



Clinical Advisory Group (CAG)

Minutes

Of the meeting held on Wednesday, 19th August 2009, Meeting Rooms 1&2, 19 Lambie Drive at 1800 - 1930 hrs

Agenda Item		ACTION
Present Apologies Minutes of May 2009 meeting	Peter Gow, (Chair), Nua Tupai, John Roke, Michael Clark, Pam Williams, Tanu Toso, Soli Henare, Jenni Coles, Sam Cliffe, , Denise Kivell, , Tom Bracken, Stella Ward, Campbell Brebner, Paula Nes, John Savory, Karyn Sangster, Allan Moffitt, In attendance: Val McCullough. Gary Jackson, Don Mackie Passed as true record. Approved Pam Williams. Seconded Peter Gow.	
Action Point	Future role of CAG and ToR Allan and Sam to amend Terms of Reference from discussion and feedback and bring to September meeting. Feedback to be sent to Alan Moffitt by Friday August 28th	
Strategic Forum Update	Nil update given	
Primary Care Quality Improvement Plan / Indicators  PHC QI and CI Plan	CMDHB Vision 'To work in partnership with our community to improve the health status of all, with particular emphasis on Māori and Pacific peoples and other communities with health disparities' CMDHB Shared Values <ul style="list-style-type: none"> ▪ Care and respect ▪ Teamwork ▪ Professionalism ▪ Innovation ▪ Responsibility ▪ Partnership CMDHB Priorities Outcomes <ul style="list-style-type: none"> ▪ Improve community wellbeing ▪ Improve child and youth health ▪ Reduce the incidence and impact of priority conditions ▪ Reduce health inequalities ▪ Improve health sector responsiveness to individual and family/whanau need ▪ Improve the capacity of health sector to deliver quality services Action Areas <u>Service development</u> <ul style="list-style-type: none"> ▪ Maori health Pacific health ▪ Child & youth health ▪ Electives ▪ Let's Beat Diabetes ▪ Mental health ▪ Primary health care <u>Enablers</u>	

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	<ul style="list-style-type: none"> ▪ Service redesign (including facilities and clinical planning) ▪ Workforce ▪ Quality Improvement & Patient Safety <p>DSP Outcome Action areas</p> <ul style="list-style-type: none"> - Community Wellbeing & Healthy lifestyles – Lets Beat Diabetes (LBD) / MICH - Child & Youth Health – reduce infections & Immunisation - Reduce the incidence and impact of priority Conditions – Diabetes complications, Cardiac Vascular Disease (CVD) events - Reduce Health Inequalities: improve access; Ethnicity Recording; Ambulatory Sensitive Hospitalisations (ASH) rates; reduce smoking; increase breast feeding - Improve Health sector responsiveness: Supported self care, afterhours coverage; culturally competent care, (Locality Planning) - Improve capacity for quality services: Clinical Indicators; Workforce Development <p>PHC Plan 2007 – 2010 - Mission Through a valued and skilled workforce, primary health care services will:</p> <ul style="list-style-type: none"> • be easier to access; • help people make healthier choices; • deliver quality services that effectively address the needs of our communities, promote good health and reduce inequalities; • involve communities in identifying their health needs and shaping service development. <p>PHC Plan Six Main Priorities</p> <ol style="list-style-type: none"> 1. Community Participation 2. Increasing Access and Reducing Inequalities 3. Innovative Models of Primary Care 4. Supported Self Care and Chronic Care Management 5. Clinical Quality Improvement 6. Workforce Development 7. PHC Information Strategy – integrated I.T. piloted with #3 above] <p>PHC Plan KPIs</p> <ul style="list-style-type: none"> ▪ Community Engagement Plans ▪ Increase Physical Activity of Maori & Pacific <ul style="list-style-type: none"> ▪ Immunisation in Children 95% ▪ Diabetes – annual review 75% <ul style="list-style-type: none"> - Management % HBA1c <8 75% - Retinal Screening 75% - BP Control <130 75% - LDL < 2.5 80% - ACR >2.5 on ACE inhibitor 90% ▪ CVD <ul style="list-style-type: none"> - CVD Risk screening 50% - Appropriate Mgt if Risk >15% (Aspirin, Statin, ACE inhibitor) 60% ▪ Reduce inequalities <ul style="list-style-type: none"> - Increase Access –Enrolment (M,P Q5) 99% - Ratio of High Needs Consults >1.1 - Ethnicity Recording 90% - All indicators reported by ethnicity breakdown - Reduce ADH for Maori & Pacific 10% redn - Reduce Smoking (recording of smoking status) 80% - Breast Feeding ▪ Supported self care – PHO programmes 100% <ul style="list-style-type: none"> - Newly diagnosed Diabetes offered SME 100% ▪ After hours plan fully implemented – all PHOs ▪ Cultural Competency training 90% ▪ PHO Performance Programme Targets met 	

