinics alongside the clinician or through virtual clinics, using validated questionnaires and X-ray results at defined intervals.

Other key recommendations:

- Greater investment is needed in telemedicine, video-conferencing, standardisation of electronic modalities across the DHBs (digital X-rays, electronic records etc), which have potential for the remote assessment of patients referred for tertiary level services. This could reduce cost of transportation of patients to and from tertiary level centres; reduce inefficiencies through unnecessary replication of tests; and facilitate access to electronic records across DHBs.
- Post-operative adult orthopaedic trauma management benefits from faster access to targeted rehabilitation and, for the elderly, geriatrician input. Rehabilitation should therefore start at admission, not discharge.
- Continued focus on public health measures including, early interventions to improve fitness and diet in young adults and throughout adulthood including the elderly are needed. People of all ages should be encouraged to follow a bone and joint healthy lifestyle
- Ongoing investment in musculoskeletal research is needed to determine the likely burden in the future, as everyone is at risk of developing musculoskeletal conditions.



- There should be greater encouragement of patient self care through technologies, screening questionnaires and simple point of care tests
- Screening of patients for potential osteoporosis and obesity and other such disorders that contribute to musculoskeletal injuries occurring/influencing their rehabilitation could be usefully done earlier.

Next steps:

The musculoskeletal workforce service review has developed a broad range of recommendations that HWNZ is currently analysing for their financial, policy and social implications.

The review findings reflect the direction of travel for the sector and links well with the elective surgery productivity and workforce development programme. It also focuses on better, sooner more convenient care which is also a priority focus for the Government. The review has identified potential ways of demonstrating expanded scopes of practice for nurses, GPs and physiotherapists as well as demonstrating productivity improvements.

HWNZ will be working with sector partners to further explore these options, with the aim of having two demonstration sites established within the next six months to test expanded scopes of practice and new ways of triaging GP referrals.

