The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

Quality Programmes

Case Studies 2026

Cover and inside: File photograph Three Rivers Medical Centre, Gisborne 2025.

Foundation Cornerstone

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File photograph Three Rivers Medical Centre, Gisborne 2025.

Foreword

From the College's President and Medical Director

Kia ora koutou,

General practices in Aotearoa New Zealand are the heart of primary health care, but they are more than clinical environments. They are places where patients feel heard, supported and understood. It's where whānau are welcomed and teams work cohesively to deliver care grounded in compassion, evidence and cultural safety.

Sustaining that level of care and excellence, however, requires intentionality. This is where the College's Quality Programmes – the Foundation Standard and Cornerstone modules – play a vital role.

The Foundation Standard provides the essential baseline that ensures every general practice in Aotearoa is delivering safe, equitable, high-quality care. It sets clear expectations across key areas of clinical care, medicines management, equipment, facilities, cultural safety and organisational processes. Importantly, it gives practices the confidence that their systems meet legislative and professional requirements, which in turn gives patients assurance that their care is delivered within a strong and trusted framework.

Quality should be seen as a journey – not a destination – and the Cornerstone modules build on this foundation by offering pathways (Continuous Quality Improvement and Equity) that help practices to refine their capability and systems and pursue excellence in areas that make the biggest difference to patient outcomes. These modules recognise that every practice is unique, serving its own community with its own strengths, pressures and aspirations. Whether you are a team working to improve equity outcomes, undertake structured improvement initiatives or prepare for reaccreditation, Cornerstone provides practical tools and guidance that fit the reality of busy general practice life.

A strength of the Quality Programmes is the adaptability. Practices can progress in ways that work for them, choosing modules based on their priorities, working at their own pace and drawing on resources that are continually being refined to remain relevant and accessible. The reaccreditation modules acknowledge the pressures on the workforce and allow practices to maintain momentum and build on previous work and changes while keeping the focus on what matters most: delivering safe, timely and equitable care to patients and communities.

This publication of case studies brings these concepts to life. They showcase the creativity, resilience and dedication of practice teams who have embraced quality improvement and view it as an opportunity to enhance patient care and their everyday mahi. These case studies illustrate how quality processes can reduce risk, improve team functions, streamline workflow and create better outcomes for patients.

To the practice teams who are represented in this handbook, and to all practices across the motu, we thank you for your ongoing commitment to excellence. Your work upholds the integrity of our profession and improves the health and wellbeing of your communities.

We hope the insights shared on the following pages inspire, affirm and support your own quality journey.

Dr Luke Bradford
President | Te Tumu Whakarae

Dr Prabani Wood
Medical Director | Mātanga Hauora

CQI module at

Gain Health Centre

Gain Health Centre is Upper Hutt's smallest practice working to provide patients with the best care possible in a very challenging environment. They have four GPs who are supported by three nurses, a clinical pharmacist, a primary care practice assistant and six administration staff including the practice manager.

They pride themselves on providing excellent all-round general practice care, including a skin clinic and minor surgery and a women's clinic including IUCDs and menopause consultations. Their nursing team provides a range of skills including punch biopsies, smears, immunisations, cannulating, long-term condition management along with many other skills.

We caught up with Dr Imogen Robertson Owner/Clinical Director at Gain Health Centre to find out about their experiences of the Cornerstone CQI module, why they did it and what they learnt from it.

What motivated your practice to complete the Cornerstone CQI module?

We wanted to make sure that patients with congestive heart failure (CHF) were being offered iron studies blood tests regularly. We had no process for this and some patients were falling through the gaps and not receiving iron infusions.

We wanted to see if there were inequities in our iron management of those patients with CHF and, if so, improve those outcomes. We also wanted to improve patient health outcomes, decrease hospital admissions and give better symptom control to generally improve quality of life.

What did you have to do to gain the Cornerstone CQI module accreditation?

We decided on this project as it was a well-defined question and touched on equity, while also involving all clinical staff. Our project leads met with a CQI assessor early in the process before the full plan was developed. This made it easier to incorporate aspects that would be required for the write up.

