Information sharing agreements

Frequently asked questions

These FAQs are in addition to those provided by Te Whatu Ora | Health NZ.

Cyber security insurance, do we NEED it and can Pinnacle help?

It is not a requirement to have cyber-security insurance.

However, in the event of a data breach, for this or any other data you hold, you may wish to get some advice from a lawyer, you may have other costs as a business related to the remediation of the breach.

Pinnacle has reached out to several brokers to look for a network discount for different options in the insurance market. As soon as we get that information, we will share it with the network.

In the meantime, if you don't have cyber insurance and you are interested if e-mail mhnadminteam@pinnacle.health.nz and we will make sure that we get back to you specifically.

Can Te Whatu Ora unilaterally change the data collected in the future?

No – but it's complicated!

This information sharing agreement talks to only 12 points of data which have been agreed by the PSAAP appointed National Data Governance Group, currently Dr Jo Scott-Jones sits alongside Angus Chambers from GenPro as "provider representatives" on this group.

The group is responsible for determining the content of this data sharing agreement and the agreeing of the points of data that will be extracted and any additional data sharing into the future,

There will be future requests for more data to be shared – but those requests must be endorsed by this group and go through the PSAAP process.

In the current PSAAP process there is an override option which allows Te Whatu Ora to impose changes without endorsement, used most often when PSAAP cannot mutually agree an increase in funding. This does technically apply to data sharing, but it is highly unlikely that it will be used in this context.

Can you opt out if things change?

Yes.

There are consequences of "opting out" of this data sharing agreement – which is basically that you will lose your share of the "contingent capitation" funding ($12 per ESU).

If you "opt out" your data will not be extracted.

The timing of "opting out" is important.

Opt out / don't return ISA by March 31 2026	Data never flows	Funding stops end of April 2026	Opt out / don't return ISA by March 31 2026
Opt In, but opt out after March 2026	Data flows from July 2026 until end of January 2027	Funding stops end of January 2027	Opt In, but opt out after March 2026
Opt out, but opt in after March 31	Data flows from end of January 2027	Funding stops April 2026, restarts end of January 2027.	Opt out, but opt in after March 31

Practices can opt out at any time, the funding and data will flow until the end of January, or the end of June after their opt out date.

Practices can opt in at any time, funding will start and data will flow from the following end of January or end of June after their "opt in" date.

Is there any cost to practices given that Te Whatu Ora's contracted IT provider DataCraft is going directly to the IT providers rather than through the PHO?

No. There should be no cost or effort required by the practices other than signing the agreement to make this happen.

What about if the data collected is used in ways that aren't constructive? The primary health care target is that 80% of people are seen in a week, if we're busy, it might be 10 days, for some even longer. What about patients who booked three months in advance?

What data is collected and how it is used is determined by the PSAAP appointed Data Governance Group. The purpose of this data is to inform the Primary Health Care Target, which is proposed to be a measure of access to care summarised by "80% are seen in a week."

The data will be able to "cut" down to a practice level, but it will only be published to the public at PHO, district and regional level.

The purpose of collecting the information is to shine a light on areas where access is most difficult and to allow solutions to be developed.

There is no intent to "name, blame and shame" individuals or practices through this process and practices will be protected from this by the role of the Data Governance Group.

What about patients booking an appointment three weeks out or longer, will this impact our target? What about telehealth? Triage?

The details of what will be included and excluded from the "80% seen in a week" primary health care target are yet to be finalised by PSAAP. This might be a reason for practices to "opt out" until those details are known.

The PSAAP working group that is going to present the details of the target to the PSAAP negotiations is still working through modelling of the various inclusions and exclusions. The goal is to measure access for enrolled patients to general practice services and avoid any unintended consequences such as those seen in the UK when they introduced a similar target.

What happens if our practice does not meet the 80% target?

This is subject to the PSAAP negotiations.

To be very clear the $12 per ESU contingent capitation is linked to the sharing of the data, not the achievement of any target. The PSAAP negotiations will determine if there is any financial incentive linked to the primary health care target. Given the uncertainty about the detail, and the need to avoid any unintended consequences for patients and practices it may be that the target is simply a "measure" with no financial incentive at least initially.

Why is there pressure to sign this, when the business rules are not known?

Te Whatu Ora has put a very tight time frame on the signing of the data sharing agreement which has been 8 months or more in development.

The data sharing process and 12 points of data is clear, what isn't clear and probably won't be clear until mid-June 2026 is what the Primary Health Target is, and how it will be implemented.