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	<ul style="list-style-type: none"> ▪ Workforce development - reporting of FTE data <p>Clinical Governance Forum (CGF) Priorities for QI Plan</p> <ul style="list-style-type: none"> • Clinical Indicators (National Health Targets: ASH, Immunisations, DGC; CCM; CVD; PPP) • Sentinel Events, with a focus on just culture before reporting is established • Plan of care (e.g. Year of Care) • Lifestyle – behaviour change = self management • Transfer of care issues (I.T., Health Event Summary (HES); Post discharge coordination; GP satisfaction; Communication) • Patient Centred Care – cultural responsiveness, patient feedback <p>Transfer of Care Issues*</p> <ul style="list-style-type: none"> • Develop personal health record (?portal/integrated/accessible) • Reconciling medication • Increased patient awareness of disease specific symptoms • Encouraging patient communication with providers <p>Plus:</p> <ul style="list-style-type: none"> • Role of coordinators/navigators <p>Medscape Review: http://www.medscape.com/viewarticle/574829</p> <p>What contributes to premature death?</p> <table border="1" data-bbox="391 824 1220 1102"> <thead> <tr> <th></th> <th>Maori</th> <th>Pacific</th> </tr> </thead> <tbody> <tr> <td>▪ Smoking</td> <td>20%</td> <td>9%</td> </tr> <tr> <td>▪ CVD</td> <td>16%</td> <td>35%</td> </tr> <tr> <td>▪ Cancer (Bowel & Breast)</td> <td>15%</td> <td>6%</td> </tr> <tr> <td>▪ Infant Mortality</td> <td>5%</td> <td>10%</td> </tr> <tr> <td>▪ Diabetes</td> <td>7%</td> <td>13%</td> </tr> <tr> <td>▪ Other</td> <td>37%</td> <td>27%</td> </tr> </tbody> </table> <p>Big Dot indicators</p> <ul style="list-style-type: none"> • Smoking • CVD • Immunisation • Acute Demand including ASH Rates • Quality Improvement & Patient Safety • Transfer of care bundle? • Access ?Primary Health Care (after hours, home visits) / Electives • Obesity (Nutrition and Exercise) <p>Discussion re transfer of care issues:</p> <p>The position of the “advice to patient” and the “advice to GP” sections in the EDS were discussed. There was unanimous agreement that the advice sections should come FIRST in the EDS. Everyone was under the impression that this had already been agreed to and implemented.</p>		Maori	Pacific	▪ Smoking	20%	9%	▪ CVD	16%	35%	▪ Cancer (Bowel & Breast)	15%	6%	▪ Infant Mortality	5%	10%	▪ Diabetes	7%	13%	▪ Other	37%	27%	
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<p>CAG ToR and Future Role</p>  <p>Primary Care into the Future</p>	<p>Discussion included the following:</p> <ul style="list-style-type: none"> • Not a lot of feedback to the draft ToR received. Feedback received to date will be incorporated. • ToR may be a bit broad and unstructured currently • Mandate – what does the CMDHB Executive team want from this group? • Currently we don’t have the right forum that crosses the primary secondary interface. CAG partly does this. • This group needs to be enhanced by increased membership including more secondary members e.g. CMO or deputised attendee, Clinical Directors and GMs • Query need more GPs • Need to take politics out of the way and make more clinical decision making focus • What are decisions making forums within CMDHB? This group needs to 																						

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	<p>enhance its mandate from CEO down and preferably from Primary Care management leaders also endorsing CAG as the group that sits across the interface</p> <ul style="list-style-type: none"> • If this group is to be effective it needs to have more teeth • Nothing from this group gets elevated to e.g. Strategic Forum • Need to have specific functions. Out of that the membership will become evident • Need a group that EOI (Expressions of Interest) issues can be presented to • Does this group make decisions or recommendations to somewhere else? • Does this group have a strategic role in making decisions and recommendations about the strategic direction of primary care or primary secondary interface? • CAG needs to have a mandate, respect, grunt, power and clout and not be another committee on the consultation round • Sam needs a group that can help give her some sensible clinical advice as to whether or not something is right and will work • Need both sides of the equation talking about whole of system process • Sam says she hasn't heard what has come out of CAG being used as a strong tool to do something different to change things at the highest possible levels in primary and secondary care • CAG has a group of champions around the table whose discussions inform the opinions and advice they take to their respective groups which, has been informal. From a Primary Care perspective if CAG had responsibility for decisions that carried weight you would see the importance of representation at CAG change very quickly and be taken seriously • CAG needs to be of value in the wider sense not just for the people that attend • Currently a safe group where members feel they can have an open discussion giving balanced views <p>In conclusion: Sam and Alan to be responsible for amending the draft ToR following tonight's discussion. Members asked to send tracked changes to Allan by Friday August 21st and to be directive about the who and the direction. The intent of the group in terms of its mandate needs to be restated and signed off at the highest level of the organisation. This should be endorsed by the Strategic Forum and/or Business Group giving it the mandate and then communicated to other forums.</p> <p>Link to the HORN report: http://www.beehive.govt.nz/release/ministerial+review+group+report+released</p>	
Standing Agenda Items Community Panel - TanuToso	No meeting held this month	
Other Business	<p>Single Theme Meeting will now be held at MSC Conference Room 1 which is on the ground floor right at the back on the right. Start time will now be 1700.</p> <p>Can you please inform staff from primary care who are interested in attending.</p>	
Next Meeting:	<p>September 16th 2009 ♦ 1800 - 1930 hours</p> <p>♦ In Meeting Rooms 1& 2 ♦ Counties Manukau DHB, 19 Lambie Drive, Manukau</p>	