The Royal Australian & New Zealand College of Psychiatrists
Tu Te Akaaka Roa
New Zealand National Office

Your Health in Mind
Hauora hinengaro Manatuhia

19 October 2020

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By email to: sanji@nzma.org.nz

Tenā koe Sanji

Re: Endorsement of the NZMA Position Statement - Continuity of Care

The Royal Australian and New Zealand College of Psychiatrists (RANZCP), Tu Te Akaaka Roa – New Zealand National Committee have reviewed the NZMA request for Endorsement of its Position Statement on Continuity of Care and agree to endorse the document on the proviso that the points below are considered and incorporated into the document, on the basis that this would provide better outcomes for tangata whaiora.

The RANZCP considers that maintaining continuity of care is an important guiding principle for the health system and should apply across all interfaces, and levels of care, e.g. mental health, general practice, old age. We uphold continuity as a core value to ensure tangata whaiora, have access to, and receive care across the health system. We note that they access care through multiple points of entry to receive care by the right people, in the right places. We support the concept of joint mahi to achieve equitable health outcomes for Māori and all New Zealanders through continuity of care.

We note that content background section is general practitioner specific. The RANZCP does not support the document in its current form due to its focus on general practice. It does not reflect the intent of a system response to care by a range of professional groups and services working collaboratively to provide continuity of care. While we consider the doctor-patient relationship is important, the position statement is about continuity, and the focus should be on joint mahi and ensuring collaboration to facilitate care so that people are able to access, the care they need, when they need it, across the health and community system.

1. **Multiple points of entry into the health system and multidisciplinary teams are a feature of continuity**

   Primary Care is in a state of transition from a traditional general practice model, to multidisciplinary teams working across a system to provide care. As the health system rolls out its vision for an integrated model funded under the 2019 Wellbeing Budget, the shift is emphasising the importance of multidisciplinary team relationships, people and their whānau being more involved in their care, and the breadth of emerging services which means access to care may not always involve a general practice and general practitioners are not solely responsible for continuity of care.

   The health sector is undergoing a transformational change process. The transition has highlighted an increasing prevalence and impact on tangata whaiora with Mental Health and Addiction, and lifestyle related Long Term Conditions, including psychosocial need,

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with many presenting in primary care services. We note that emerging evidence[1] for new ways of working shows, access to better data and enhanced multidisciplinary teamwork can improve wellbeing (mental and physical health), reduced secondary service utilisation, and increased patient/whānau satisfaction with care.

2. **Relationship continuity - The concept of continuity changes depending on people requiring short-term or longer-term care**

   Continuity in the traditional general practice model of the doctor-patient relationship is undergoing a shift in emphasis. Collaboration is now a key concept in continuity of care.

   The Health Care Home[2] is being widely adopted across general practice. Its focus on a person's relationship with a service rather than an individual. This means collaboration within the team and the system that supports them is paramount. Patients may see a different doctor for each visit or been seen by a range of other providers in the healthcare team. The Health Care Home approach emphasises achieving continuity through robust system and processes, high standards of professional practice, teamwork and collaboration. The shared electronic record is the key enabler for facilitating continuity of care and access to other services or providers within the health system.

3. **Position and Recommendations**

   The RANZCP supports the intent of the recommendations but suggests the points below are changed to reflect current direction:
   Point 1 - The reference to the *doctor-patient relationship*, instead refers to *quality of care or experience of care*
   Point 3 – Add *collaboration* after continuity.
   Point 8 – Replace doctors with *multidisciplinary teams.*

We look forward to discussing the points we have raised and endorsement by the RANZCP once the points we have raised in this letter have been resolved. We appreciate working with you to achieve an outcome. Please contact the National Manager, Ms Rose Matthews, by email rosemary.matthews@ranzcp.org or by telephone on 04 472 7265 to discuss.

We look forward to seeing the final version.

Ngā mihi

Dr Mark Lawrence
Chair, Tu Te Akaaka Roa- New Zealand National Committee

References

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[1] Baker, R., Freeman, G.K., Haggerty, J.L., Bankart, M.K., and Nockels, K.H., (2020), Primary medical care continuity and patient mortality: a systematic review, *Br J Gen Pract* 2020.

[2] Health Care Home Collaborative. New Zealand Health Care Home. Model of Care Requirements. 2018. Available at: https://www.healthcarehome.org.nz/download/health-care-home-model-of-care.pdf?inline