NEW ZEALAND NURSES ORGANISATION

Finance, Procurement and Supply Chain

Submission to: Health Benefits Limited

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NEW ZEALAND NURSES ORGANISATION (NZNO)

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 46,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces Te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is Freed to care, Proud to nurse.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the next stage of confidential proposals for the integration of finance procurement and supply chain (FPSC) service delivery for district health boards (DHBs).

2. NZNO has consulted selected members and staff in the preparation of this submission, in particular Clinical Procurement Co-ordinators (CPCs) and industrial and policy advisers.

3. NZNO is an affiliate of the New Zealand Council of Trade Unions (NZCTU) and endorses its submission and that of other unions, especially with regard to their comments and recommendations concerning provisions for transitioning employment and services.

4. NZNO members are both directly and indirectly affected by the proposals and we are especially concerned at the potential loss of CPC roles.

5. The CPC role provides an essential link between clinical and support services and is critical to patient safety, clinical confidence and efficient hospital management and service delivery. NZNO strongly advocates that the CPC role is included in the change proposals.

6. NZNO reiterates its position of support for shared services in public health to reduce duplication and waste, improve consistency and safety and maximise the frontline use of resources. As per our submission on the proposals for change for Food and Linen and Laundry services, we note that amalgamation is not appropriate for services where patient safety, or clinical effectiveness would be adversely impacted. This is also true of some purchasing functions.

7. We resubmit our strong contention that improving health outcomes should be the prime motivating factor for any restructuring of health services and that change should be measured and evaluated consistently against access to services and population health measures.

8. We are concerned that the intention to retain capacity for localised sourcing decisions, articulated in the *Indicative Case for Change - FPSC,* is no longer evident. NZNO is not assured that the impact of centralising services on the health and infrastructure of communities losing services has been fully explored and particularly questions the relocation of services to Auckland.

9. Similarly, it is not clear that efficiency savings from amalgamating publicly funded FPSC services will remain in the public health domain.

10. The opaque relationships between the multiple organisations/businesses involved in these proposals and the potential for privatisation as per government agenda, increases the risk that private companies will beneficiary of efficiency savings. NZNO opposes further privatisation of public health services and seeks an assurance that public health will be the beneficiary of change.

11. NZNO welcomes HBL's recognition of the need to include nurses in procurement and supply chain processes, and the need for significant and ongoing investment in training.

12. NZNO has appreciated opportunities to consult with HBL and the consultation packs have been well received and discussed. However, members have expressed concern that the decisions have already been made ("it feels like a 'done deal'") and have described a number of specific circumstances where the proposals need changing or clarifying.

13. In general, NZNO **supports** the FPSC document and **recommends** that you:

- maintain consultation with the health sector, including professional and workforce (Union) groups, through the National Bipartite Action Group and Health Sector Relationship Agreement processes;
- ensure that continuity of services and employment conditions of employees are maintained, and workplace disruption minimised by changes;
- ensure accountability and transparency through robust, timely evaluation and review processes;
- ensure the local supply of food and linen and laundry services;
- assess the broad health and infrastructural impact of job/service losses in the smaller regional communities and consider these in terms of overall and long term costs, and risks to public safety;
- ensure that savings remain in the public health domain and that privatisation does not follow the centralisation of services;
- note and address the specific areas of concern raised by members.

DISCUSSION

14. There is a misconception that NZNO members will not be affected by changes to FPSC services.

15. Our nurse and nursing support members deliver health care; their work is directly affected by the availability of, and access to, resources, including information, medical devices and equipment, pharmaceuticals, food, linen, diverse consumables and relevant expertise which will be affected by changes in FPSC service delivery.

16. Nurses also negotiate the clinical and patient interface, providing a vital connection between medical science, health service systems and supplies and patient needs. They are involved in research, assist in the development of new technologies, use -and educate others to use - a wide variety of medical devices, coordinate and manage supplies and services, and provide health care.

17. Nurses are well positioned to provide direct feedback on the effect of proposed changes, and NZNO is pleased that the proposals identify a consistent level of nursing involvement and clinical input into procurement.

18. As indicated in our three previous submissions, we contend that improved health outcomes should be the principal measure of success for the change proposals.