To provide information about the target Te Whatu Ora need the data, and they want to start providing the data as soon as possible after 1 July 2026.

They will need time to collect, tidy up, collate and report on the data as they are learning from the 20+ "pilot sites" across the country they are currently working with this is not an easy task given the variation in the way data is input and stored in different PMS systems.

They estimate that getting the agreements back by 31 March will allow them to time to get the data flowing from 1 July.

How will measuring the target this year affect the current PSAAP negotiations? Surely, they have to wait another year before they can incentivise a target they don't know the business rules for?

There is a little bit of chicken and egg in this and given the need to build trust in the system it is not an easy place to accept that the PSAAP process and Data Governance Group will protect practices and patients from harm.

But having the PSAAP negotiation set the access target based on that data with both contracted providers and PHOs sitting around the table should hopefully give practices some degree of comfort that they're being represented. We do not think that achieving the target will come with any incentive funding at least for the first 12 months.

Do we know yet whether this data will be broken down into individual targets in future?

There's been no discussion that HNZ would set individualised targets for individualised practices, any

such plan would be subject to the PSAAP negotiations.

The target and data collected will capture waiting times for appointments, but I do not think it will capture quantity or quality and complexity of care. I think this needs further discussion.

Absolutely correct. It is a measure of access and doesn't consider any of those complexities you mention which makes it only a very simple measure and shouldn't be looked at alone.

I could not find any recognition of ethnicity in the new model. Did I miss it?

Good question. Ethnicity has also been removed from the proposed capitation re-weighting model. That has yet to be negotiated nationally. This agreement is separate from this and purely relating to collecting de-identified data for the primary care access target.

Are patients entitled to be informed that their data is being shared?

The Privacy Impact review has determined that as there is no identifiable data being shared there is no need to get formal consent from enrolled patients who have already signed the standard enrolment form which states this sort of administrative data can be shared in the system.

Te Whatu Ora will produce leaflets and posters talking about the change for use in waiting rooms.

Is Services to Improve Access (SIA) funding going to stop?

SIA funding isn't related to the "contingent capitation" funding. SIA is continuing and will continue whether you opt in or out. The only financial impact to a practice will be the loss of their share of the $60m contingent capitation that came into effect 1 July last year. approx. $12 per patient.

If we deal with more than one issue in a consult, would the data benefit us more if the patient had a second appointment booked on the same day?

These are the issues we need to ensure are part of the business rules to avoid unwanted changes to how we work in practice.

Do PSAAP negotiations happen throughout the year? Or only in June?

It’s an annual process. Starts about March for implementation in June/July. Includes the annual uplift process.

What are the 12 data points? I cannot find them.

Take a look at pg. 19 Appendix 2 of the ISA for the 12 data points (see over page).

Appendix 2: Data Details for PCHT Phase 2

The following table describes the PMS Information that is to be supplied under this Agreement, for the Approved Purposes. The elements are intended to be indicative only, as some metrics and the feasibility of each element may limit its availability. There is a table of **endorsed encounter data elements** that shares several similarities with the specification outlined below. However, the details provided here reflect what will currently be extracted, with the expectation that as data quality improves, more Participating Practices can eventually align with the encounter domain.

Position	Name	Description
1	PMS	The Patient Management System (PMS) the appointment was sourced from
2	Appointment Record ID	A practice and PMS specific id for a given appointment
3	Facility HPI	HPI Facility ID is the unique identifier of the Provider Organisation providing the Primary Care service.
4	Appointment Provider HPI	A unique lifetime identifier for practitioners and health workers which takes precedence over all other identifiers for the person across the HPI.
5	Appointment Provider ID	A practice and PMS specific id for a given provider
6	Appointment Provider Type	Indicates whether the provider is a doctor, nurse, nurse practitioner, or is unknown
7	NHI	The NHI number is assigned to each person at their first use of health and disability services. The NHI number is the primary key used to associate people with their health information
8	Appointment Booked	The date time that a booking was made for an appointment, for example when the patient rang their practice to organise to see their GP
9	Appointment Started	The data time that the appointment started, for example when the patient sits down in their GP's consultation room
10	Appointment Duration	The elapsed time, in minutes, between the Appointment Start and Appointment End.
11	Appointment Ended	The date time that the appointment ended, for example when the patient left their GPs consultation room
12	Appointment Access Time	The number of days between the Appointment Booked and Appointment Started dates