


Clinical Advisory Group (CAG)

Minutes

Of the meeting held on Wednesday, 17th February 2010, Meeting Rooms 1&2, 19 Lambie Drive at 1800 - 1930 hrs

Agenda Item		ACTION
Present	Peter Gow, (Chair), Michael Clark, Tom Bracken, Campbell Brebner, John Savory, Karyn Sangster, John Roke, Gary Jackson, Tina McCafferty, Soli Henare, Paula Nes, Pam Williams, Allan Moffitt, Nua Tupai	
Apologies	Don Mackie, Sam Cliffe, Denise Kivell,	
Minutes of August 2009 meeting	Passed as true record	
QSTAT	<ul style="list-style-type: none"> • KPI reports published monthly on website. • GPs still getting results not belonging to them approximately 2 times per week. • In CAGs view intensive monitoring still warranted. 	
Regional Cardiology Draft Strategic Plan	<ul style="list-style-type: none"> • Initially didn't have as much primary engagement as it might have had • Representation on group is heavily secondary focused and heavily non clinical • All Eols will have cardiovascular disease included somewhere which will have to fit with the strategy or the strategy fit with the business plans • Can have a regional focus 	
Eol Business Development Plans  Summay of BSMC proposal	<ul style="list-style-type: none"> • To date still in draft form. Final plans due Friday. GAIHN Focus around reducing acute demand growth, management of long term conditions, elective services, prevention, reduction in inequalities, consistency between DHBs Four work streams: <ul style="list-style-type: none"> - project management and communications, - outcomes and models of care, - service delivery and infrastructure, - resources and governance Governance GAIHN partners sign up to: <ul style="list-style-type: none"> ▪ Participate in a formal network ▪ GAIHN charter and principles (e.g. Information sharing) ▪ Participate in development of GAIHN Regional Annual Plan (outcomes/measures) ▪ Commit to implementation of plan – which may require resource re-orientation ▪ DHBs – GAIHN Regional Plan in DAPS ▪ PHOs – GAIHN Regional Plan in contracts Key programmes to be initiated in some way in year one Long term conditions programme A regionally consistent programme that includes <ul style="list-style-type: none"> - self management - annual interdisciplinary review - pulmonary and cardiac rehabilitation in the community Establish health navigators Improve health literacy Maintain and expand CCM depression programme	

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	<p>Palliative Care Managing acute demand Expand and strengthen Primary Options for Acute Care Telephone triage services Integrated care pathways</p> <p>Preventative Health Implement health promoting practices quality framework Optimise general practice systems for immunisation, screening, counselling and support.</p> <p>Enablers Access to diagnostic tests</p> <p>Key organisational change No commitment to consolidation although there is a recognition of issues.</p> <p>GAIHN will create the bare minimum of structure necessary to fulfil its functions in year one. For years two and beyond the structures and governance for GAIHN will evolve, with the <u>minimum</u> of change to structures and governance necessary to fulfil the needs of the consortium and its partners.</p> <p>Alliance Model Organisations involved: AuckPac Ta Pasefika Health Trust Tongan Health Society Inc</p> <p>Focus</p> <ul style="list-style-type: none"> • Structural Change • Establishment of Integrated family health centres • Enhanced Primary Health Care Services • Nurse-led Services • New Population Health Programmes • Acute Demand Management • Care Coordination Function • Shared Care Arrangements • Afterhours Care • Community Based Initiatives • Patient Literacy • Intersectoral services • Patient Portal <p>Process A series of meetings held with clinicians, NGOs and key stakeholders. Regular feedback from DHBs</p> <p>Governance The organisation will become an incorporated charitable trust. The organisation will have a CEO and Clinical Director and a change management team</p> <p>Key Organisational change The proposal includes the consolidation of the three Pacific PHOs into one regional Pacific led and governed PHO by June 2010. The PHO will be a charitable trust.</p> <p>IFHC and Infrastructure Integrated Family Health centres will include the following: - core general practice services, well health services, allied clinical support services and inter-sectoral services. The proposal includes up to three integrated family health centres to be established in the first 12 months of operation</p> <p>Outcomes The proposed framework to track progress will be based on four outcomes</p> <table border="0" style="margin-left: 40px;"> <tr> <td>*accessibility</td> <td>*affordability</td> </tr> <tr> <td>*quality of care</td> <td>*continuity of care</td> </tr> </table> <p>Maori Coalition Focus The Whanau Ora approach will implement the objectives of “Better, Sooner, More Convenient” Primary Health Care:</p> <ul style="list-style-type: none"> • Putting patients first • Care close to home 	*accessibility	*affordability	*quality of care	*continuity of care	
*accessibility	*affordability					
*quality of care	*continuity of care					