19. Recent publicity over a leaked HBL spreadsheet which was hailed as evidence of cost *savin*gs by the Minister of Health and decried as health funding *cuts* by the Labour spokesperson for Health, highlight the absurdity of drawing conclusions about public health spending from any set of statistics taken out of context.

20. NZNO strongly submits that the only context by which efficiencies in changedFPSC service delivery can be measured is in improved health outcomes. Dollar savings are unlikely to reflect real value of reducing health demand and realising population health potential in the long-term.

21. It is thus disappointing to note that there is *still* no provision for measuring and evaluating this fundamental indicator of the value of change to the FPSC at all levels and particularly in more remote areas where the potential impact for both job losses and loss of services is greater. Once more we draw your attention to the Health Impact Assessment tools developed by the Ministry of Health and insist that they be incorporated into planning.

22. We also note the importance of these communities to the national economy; losing even a small number of jobs could seriously undermine the capacity of the highly productive agricultural sector and may increase existing inequity in term of access to health services. In this regard we question whether it is necessary for the extent of service relocation to Auckland proposed.

23. It is equally essential that privatisation does not follow these proposals to ensure that savings are reinvested in frontline public health services rather than corporate profits, or administering and monitoring contracts to private providers.

24. We note, for instance, that in recognition of increasing complexity in aged care, a national agreement has been established between DHBs (Planning and Funding) and aged care providers that extra (public) funding will be provided if the total cost of wound care products exceeds the 20 percent threshold of the Aged Related Residential Care (ARRC) bed day rate. The threshold is often exceeded because the cost of wound care products is higher for private providers.

25. However, the 'backroom' costs of administering an additional funding/monitoring process to reimburse ARRC, actually *reduces* funding available for frontline services - a familiar pattern with the privatisation of public services and restructuring.

26. A more rational approach would be to allow ARRC providers access to purchase products at the standard PHARMAC rate, but this raises the same issues with publicly funded private services: what protections are there, to ensure that the savings go to improved health care, not the 'bottom line' of company profits?

27. It is important that all those affected by the FPSC changes are consulted. NZNO is concerned that suppliers who are directly impacted by this document have not been given information or consulted. We also note that DHBS contract out a number of services, including for example District Nursing services, and contractors agencies such as Nurse Maude whom the DHB contract District nursing services from must be taken into account with decisions that are made to the future of the FPSC process.

EMPLOYMENT

28. The level of uncertainty around change management.

29. Most NZNO members are on the DHB Multi-Employer Collective Agreement (MECA). Section 24, (p41-47) makes explicit provision for "cooperation, consultation and management of change", which should ensure their fair treatment should they be affected by changes to FPSC service delivery.

30. However there is a unacceptable level of uncertainty that needs to be addressed, including uncertainty with regard to employers under the transitional and new structures, particularly the lack of clarity around the PHARMAC and healthAlliance, appropriate relocation support costs, opportunities for retraining etc.

31. Current proposals do not meet these requirements. It is unsettling and potentially confusing that employees could be moved variously between a number of number of private or government employers - DHBs, PHARMAC, OneLink, Health Alliance, Datacom - for example.

32. The failure to provide information on employee benefits or commit to good employer obligations as recommended in earlier submissions, is not consistent with Section 4 of the Employment Relations Act 2000

requiring all parties to employment relationship to deal with each other in good faith and is not reassuring.

33. It is fair to say that there is considerable disquiet and suspicion, which is common with all change, but still needs to be addressed. Note the following, for example.

> *The media release stated that 13 jobs would be lost, nationally, with this restructure. That sounds fantastic. How many other businesses can propose a $500M saving with 13 jobs lost, and a bit of restructuring? But this is misleading, as it will be disproportionately spread across the country. What the media release did not say was that most jobs were moving to Auckland. How many people south of Auckland are actually going to want to move there, for reasons already mentioned? There is potential for Christchurch to have 42.85FTE positions gone. That equates to 214.25 years experience, based on 5 years at the DHB per FTE. That's a lot of experience and knowledge potentially lost to the health area if they cannot all be redeployed within CDHB*
> NZNO member

34. The allowance of $6,500 for relocation is inadequate, especially for families, who will have to bear additional costs. Members who have relocated from the South Island to Auckland in the past five years indicate that packing and shipping costs alone are around $7, 500 for a small home. Accommodation costs and increased housing costs should also be taken into account; the cost of relocation should not be borne by employees, especially when their living expenses are likely to increase, especially for those moving to Auckland.