We pulled a report of CHF patients to understand if they had had an iron studies blood test in the last six months and added recalls if they hadn't. We presented the first data at a full staff meeting which was great as it fuelled the enthusiasm to improve, and discussion helped formulate a standardised process going forward for management of iron deficiency at Gain Health Centre. A second report was run six months later.

The write-up of our project was in a PowerPoint document and our assessor was very responsive to questions and helping with the format.

What were the results of your CQI initiative?

We redesigned a six-monthly recall system for patients with CHF to create a consistent standardised process. We also implemented a structured process for CHF patients follow-up to include iron levels advised as per bpac^{nz} guidelines and Health Pathways, with iron infusions administered at the practice where necessary.

Initial results (out of 42 patients):

- Eight patients met the criteria for iron infusion
- Four patients had infusions in the previous six months
- 15 patients (36%) had existing recalls set for the next iron studies
- Six-monthly recalls with prompts for ideal iron levels added to the remaining 27 patients (64%).

Iron studies blood tests in the last six months in Māori and Pacific patients with CHF were 40% and 50% respectively, and in the second query it increased to 100%. So, we've made a significant improvement. European and other ethnicities have not quite reached our target of 80%.

This project has highlighted for us that there are continual improvements regarding updating recalls.

What is different for your team because of doing this work?

Keeping staff on board was key to keeping the project on track. Whenever the audit of numbers of patients who had had iron studies in the last six months was run, we found errors and processes to update and communicate to staff.

The project was great because it brought the clinical team together to look at a topic that has had variations in practice, and now we have a consistent approach leading to a higher quality of care and staff satisfaction.

Unfortunately, two patients died over the project duration due to the natural history of the condition, and all staff gained a greater understanding of the delicate balance of care for those with CHF and the need for increased vigilance with this population.

Our key take-home messages were:

- There is a need for clear written notes so no matter which GP is filing the results, the low iron levels that may look normal for other patients are not missed.
- Blood test challenges: Patients who were in hospital unknown to the practice and therefore missing routine tests, home visits not requested when needed, patients not going for blood tests. They are difficult to resolve but as a primary care provider we continue to keep trying.

The team really enjoyed the CQI process and would like to do it again in the future. We loved getting the results for our patients and it was a much more manageable task than expected!

Photo supplied by Gain Health Centre

CQI module at

Pihanga Health

Hilary Morrish Allen is the practice manager at Pihanga Health. We caught up with her to find out about their experience completing the Cornerstone CQI module, why they did it and what they learnt from it.

A little bit about Pihanga Health

Pihanga Health is a not-for-profit primary care charity located in the remote rural area at the southern end of Lake Taupō. As a Very Low Cost Access (VLCA) practice they provide first-line health care for their community. They serve approximately 4800 registered patients with 59% identifying as Māori and 41% from other ethnic backgrounds. About 80% of their patients are classified as Quintile 4 or 5.

Hilary says, "We're honoured to carry the name Pihanga, a treasured taonga of Ngāti Tūwharetoa and Ngāti Tūrangitukua."

What motivated your practice to complete the Cornerstone CQI module?

As a committed teaching practice, completing the Cornerstone CQI module was a requirement for us. However, its focus on continuous improvement aligned perfectly with our established practices.

What did you have to do to gain the Cornerstone CQI module accreditation?

Cases of Strep A are high in our community. In 2022, we conducted an audit of our adherence to the New Zealand Guidelines for Rheumatic Fever and found that our compliance was lacking.

This prompted us to enhance patient outcomes for those with potential Strep A through early detection and effective treatment, with the aim of reducing the risk of rheumatic fever. We recognised our previous management of potential Strep A cases often led to delayed treatment or overprescription of antibiotics, and adherence to antibiotic regimens was inconsistent. To address this, we included improved antibiotic stewardship as a secondary aim of our project.

In our remote setting, we saw the benefits of point-of-care testing for patient access and care. We successfully raised funds to purchase an Abbott ID NOW™ Strep A 2 machine for identifying strep throat, which we hoped would transform our approach to Strep A presentations.

