

# Clinical Advisory Group (CAG)

## Minutes

Of the meeting held on Wednesday, 20th May 2009, Meeting Rooms 1&2, 19 Lambie Drive at 1800 - 1930 hrs

Agenda Item		ACTION
<b>Present</b>	Allan Moffitt(Chair), John Roke, Michael Clark, Pam Williams, Karyn Sangster, Tanu Toso, Soli Henare, Jenni Coles, Sam Cliffe, Gary Jackson, Denise Kivell, Paula Nes, Val McCullough, Campbell Brebner	
<b>Apologies</b>	Don Mackie, Stella Ward, Nua Tupai, Peter Gow, Tom Bracken, John Savory,	
<b>Minutes of March 2009 meeting</b>	Passed as true record	
Action Point Update	CMEC Secretariat queried the accuracy of the following statement - Page 2 – ‘Discussion that Ensued’ included - Currently the biggest proportion of savings will likely come from the Funder Arm i.e. the primary sector. Response from Sam: Savings have been fairly evenly 45/55 across provider and funder arms.	
<b>Strategic Forum Update</b>	Nil update available	
CMDHB Planning and Funding Structure  Sam Cliffe	<ul style="list-style-type: none"> <li>• Given clear instruction from Minister and Board DAP needs to break even</li> <li>• In real terms this means taking about \$20 million from the entire DHB budget. The money we should have got under the population based funding formula would have more than covered this if it was not capped</li> <li>• MoH capped growth at 7% which equates to approximately \$25 million of revenue</li> <li>• Strategic intent of structure says we are not making fast enough traction on key priority areas, particularly areas of inequalities.</li> <li>• What do we need to do differently</li> <li>• How do we structure ourselves to get better traction and usage of staff we have.</li> <li>• The intent didn’t change but the affordability did. We are net 6 roles less than when we started as a result of the line-by-line review.</li> <li>• Cost savings have made minimal impact to our contracted providers keeping impact to the lowest possible level</li> <li>• Less money so innovative projects need to be done smarter.</li> <li>• Funding will be a problem for up to years 11/12 at least. (i.e. despite reassurances from MoH that our share of funding will return to PBFF this is not a one year problem)</li> <li>• Need to find ways to manage demands and pressures to make savings sustainable.</li> </ul> <p><b>Restructure</b></p> <ul style="list-style-type: none"> <li>• A week for feedback on structures</li> <li>• CEO says big picture will not change except for minor tweaking or unless there is something that is patently not a sensible thing to do.</li> </ul> <p>Major differences:</p> <ul style="list-style-type: none"> <li>• Changes of line management accountability for contract and programmes and staff for the Maori and Pacific Team</li> <li>• Roles of GM and teams for contracts and programmes now report to Director of Service Integration</li> <li>• New role created which has a working title of Director of Maori Health</li> </ul>	