35. Indeed we question why, given the poor state of its housing, transport and energy infrastructure Auckland should be selected as a preferred base for national services which could be delivered more cheaply and just as efficiently from elsewhere and discuss this in the next section.

36. The indicated timeframe of only five working days to decide whether or not to accepted the mapped jobs or not is clearly inadequate, when it may involve families moving cities. We suggest a minimum of ten working days would be more suitable and would allow for consultation with external advisors.

37. NZNO also has nurse members who are not working in nursing positions but who are directly involved in coordinating procurement are on individual agreements (IAs), which may not afford them the same employment protections as the MECA.

38. NZNO advocates that all employees are afforded the same good faith employment protections embodied in the DHB MECA. Consultation with employees /unions and job protection to ensure a transparent and fair process should be a priority for those who may be affected by change.

39. Two technical issues have been raised by members: how sick/annual leave is going to be managed when the numbers are so lean at the satellite sites; and how hospital IDs will be managed for purchasing officers visiting hospitals when, with category management from Christchurch, Wellington or Auckland, they may not be affiliated with any particular hospital.

CONCENTRATION OF SERVICES IN AUCKLAND

40. As indicated, we are concerned that the proposals exacerbate the unsustainable drift of services and people to Auckland, where labour, land transport costs are higher, and where there are already considerable strains on energy and water supplies, which have been subject to outages and rationing over the past few years.

41. Auckland may have the largest population, but 75 percent of the population live elsewhere, including primary producers whose contribution to New Zealand's GDP is dependent on regional infrastructure which may be undermined by the relocation of services.

42. Work/life balance, healthy environments, housing affordability are common factors governing people's choice to live in smaller urban or provincial locations, while new technologies make that choice more possible. NZNO recommends that consideration is given to locating national teams in other centres besides Wellington and particularly recommends that the South Island is not further disadvantaged by these proposals supporting the drift northwards and to Auckland.

43. We note Minister Joyce's comment following the release of the Regional Government Expenditure Report (2013) that " The Government remains committed to strengthening investment in all our regions, helping them achieve their potential and boosting jobs and quality of life for all New Zealand families" but it is difficult to see that commitment in these proposals, which disproportionately move jobs to Auckland

44. The Minister notes that the "results in the expenditure report show that regional expenditure broadly reflects the size of the population in each region", but it is surely disingenuous to equate regional investment with population size which is meaningless in terms of strengthening investment in regions? Relocating jobs to Auckland will not change regional expenditure in relation to population, but it will certainly reduce investment in, and take people from, the regions.

45. This will exacerbate unemployment (not everyone will be offered or be able to move) and add to the difficulties recruiting skilled workers in the regions.

46. Migration is a common solution to the latter problem and currently occupations in both health and finance, including nursing, procurement and accounting roles, are on the Immediate and Long-term Skill Shortage List and migrants are given an additional 10 bonus points for work in a region outside of Auckland. Relocating jobs to Auckland is clearly not consistent with current immigration policy.

47. The health, economic, environmental and social costs of regional disinvestment are well established and notable efforts are being made in Australia and other countries to reverse urban drift and revitalise the regions to ensure more balanced and sustainable resource use and better quality of life.

48. NZNO suggests HBL consider revising the proposals to do the same.

NATURAL DISASTERS/EMERGENCIES

49. Supporting regional development and more balanced population and service distribution would also help to offset the risk from natural disasters and national emergencies.

50. An important lesson from the Canterbury earthquakes was how critical it was that there was an onsite warehouse that products could be drawn from immediately. Note the following comments from members:

> We were able to physically walk product to the field hospitals and triage centres, and ensure the hospital was prepared for the incoming patients. We worked closely with the suppliers, Army and airports to

> ensure we had everything we possible needed, on site, ready to go when the calls started to come in. We spent the first eight hours solidly on the phone talking with suppliers around the products we would need, based on the information we were getting from the emergency response teams.
>
> NZNO member

> Our saving grace was that we were given control to get what we needed and that the purchase orders would be sorted out at a later date. That meant that we didn't have to have purchasing teams working around the clock doing purchase orders, they could be in the warehouse picking what was required, looking after their families, or running required items to places like the field hospitals and triage centres. We were on site, and we understood the urgency behind the requests. I suspect that with everything centralised in Auckland we would not be able to respond the same way again, and more lives could be lost as we worked through the red tape of getting products to the DHB in a timely manner. We also benefited from being able to draw down from other DHBs warehouses.
>
> NZNO member

51. We assume that the additional risks posed by the concentration of services/teams in one or a few locations rather than spread over many have been considered.