Before fully implementing this testing method, we conducted a year of dual testing – using both point-of-care tests and standard laboratory GAS tests – followed by a retrospective audit of the results. Our findings showed a 30.7% positive rate with the point-of-care test compared to 23.2% from the laboratory tests, with no negative point-of-care tests yielding positive laboratory results. This evidence gave us confidence that the point-of-care test was safe, accurate and suitable for guiding antibiotic prescribing in our high-risk rural population.

During the same period, we found that 100% of positive cases (both point-of-care and laboratory confirmed) received antibiotics at their initial consultation with 95% of prescriptions dispensed. This increased confidence in our point-of-care testing, which led to a 33.2% reduction in antibiotic prescriptions overall while ensuring the right patients received treatment, thereby enhancing antimicrobial stewardship.

What did you have to do or think about differently as you worked through the CQI module?

Currently, the New Zealand Rheumatic Fever guidelines do not recommend point-of-care testing for GAS pharyngitis due to a lack of local studies, although international guidelines support its use. We had to embrace the idea that thorough, data-driven research could lead to better treatment pathways for our patient population. Initially risk averse, we prioritised patient safety, but as we collected and analysed more data we grew more confident in our approach. External peer review and objective validation of our results were also crucial.

We learned the importance of a thorough design process. Collecting accurate data from the beginning was essential, and we needed to plan our analysis in advance to ensure we gathered the right information.

Taking a whole-practice approach to tackle this clinical issue allowed us to leverage the skills of our entire team – from data collection to analysis, documentation, review and patient communication.

What is different for your team because of doing this work?

Our focus on managing patients with sore throats has sharpened significantly. Now when a patient visits another clinician with a sore throat and doesn't get tested, we question why.

This experience has shown us we can effectively address major issues, and we feel more confident using data to support our hypotheses and actions. We are better at recognising when we talk about perceptions as if they are facts, prompting us to refer to data for confirmation. This shift has inspired several other projects aimed at challenging our assumptions through data.

What is different for your patients?

Our patients now experience a significantly improved care pathway. Our responses are quicker and more targeted, and we provide better support and education to our patients and their whānau. The skills and confidence we gained from this extensive project have strengthened our overall approach to continuous improvement activities, ultimately benefiting our patients through enhanced services and care.

Former College President Dr Samantha Murton with Hilary Morrish Allen, practice manager of Pihanga Health.

CQI module at

Travis Medical Centre

Travis Medical Centre is a GP/manager-owned practice in the east of Christchurch with an enrolled population of approximately 6600. They have an even mix of quintile 2–4 made up of:

- 12 percent Māori
- 2 percent Pacific Peoples
- 1500 high needs
- 2000 Community Services Card holders.

They are a multidisciplinary team with a flat hierarchy where everyone is supported to be the best they can be, to pursue their interests and contribute to the improvement of the practice. We caught up with Nurse Nicky to find out about the team's experience completing the Cornerstone CQI module, why they did it and what they learnt.

What motivated your practice to complete the Cornerstone CQI module?

We are a long-term Cornerstone-accredited practice and Health Care Home and Hikitia accredited. We have always focused on quality care and meeting the needs of our community.

Tell us a bit about your CQI initiative

The CQI initiative we implemented at Travis focuses on improving the care and diabetes management for Māori and Pacific patients living with high HbA1c levels (above 64 mmol/mol). The primary goal of this project is to reduce the health inequities faced by these populations, which are disproportionately affected by diabetes.

To help guide us we followed the Kia Kotahi Partnership in Design framework, which is a flexible, six-step, values-based framework ensuring people and their whānau are at the centre of (re)designing equitable health and wellbeing services in a genuine, purposeful partnership.

A key difference of this co-design framework from Eurocentric approaches is its foundation in whanonga pono (values) and it is informed by Te Tiriti o Waitangi. We worked closely with patients and their whānau to develop culturally sensitive, tailored strategies for improving access to care and overall diabetes management. We also used a LEAN methodology and the Triple Aim Framework, which helped us streamline care processes, improve patient experience, enhance population health and reduce health care costs.