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	<p>Equity. Strategic role with intent to separate out operational management of contracts programmes and budgets that sit with the Maori Health and Pacific Health teams, separating out the strategic so that someone can be freed from the operational to concentrate on how to change the DNA of the organisation in terms of addressing inequalities, putting the Treaty at centre stage. This is controversial and needs more thought.</p> <ul style="list-style-type: none"> <li>We have great pockets of work. How do we pull these together and work better with the lesser resources we have.</li> <li>The Director of Maori Health Equity role will take a bit of working through with consultation outside the DHB with local groups and stakeholder groups. Will be a contestable role.</li> <li>Within structure there will be a number of new contestable roles. There have been a number of roles disestablished.</li> </ul> <p>Process for finalising:</p> <ul style="list-style-type: none"> <li>One week for Feedback</li> <li>Feedback to date mixed erring on side of positive</li> <li>Big picture structure, lines of accountability and big building blocks of structure are set. How to get the best use of the teams is up for debate.</li> <li>Structure should look simpler in that big priority areas have been identified and activity has been clustered around these areas.</li> <li>CMDHB has a history of making a difference. We have lost traction and we need to rev it up again.</li> </ul>	
<p>Future role of CAG and ToR</p> <p>Sam Cliffe/Allan Moffitt</p>	<ul style="list-style-type: none"> <li>Useful forum</li> <li>People keep attending so must have some value</li> <li>If goals are as stated on the agenda then needs higher visibility</li> <li>Where does this forum feed to? Strategic Forum? Should go there. Currently not a lot is fed out from this group</li> <li>At inception had different membership. Discussion informed highest level</li> <li>Funder Arm fallen out now</li> <li>Invention of former CEO. With changes of CEO visibility of this group decreased.</li> <li>Open, safe, robust discussion forum which is rare and valuable</li> <li>Currently interface between Primary and Provider Arm.</li> <li>Accountability, clinical leadership, performance measurement could be utilised here.</li> </ul> <p>Membership Who: Should include CD Quality, Chief Medical Officer and DON, Director Primary Care, Director Public Health, Director of Service Integration, ? Residential Care, ? Mental Health, GPs, Practice Nurses, Pharmacists.</p> <ul style="list-style-type: none"> <li>Director of Service Integration has no other forum where she gets input from above suggested membership without attending multiple forums. She has no direct contact with GPs.</li> <li>We need to be clear about our decision making processes, what needs to be fed into and out of this group?</li> <li>Need to get back to being a recommendation making forum</li> </ul> <p>Action Point: Allan and Sam to work on new Terms of Reference</p>	
<p>Standing Agenda Items</p> <p>Community Panel</p> <p>TanuToso</p>	<p>Met with Don Mackie who walked the panel through the credentialling process. Deep Vein Thrombosis Pamphlet Adapted from Australian pamphlet with proviso they would provide us with translations for South Asia and we translate for Maori. Recommend on back page we put our logo ahead of the Australian logos. Translated versions – who owns the intellectual rights? Needs to make sense and not be a literal English translation. Needs to have on pamphlet what other languages it is available in (in those languages).</p> <p>Locality Planning Panel members who live in Papakura and Manurewa were invited to participate</p>	

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	<p>in the workshops.</p> <p>RISSP Requested two representatives. The two representatives felt this group wasn't prepared for the community lens. This process has now been pulled and restarted as a much more technical group.</p>	
<p><b>Other Business</b></p> <p><b>Impact of Super City on health projects</b></p> <p><b>Tanu Toso</b></p> <p>Science Fest</p> <p>Swine Flu Update</p> <p>Karyn Sangster</p>	<p>Need to look at some of the impacts of the Super City in our community. Tanu stated that 75% of public health contracts are managed by Council. Tanu questioned what will happen to the public health initiatives and contracts when the Super City happens? Will they continue to be funded? Tanu suggested there needs to be a stock take on the public health contracts we have with the council. Will these contracts stay in Manukau or be dissolved CMDHB is one of the Healthy City Charter signatories.</p> <p>Allan Moffitt suggested this could be raised at CPHAC where some Manukau counsellors sit.</p> <p>Soli suggested we need to get clarity in terms of relationship between funding Council may have and what they get directly from CMDHB.</p> <p><b>Action Point: Gary Jackson to raise at CPHAC the question whether CMDHB should make a submission to the Select Committee.</b></p> <p>Broad selection of presentations. If you want to attend the dinner don't forget to purchase your \$30 ticket from the reception desk at either MSC, DHB Staff Centre Support Building.</p> <ul style="list-style-type: none"> <li>• Hotel quarantined 40 travellers so far</li> <li>• Rates have increased around the world</li> <li>• Increasing screening of incoming flights from Japan</li> <li>• Quarantine for 72 hours with children under 5 for 5 days</li> <li>• PH nurses meeting round clock at airport with 6 nurses working 24/7</li> <li>• Looking at what would happen if WHO increased pandemic response to level 6</li> <li>• Containment phase strong</li> <li>• Major issues happening – heating up again – risk of second wave or more virulent 'flu'</li> <li>• Looking at 1918 experience</li> <li>• Hopefully if resurgence in next season will have a vaccine</li> <li>• Case mortality less the 0.4%</li> <li>• Information to GPs getting through – ready and prepared</li> </ul> <p>Community based teams need to be made aware of at risk homes. An alert is to be placed for 1 week on PIMS. Pointed out this won't help primary care.</p> <p><b>Action Point:</b> Place on June agenda</p> <ul style="list-style-type: none"> <li>• CAG TOR</li> <li>• Primary Care Quality Improvement Plan</li> </ul>	<p>Val Completed</p>
<p><b>Next Meeting:</b></p>	<p><b>June 17th 2009 ♦ 1800 - 1930 hours</b></p> <p>♦ In Meeting Rooms 1&amp; 2 ♦ Counties Manukau DHB, 19 Lambie Drive</p>	