52. As this is an issue of considerable concern to members, we recommend that HBL ensures a high level of engagement and information sharing with regard to disaster preparedness and risk management of emergencies.

CLINICAL PROCUREMENT/PRODUCT COORDINATORS

53. NZNO does not see the link between clinicians and Procurement/HBL/PHARMAC in this document. Lack of, or barriers to, clinical engagement, are unsafe, may lead to non-compliance from

clinical staff and are unlikely to lead to greater efficiency.

54. NZNO further understands that CPC roles may be disestablished, relocated or changed significantly, which would adversely affect the safety and cost effectiveness of local service delivery and may result in a deterioration of terms and conditions for employees.

55. NZNO strongly advocates retaining this essential coordinating role.

56. One of the main roles of the CPC is to focus on patient safety and to manage clinical risk, neither of which is covered in the document.

57. Patient safety is maintained through checking of the mandatory paperwork and research into products and best practice, working with the link services i.e. Infection Prevention & Control and Clinical Engineering.

58. Mitigating clinical risk also means to be gatekeepers for suppliers and ensures standardisation across each DHB. Without onsite CPC oversight and expertise, it will be difficult to prevent duplicative purchases.

59. The role of CPCs is broad and straddles both the Procurement and Supply Chain. It includes the management of product recalls, product complaints, product evaluations, meeting with suppliers and clinicians attending DHB committees, national/local liaison etc.

60. CPCs provide an essential link between clinicians and the procurement team. They ensure effective communication between clinicians and the varying stakeholders, and in particular understand the complexities and between current national contracts and their local level impact.

61. CPCs are instrumental in ensuring clinical engagement is maintained throughout the procurement process and in getting buy-in from end users.

62. They have been the ones to “sell” the national contracts to the clinicians, and to have kept them informed about HBL and the agencies involved in the proposals, and why they are important.

63. This momentum will be lost if CPCs are removed from the DHBs or focussed on product categories.

64. Clinicians will be under more stress if they are contacted directly by suppliers, which is likely. There is also considerable potential that there may be an increase in inappropriate or duplicative items being bought as clinicians are do not have the same overview of procurement and supply as CPCs. The extraordinary range of orthopaedic hip joints purchased by some hospitals, for example, reflects clinicians' personal preferences rather than patient needs or efficient resource management.

65. CPCs have a good working relationships with specialist groups, including wound care specialists and clinical engineering. There is a high degree of trust and respect for the CPC role among clinicians, who can help guide them in making the best choices possible.

66. Product recalls and product complaints are difficult to manage currently and, without the local knowledge of CPCs, itwill be much harder to ensure an efficient, timely and safe response.

67. Variations in coding - for example Oracle and 3PLs tend to use their own product codes which differ from the supplier's code, and/or the code on the packaging - can make it difficult to identify the supplier or the product. For example, in one hospital, a Safety Alert for Hospira Receptal Suction Liners and Canisters (14/10/13) contained the Hospira product codes, but were set-up in Oracle under the Healthcare Logistics (HCL) product codes the hospital used to order them. It was necessary to get the correct codes from HCL to find the products in Oracle and then send the information to the correct departments.

68. Replacing/building that depth of knowledge, experience, and the right networks, not just at each DHB but in all hospitals, would be hugely problematic and the consequences of not having the right person to hand are serious as the following example illustrates.

Obex recall 17/10/2013 - *I ran reports in Oracle based on the product codes provided, and we did not appear to have purchased any. Theatres then notified me about the plan they are putting in place to manage this and provided me with the Oracle code that they have been purchasing under. When I checked that code, I found that there*

were actually an additional 3 letters "SYN-"at the beginning of the product code. If I did not have the relationship with the theatre staff that I do, I could have got this recall very, very wrong and notified Obex that we had never purchased these. If we get recalls wrong, there is the potential for patient deaths.