> Holistic care has become an essential part of our CQI efforts, addressing the medical aspects of diabetes care and the social, emotional, and financial challenges patients face.

What did you have to do or think about differently as you worked through the CQI module?

As we worked through the CQI module we had to adopt a more patient-centred and holistic approach. That involved understanding the medical needs of the patients and their cultural preferences, personal and social circumstances, and the challenges they faced accessing care.

We learnt that:

- flexibility was key in scheduling appointments, offering after-hours and phone/video consultations, and involving whānau in decision-making.
- we had to rethink data collection, as the initial survey approach was confusing for patients. Adjustments were made to ensure feedback was gathered more effectively, making it accessible and aligned with patient needs.
- holistic care has become an essential part of our CQI efforts, addressing the medical aspects of diabetes care and the social, emotional, and financial challenges patients face.
- incorporating continuous feedback loops helped us refine the care process, ensuring that our efforts were always aligned with what patients needed at each step of their journey.

One patient shared that the presence of a Māori diabetes nurse made them feel more at ease discussing their health.

What is different for your team because of doing this work?

This initiative has fostered a more collaborative and holistic approach within our team, and we now:

- work together more effectively across disciplines within our Travis team, including doctors, nurses, a health improvement practitioner, health coach, social worker, and also when the patient wants it, we refer them to a culturally appropriate diabetes nurse specialist, which all contributes to a comprehensive care plan for each patient.
- understand the importance of cultural competency and how it plays a significant role in improving patient engagement and outcomes.
- regularly use data-driven decisions to refine our care delivery, constantly seeking opportunities for improvement.
- have learned to be more adaptable in response to patient needs, such as offering flexibility in appointment scheduling or finding creative solutions to logistical challenges like transportation and financial barriers.
- additionally have enhanced communication among the team and patients, ensuring everyone is on the same page and that no patient falls through the cracks.
- offer the redesigned questionnaire to all patients with diabetes to ensure they are offered all the services available to them and a plan tailored to their needs. Our Health Coach is initiating this at the time of recalls.

What's different for patients?

For patients, the differences have been profound and include:

- **Improved access to care:** For example, a patient working night shifts who previously found it difficult to attend 8am appointments was offered afternoon phone consultations. This flexibility allowed them to receive care without disrupting their work schedule. We noticed that patients >80 HbA1c weren't getting blood tests, so we offered in-practice tests, which was much appreciated.
- **Culturally relevant support:** Māori and Pacific patients now feel more comfortable and understood in the health care environment. Involving whānau in consultations and having Māori or Pacific health care professionals available has improved trust and engagement. One patient shared that the presence of a Māori diabetes nurse made them feel more at ease discussing their health.
- **Tailored diabetes management plans:** The focus on individualised care has led to better outcomes. For instance, patients with high HbA1c levels (above 64 mmol/mol) received personalised care plans, including education on diet, medications and lifestyle changes, leading to better glucose control and reduced complications.
- **Holistic support:** A patient facing financial challenges was able to access support from a social worker, who helped them with transportation costs for medical appointments and funded scripts. Additionally, home visits were arranged for those who couldn't attend the clinic, ensuring that diabetes education and monitoring were still provided.

Overall, patients are experiencing a more personalised, supportive and culturally aware approach to their diabetes care. This has resulted in better management of their condition and greater satisfaction with the health care they receive. The project has significantly reduced barriers to care, allowing Māori and Pacific patients to engage in their diabetes management more effectively.

CQI module at

Burwood Health

Burwood Health opened in November 2019 as a purpose-built medical centre for the local community. Two local practices were combined to create a centre that could meet the demands of the growing local population. They offer a range of services to their local community and continue to expand to meet the demands of their population.

We caught up with Tahlia Simpson, Business Manager at Burwood Health, to find out about their experiences with the Cornerstone CQI module, why they did it and what they learnt from it.

What motivated your practice to complete the Cornerstone CQI module?