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	<ul style="list-style-type: none"> • Integrated care • Trusting health professionals • Working together for better care • Healthier lifestyles <p>Governance Whanau Ora service delivery will be led by a collaboration between Maori and high needs providers across the primary healthcare and social sector delivering on service user outcomes. They will share: A rohe based governance board Develop and commit to an outcomes framework Outcomes based relational contracts for service users A network lead which provides infrastructure and support</p> <p>They retain: Their sovereignty as organisations Respect the relationship between Whanau, hapu and mana whenua</p> <p>They will deliver: A way to integrate Maori and high needs health providers and NGOs across the rohe Coordinated and integrated pathways of care and programmes for their Whaanau. which may include virtual networks and multidisciplinary teams that work across organisations to benefits Whanau Critical mass to support high performing Maori providers across New Zealand Accountability for locality networks performance for Maori and high needs communities.</p> <p>Key programmes to be initiated in year one Mama, pepi & tamariki Design commission and implement a new integrated package of care that transforms formerly fragmented services across multiple health sector strategies into a unified continuum of care across: pre-conception, haputanga (pregnancy), birth, pepi (0-1 year) and tamariki (1-4 years)</p> <p>Long term conditions Comprehensive planned approach to assessment and management of long term conditions including care support, supported self care and medical management, whanau ora coordinator and intensive case management. Evidence-based, best practice and Maori models of health –applying aspects of accepted models including Te Pae Mahutonga, Te Whare Tapa Wha, Kaiser Model, Chronic Care Management, Self Management, health literacy, etc. Cultural concordance -tikanga Maori is incorporated at all levels from strategy, planning and governance to practical delivery Whanau Ora-centred care –promoting the integration of whānau (inclusive of the individual) into the care pathway Kotahitanga-centred care –working in partnership with others to achieve a unified and streamlined approach for the benefit of whānau and prioritising team-based, interdisciplinary processes Whanau Ora outcomes focused –working to achieve the four Whanau Ora outcomes</p> <p>Key organisational change There is no plan to bring organisations together instead the Coalition will operate as a network.</p> <p>IFHC and infrastructure Core components of an IFHC would incorporate:-</p> <ul style="list-style-type: none"> • General Practice, Nurse led walk in clinics, extended and after hours care • Whanau Ora triage, assessment and coordination, Kuia and Kaumatua • Rongoa and Mirimiri, Kaupapa Maori specialist services <p>In addition the whanau ora centres may include a range of health and social service provision</p> <p>Whanau Ora Case Coordinator Roles-all Whanau will be allocated a Whanau Ora Case Manager (if required) who walks beside the Whanau on their Whanau Ora journey.</p> <p>Internal integration-building and strengthening current infrastructure, systems</p>	

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	<p>and processes amongst Maori providers and those within the wider locality networks</p> <p>Horizontal Integration- in order to improve health gain for Maori and high needs Whanau, the social determinants of health must be addressed in conjunction with health.</p> <p>Intersectoral collaboration- Effective strategic alliances will be key to the success of these networks.</p> <p>Will be part of a credentialing process to ensure consistency of service delivery, quality, best practice and business sustainability</p> <p>Outcomes includes population outcomes, service user outcomes and whanau ora performance measures.</p>	
<p>CAG ToR</p>	<ul style="list-style-type: none"> • Delay due to holding back re process around GAIN but agreed need to get on and formalise • Could be stronger and better linkages with Provider Arm with CMO in particular • Membership changes – Add roles currently held by Tina McCafferty, Soli, Paula • Need to look at goals. Remove old ones from agenda. • Might require reviewing in a year or so • Community Panel – Proposed 1 plus 1 community rep. Who would the community rep feed back to and be nominated by. Would lack DHB context that a community panel member has. CAG feels we continue to use the Community Panel (birthed by CAG). Suggest Soli feeds back to panel we have up to two reps from the Community Panel but recommend one panel member and Soli attend. <p>Action Point: Think about new goals for CAG and bring to next meeting</p>	
<p>Thriving in Difficult Times</p> <p>Tina McCafferty</p>	<p>CMDHB must post a zero deficit in 2009 -10; 2010-11 and future years to retain ability to determine its own future. This means identifying opportunities to increase productivity, realise savings, make efficiencies, increase revenue and improve systems performance.</p> <p>Savings in some areas are dependent on significant changes in the 'way we work' and require significant clinical commitment.</p> <p>Implementation planning of the actions outlined in the TiDT workstreams need to be finalised and included in the District Annual Plan (DAP) that must be signed off at the march Board meeting.</p> <p>Key Summary Actions:</p> <ul style="list-style-type: none"> • Budget meeting across all Divisions have occurred with some savings already loaded into budgets • Funding envelope has identified a change to the proposed deficit from \$50 million to \$25 million • DAP planning well underway with core TiDT actions to realise savings incorporated • Savings work streams are finalising the \$s for savings and an approach for capturing these that will be reported monthly to CFO and form part of his monthly report to the CEO and Board • Enabler work streams have yet to meet – no progress to report. Activities will form part of the final report for the Strategic Review: Delivering the Triple Aim extension of TiDT project. Not yet identifying savings but improved processes should realise some savings via efficiency. • Union update held on January 26th • Management Support group re-convened February 8th <p>Risks and Issues:</p> <ul style="list-style-type: none"> • Risks re operating costs focus and not waste reduction and patient safety • QIU savings and budget must be clearly different from savings identified as part of Patient Safety top slice • Issues with double counting need to be cleared up as this is a recurring comment from across organisation • Must complete 09/10 savings plan actions as will risk replicating issues for 10/11 • Now need ownership and leadership from Business Group and within each 	

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	<p>workstream to ensure each action is completed and these savings realised.</p> <ul style="list-style-type: none"> Disciplined approach to achieving savings and efficiencies will require consistent application of our problem solving methodology 	
<p>Standing Agenda Items Community Panel - Soli Henare</p>	<ul style="list-style-type: none"> Community Panel representation on CAG – Proposed 1 community panel representative plus 1 community rep. Queried who the community rep would feed back to and be nominated by. Would lack context that a community panel member has. <p>CAG decided to continue to use the Community Panel (birthed by CAG). Suggest Soli feeds back to panel we have up to two reps from the Community Panel but recommend one panel member and Soli attend.</p>	
<p>General Business</p>		
<p>Next Meeting</p>	<p>March 17th 2010 ♦ 1800 - 1930 hours ♦ In Meeting Rooms 1 & 2 ♦ Counties Manukau DHB, 19 Lambie Drive, Manukau</p>	