NZNO member

69. Maintaining the CPCs at each site will ensure efficient co-ordination of recalls and maintain safety standards and good communication between the hub and clinicians.

70. Standardisation of policies and procedures would ensure smoother processes, and a shared financial system and national catalogue will allow for visibility across all the DHBs. In the transition period there is a further risk if CPC roles are disestablished, as there will be no one to run the reports identifying which departments ordered a recalled product. That will be dependent on all DHBs having the same finance system, which will not occur until 2016.

71. Product complaints are similarly problematic. It is very hard, even with a CPC already on site, to get staff to report faulty products. They are going to be less likely to do that when their contact person is in another city, and they do not have a relationship with them.

72. A CPC based at each site, with a good working relationship with clinical staff, is better equipped to sort a product complaint than someone working from a distance, and this direct feedback is essential in ensuring the safety and improvement of products and devices.

Due to the relationship I have with the theatre staff at one of my hospitals, one of the products that we notified the supplier we had an issue with initiated a worldwide recall. Without that relationship between staff, Clinical Product Co-ordinator and supplier it would have taken longer for the manufacturer to be notified there was an issue and to act on it.

NZNO member

73. Similarly, we suggest that roll out plans are going to be very difficult to manage in DHBs without CPCs on site. Good implementation and “a strong clinical engagement framework…” will depend on good working relationships with the DHB, and this is not possible from a distance.

74. Building relationships takes time to establish and consistent support. CPCs currently demonstrate effective “Liaison between clinical customers and procurement” but without an onsite presence, these essential relationships could not be maintained, let alone developed anew.

75. Nor is it possible to 'spread' the CPC role over a large number of hospitals. Canterbury DHB has 17 hospitals, for example and the West coast 9. It is not possible to have the right relationship with that number of hospitals without an onsite presence.

76. Moreover, trying to manage a category across the country would be unwieldy, time consuming and expensive and will involve a lot of travel. CPCs are already in a position to "deliver localised support to the DHBs that will include clinical co-ordination services".

77. While there may need to be some changes, NZNO strongly recommends that rather than disestablishing the CPC role, it should be central to rolling out integrated services. CPCs would be ideally suited to run the proposed DHB Product Committees, for example, as it is something the majority of them do already and they are familiar with the national developments over the past three or four years. That would ensure the transition of an established, consistent link between the Product Committees, Procurement, HBL, healthAlliance, OneLink and PHARMAC, with all the Product Committees receiving the same, consistent message nationally.

78. CPCs based in DHBs that are retaining Procurement teams, i.e. Auckland, Wellington and Christchurch, could also liaise between the Procurement teams and CPCs at other sites, minimising disruption and maximising the use of CPCs knowledge and expertise.

TRAINING

79. NZNO welcomes and supports the *Training Needs Analysis Approach* HBL has developed, but notes that a specific timeframe for reviewing the training and responding to gaps/updating training needs to be clearly articulated.

80. Members at Canterbury DHB report that while *basic* training was provided to staff using Oracle, much of it had to be self-taught and they haven't been able to write their own reports. It is essential that training is not only evaluated but that there is a process for ensuring that knowledge and skills gaps are addressed within a relevant timeframe.

PURCHASING

81. The following paragraphs from members describe specific circumstances where national management of purchasing would be more difficult or even unsafe since there are critical timing and relationship factors that make onsite management more reliable.

RENTAL EQUIPMENT

We have a number of patients both in the hospital and in the community who are on rental equipment i.e. mattresses and Negative Pressure Wound Therapy pumps. These items are rented through the supplier and our Purchasing team keeps track of who is on the items and where they are located. They do a lot of follow-up work with the patients to ensure that the rental terms are maintained and that we are not charged for days when the items are no longer in use. This is not a service that will be able to be done nationally as it would be very time-consuming to contact every patient in every DHB.