We wanted to improve services for our population, specifically our diabetic patients. We also wanted to become a practice to support registrars. While patient care is our main focus, we are also dedicated to training and supporting a new generation of GPs in Aotearoa. Incorporating our registrars into the quality improvements that we are focusing on in the future and participating in our diabetic care appointments is an important part of our patients' wellbeing as well as registrars' training within the practice.

Please tell us a bit about your CQI initiative

We undertook a review of the practice's diabetic patient population to ensure patients were accessing appropriate health care as and when required. A team led by practice doctors and nurses to address patients' ongoing health needs identified key areas, including:

- patients with an HbA1c >65
- identifying diabetic patients not seen for more than 12 months
- updating patient Read codes within the practice management system to diabetes mellitus (C10).
- The practice then initiated nurse-led diabetic care clinics with the purpose of offering 30-minute appointments to diabetic patients, whereby health initiatives were discussed and implemented. From these appointments, patients could then either continue to monitor and improve their health as required or speak further about their needs with either their doctor or the practice health coach or health improvement practitioner.

What did you have to do or think about differently as you worked through the CQI module?

Whilst the practice already had a diabetic plan in place for our patients, it was not as cohesive as we would have preferred. This meant our team needed to work together to come up with the parameters for those patients, including whether we were going to include pre-diabetic patients in our CQI module and the beginning stages of our diabetic care performance. We also needed to decide how the clinic was going to work for initial appointments and what follow-ups were with the diabetic care nurse versus the patient's doctor. There were several group discussions regarding this and other factors before the clinic was initiated.

> “Our team also now has a dedicated nurse lead for diabetic patients... This has allowed other appointments for patients to be scheduled with the GP whilst ensuring ongoing care for our diabetic patients.

What is different for your team because of doing this work?

Our team now has clear guidelines for our diabetic patients, and we have been able to start incorporating this into other care plans and initiatives the practice is undertaking.

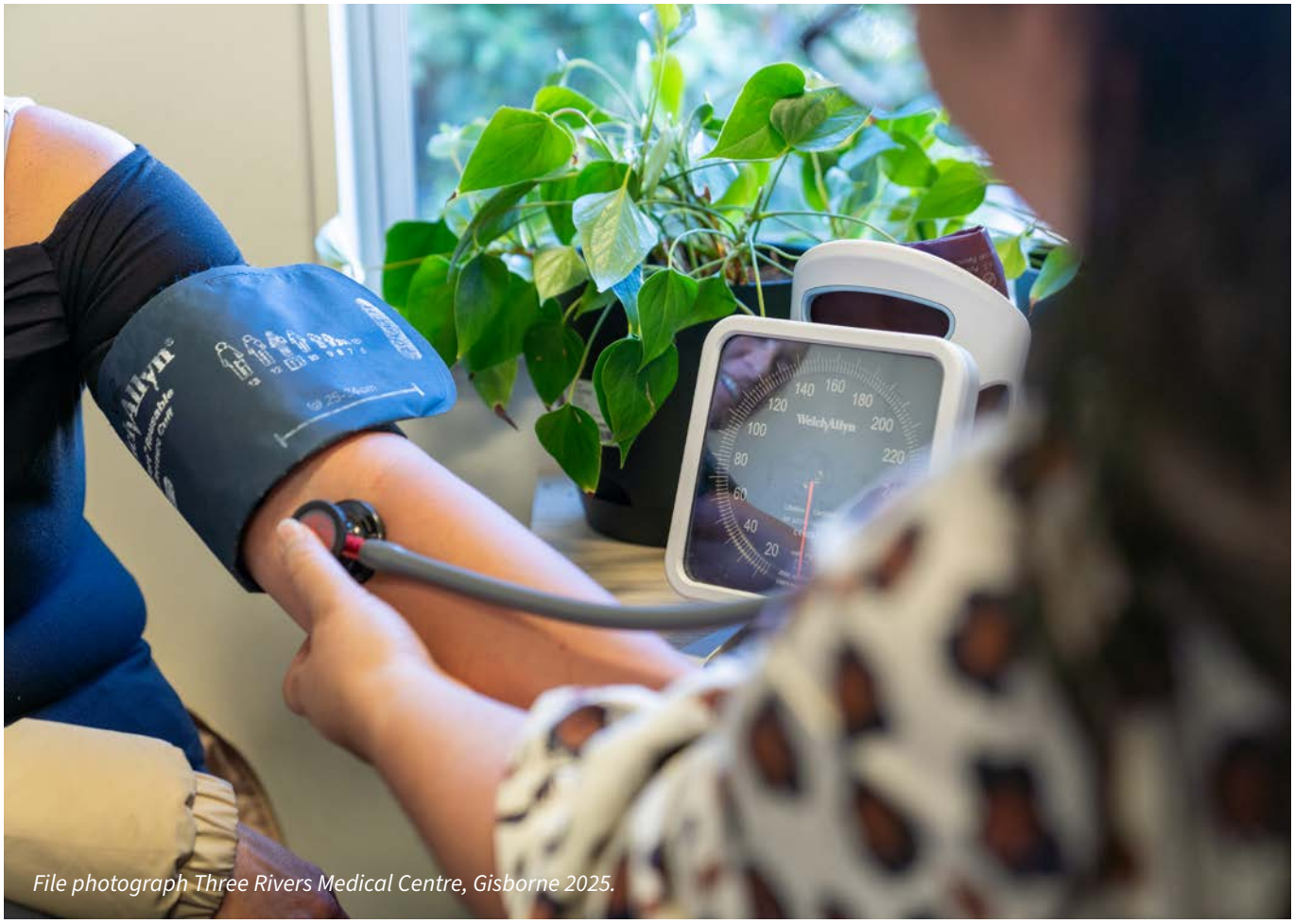
Our team also now has a dedicated nurse lead for diabetic patients, who has created a platform for the practice nurse team to have consistency in the care of diabetic patients. The new diabetic care clinics have meant that patients can see a clinical team member regarding their ongoing diabetic care without having to see their GP for every appointment. This has allowed other appointments for patients to be scheduled with the GP whilst ensuring ongoing care for our diabetic patients.

What is different for patients?

Overall, patients feel more empowered and supported in managing their condition. We're hopeful this will reduce secondary care input and maintain up-to-date research for best practice.

Patients have made reference to knowing who to go to for their diabetes care, and they tend to like having someone consistent overseeing their diabetes care.

It allows patients to be up to date with the screening needed to maintain and prevent or have early detection of any diabetes complications. This also allows recall and screening measures to be up to date on the patient management system (PMS).



File photograph Three Rivers Medical Centre, Gisborne 2025.

Equity module at

Avondale Family Doctor

We caught up with Wendy, the practice manager at Avondale Family Doctor to find out about the team's experience completing the Cornerstone Equity module, why they did it and what they learnt.

Tell us a bit about your practice

Avondale Family Doctor is a solo GP practice with two nurses and one practice manager/receptionist. We're a VLCA practice with a culturally diverse patient population, and as a team, we're very passionate about equitable patient care, health promotion and positive health outcomes for all our patients, with a special focus on Māori, Pacific Peoples and those with high needs.

Do you have tips for other small practices wanting to get accreditation?

Being a small team, we work together to plan, identify barriers and implement equity. Our health equity policy was a team collaboration led by Dr Khan; Nurse Pam is our Equity Champion who leads and oversees the implementation of our equity initiatives.

We have a monthly team meeting, weekly clinical meetings and morning huddles to check on progress. We also have a monthly meeting with our PHO clinical advisor to review health targets, identify health equity gaps and discuss the way forward to achieve the targets.

We are a team that communicates effectively and open communication is encouraged. Completing the Equity module required communication, sound teamwork and a good understanding of what we wanted to achieve.

What motivated your practice to complete the Cornerstone Equity module?

Avondale Family Doctor recognises the longstanding barriers to health care for identified groups of people (particularly Māori), and the practice is committed to eliminating these inequities and improving health outcomes for our Māori patients.

We believe patients of all cultural backgrounds should be able to access quality health care services and treatment and have these services delivered to them in a culturally inclusive and respectful manner. We're committed to the ongoing education of practice staff to ensure culturally competent practice and aim to be inclusive in the way we deliver health care services to patients from all backgrounds. We work to remove barriers to health care and address any issues of inequity that may prevent patients from accessing services.