NZNO Member

PATIENTS WITH SPECIAL NEEDS

These patients have to be worked with very closely to ensure they get

the products they need at the right time. For example, we have 13 children affected by Epidermolysis Bullosa (EB), also known as Butterfly Children, within the CDHB catchment area. EB is an inherited connective tissue disease causing blisters in the skin and mucosal membranes, with an incidence of 1/50,000. It is a result of a defect in anchoring between the epidermis and dermis, resulting in friction and skin fragility. Its severity ranges from mild to lethal.

This is a very painful and distressing disorder, and the relationship between all of the hospital staff providing care for these children is critical. They often require dressings and equipment which are not used in the rest of the hospital, and any changes to their dressing regime is very stressful for them. Purchasing works very closely with the family and the suppliers to manage any product issues, in some cases working on their own time to ensure dressings get to the children. This not something that can be managed from one site as face-to-face communication is so important for these children.

NZNO member

PERISHABLES - LEECHES

We order approx 80 leeches per month. When the orders arrive the Purchasing Officer must ensure the order is filled promptly; delay in ordering leeches will adversely impact on patient care. Because the leeches are alive, orders need to be managed during business hours to ensure they are not sitting on any docks. Couriers deliver direct to the wards to ensure they arrive alive.

Chilled, frozen or dry ice products are usually laboratory items that also require special handling by the courier company. The items are perishable, and must reach their destination in good condition, to be usable. This may be difficult to achieve if everything has to come from Auckland.

NZNO Member

OTHER PURCHASERS

We support a number of other groups in the community i.e. schools, Primary Healthcare, wildlife parks, Westpac Rescue Helicopter, Charity Hospital; they have the ability to purchase our stock products held in our on site warehouse). Patients also have the opportunity to purchase from our warehouse. How are we going to be able to continue supporting them?

NZNO Member

MEDICAL DEVICES

Around five to seven percent of DHBs budget is spent on medical devices. When the potential impact on patient safety (recalls being handled incorrectly, inferior products being brought in because the 'gate keepers' are gone), the potential loss of suppliers in the New Zealand market which is too small to support suppliers who have not managed to get national contracts, which impacts innovation, latest technology and the Private Hospitals), inability to provide personalised assistance to key vulnerable patients is considered, the value of centralisation must be questioned.

South Island Alliance has worked well over the last few years, making significant savings while providing the best care to our patients. Regional hubs for Finance, Procurement and Purchasing would be a more secure way to go. They would ensure competition remained in the medical device market, retain relationships with clinicians in the DHBs, and ensure everything is not based in one area and avoid the risks of natural disasters, power cuts etc).

NZNO member

82. Some members support have a Purchasing team in the South Island, reporting to healthAlliance, able to handle all the work that comes through the South Island DHBs.

83. It is not clear who will manage the purchasing of items, as not all DHBs will be on the new Oracle system by the time the Purchasing roles are disestablished. Will staff in healthAlliance have access to all the current financial systems to be able to facilitate those?

CLINICAL ENGINEERING

84. NZNO members seek more clarity around the decision making process to identify which Clinical Engineering department is going to check equipment prior to entering the DHB, and specifically whether that will be left up to each DHB. Their concern is to ensure that the correct team inspects the equipment and that it is done.

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CONCLUSION

85. We trust that the foregoing is useful and identifies areas where there is potential to improve on the current proposals.

86. We look forward to working with HBL in future and **recommend** that you:

- **note** NZNO supports the plan for FPSC service delivery in principle;
- **agree** that change must be evaluated in terms of health outcomes;
- **agree** that CPC roles are vital and should be retained;
- **agree** that consultation with the health sector, including professional and workforce (Union) groups, and all those affected by the proposals for change, is essential;
- **agree** that the employment conditions of employees on CA or IAs must be maintained, and workplace disruption minimised by changes to FPSC services;
- **agree** that the impact of job/service losses in the regions is disproportionate and will increase inequity;
- **agree** that relocating jobs to Auckland is inconsistent with government policy on immigration and strengthening regions;
- **agree** that there is a need to maintain a degree of flexibility to ensure patient safety and continuity of services;

- **note** that amalgamation is not appropriate for services where patient safety, or clinical effectiveness would be adversely impacted and that this is also true of some purchasing functions;
- **note** the need for timely evaluation and review processes;
- **note** that savings remain in the public health domain and that privatisation does not follow the centralisation of services; and
- **note** and address the specific areas of concern raised by members.