What did you have to do to gain the Cornerstone Equity module accreditation?

We researched our patient database to better understand our patients' needs for their medical requirements and the challenges they faced. Team meetings were held to discuss the results and form a plan of action to better address our patients' needs.

What has changed for your team following this work?

All team members are aware of their roles in achieving equity, and we support each other in achieving the best health outcomes for all our patients. The staff performance appraisal was updated and now includes equity goals, health promotion/training and cultural safety. Completing the module has given us a sense of achievement and assurance that we are giving our patients the best possible care.

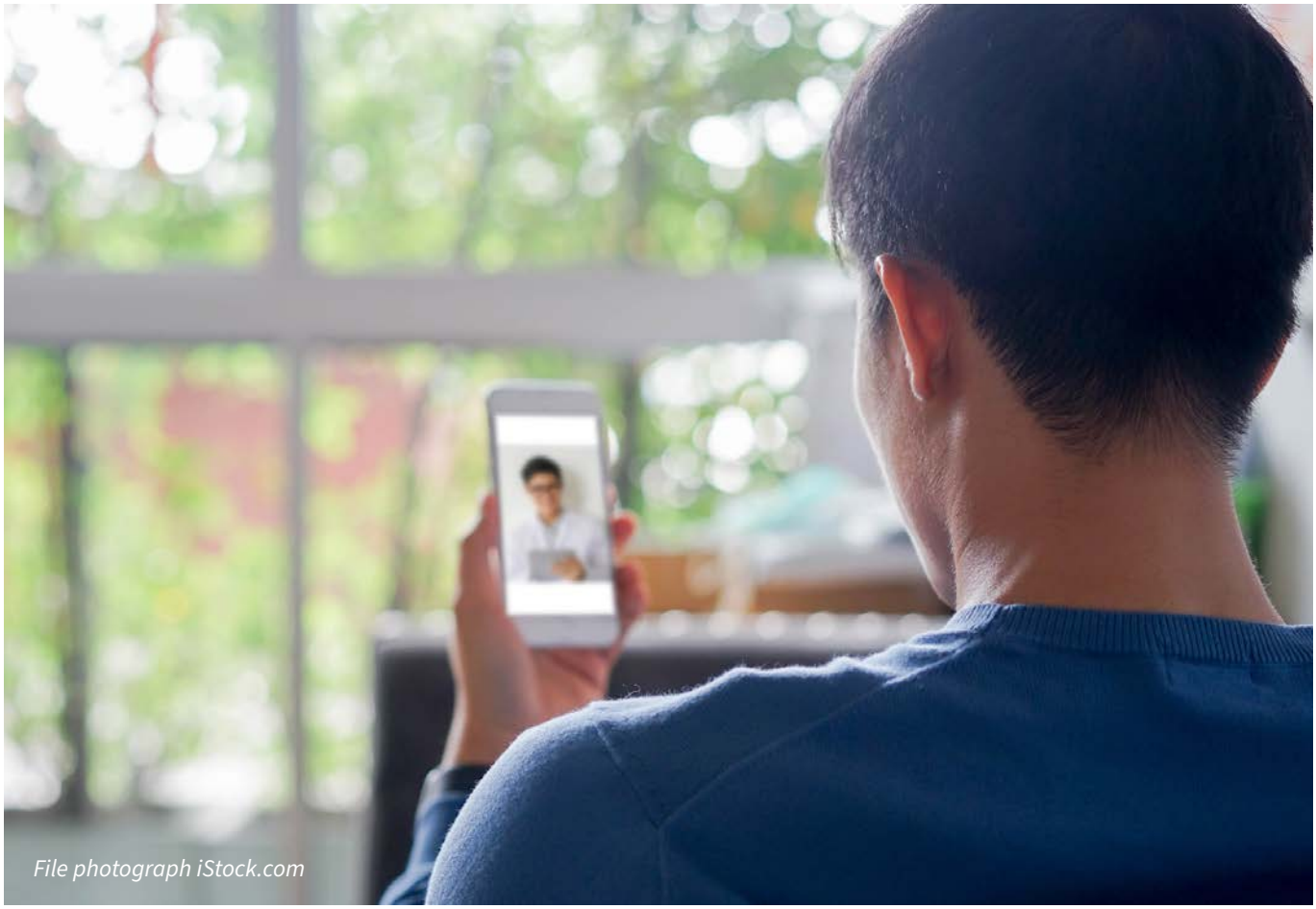
Equality

Equity

What is different for patients?

Patient experience has improved as we have agreed as a team to consistently offer the following (as much as possible and depending on workload):

- Extended consultations for education on health, diagnosis and health outcome, and follow-up in nurse-led clinics
- Whānau involvement in patient care and decision making with the patient's consent
- Accommodating patients who walk into the clinic to aid in health care accessibility
- Phone consultations and home visits by Dr Khan where needed
- Accommodating other family members in one consultation slot
- Consultations for contraception and minor ailments by practice nurse Nileshnee, a registered community nurse practitioner
- Discretionary funding/care where there are financial barriers
- Free Uber service where there are transport barriers
- Free interpreting service for refugee patients and patients with English as a second language
- Resource material/patient information pamphlets in appropriate languages
- Multilingual staff.



File photograph iStock.com

Equity reaccreditation module at

Bream Bay Medical Centre

Bream Bay Medical Centre (BBMC) is a GP and nurse-owned rural VLCA practice, with two clinics serving an enrolled population of approximately 9200 patients. They are part of a small community, and their team works with other local providers to offer wraparound services for their patients. They are an accredited teaching practice and also completed the Cornerstone CQI reaccreditation module pilot in late 2024. The culture of their practice is grounded in valuing colleagues and the community they care for. This commitment starts with the owners and is reflected through the entire team.

In July, the College launched its Equity reaccreditation module as part of the Cornerstone programme for practices wanting to maintain their Equity accreditation status. BBMC was one of the first practices to complete the new module.

We caught up with Kay Brittenden, practice manager at BBMC to find out about their experiences with the Cornerstone Equity reaccreditation module, why they did it and what they learnt from it.

What did you do to gain the Equity reaccreditation module?

We had given equity some thought and made a conscious effort during the three years to document what we were doing. In the past, we felt we did what was required regarding equity for our patients; however, we weren't good at the documentation. This time, we had prepared better, documenting our projects and our programmes.

We concentrated on the high-needs patients of our enrolled population. This included the topics below (not an exhaustive list):

- Mental health
- Chronic care (for example COPD)
- Abdominal aortic aneurysm and atrial fibrillation
- Ambulatory sensitive hospital admission rates.

We used data lists to help identify and prioritise patients and ran specialised nurse-led clinics. Extra supports were utilised when needed to give wrap-around services for patients when required, e.g. HC and HIP, local community support groups.

What did you find were the key differences between the Equity module and Equity reaccreditation module?

The Equity module concentrated more on policy and process; the Equity reaccreditation focused on how we worked and reflected on our processes and results.

What did you have to do or think about differently as you worked through the Equity reaccreditation module?

The reflection, with an equity lens, on what we did well and what we could improve on was a new process. Feedback from a new staff member was helpful in this process.

What is different for your team because of doing this work?

We have taken on board the recommendation from the staff member and will put a process (re: unconscious bias) in place at the orientation of any new staff. The team have a higher confidence in their skill set and the knowledge and skills of each other.

What is different for patients?

Our chronic care clinics are now permanent, so health outcomes have improved overall. We believe our reputation in the community has improved, and patients have a higher level of trust with the practice and the team.

If you are interested in finding out more about or purchasing our Equity and CQI modules, including the reaccreditation modules, visit the College's website.

File photograph Tuahuru Marae, Māhia 2025.

The Royal New Zealand
College of General Practitioners
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Published by The Royal New Zealand College of General Practitioners, New Zealand, 2026.

File photograph Wairoa Hospital & Health Centre, Wairoa 2025.

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