


# Clinical Advisory Group (CAG)

## Minutes

Of the meeting held on Wednesday, 15th July 2009, Meeting Rooms 1&2, 19 Lambie Drive at 1800 - 1930 hrs

Agenda Item		ACTION
<b>Present</b>	Peter Gow, (Chair), Nua Tupai, John Roke, Michael Clark, Pam Williams, Tanu Toso, Soli Henare, Jenni Coles, Sam Cliffe, Gary Jackson, Denise Kivell, , Tom Bracken Don Mackie, Stella Ward, Campbell Brebner, Val McCullough.	
<b>Apologies</b>	Paula Nes, John Savory, Karyn Sangster, Allan Moffitt,	
<b>Minutes of May 2009 meeting</b>	Passed as true record	
Action Point Update	Future role of CAG and ToR <span style="color: red;">Allan to work on new Terms of Reference and bring to August meeting</span> <b>Impact of Super City on health projects</b> <span style="color: red;">CPHAC clear they would not be making any submissions re this</span>	
<b>Strategic Forum Update</b>	Nil update given	
<b>GP Liaison Service</b>  <b>Campbell Brebner</b>   GP Liaison Presentation	Consists the following team members: ▶ <b>Dr Campbell Brebner</b> Medicine, Radiology/Lab, Emergency Care, IT and Healthpoint ▶ <b>Dr Andrew Stacey</b> Surgical Specialties, Kidz First and Women's Health, Pandemic Planning and GP Newsletter ▶ <b>Dr Russell Smart</b> Elective Services ▶ <b>Dr John Cosgriff</b> Mental Health Services <b>FIRST IMPRESSIONS</b> <b>Confusion</b> <ul style="list-style-type: none"> <li>• Sheer number of other staff and their roles</li> <li>• Broad job description</li> </ul> <b>Complexity of decision making</b> <ul style="list-style-type: none"> <li>• Myriad of people involved</li> <li>• Difficulty getting everyone to agree</li> </ul> <b>Communications</b> <ul style="list-style-type: none"> <li>• Emails flying around everywhere</li> </ul> <b>Commitment</b> <ul style="list-style-type: none"> <li>• Staff seem to want to make a difference</li> </ul> <b>GP Outpatient Referrals</b> <b>Perspectives</b> <b>Feedback from departments</b> More could be done before the patient is referred <ul style="list-style-type: none"> <li>- Initial Investigations</li> <li>- Preliminary treatment steps</li> </ul> Patients not referred back to the same clinician <b>GP's perspective</b> Issues re access to system <ul style="list-style-type: none"> <li>- 'leap frogging'</li> </ul> Inadequate feedback when referrals declined 'Circular referrals'	

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	<ul style="list-style-type: none"> <li>- E.g. refer pt for u/s and assessment, letter: "do u/s first".</li> </ul> <p><b>Reasons for issue</b></p> <ul style="list-style-type: none"> <li>• Familiarity of GP with condition and preliminary steps; Generalist vs Specialist</li> <li>• Access to public Ix and costs of private Ix</li> <li>• Costs to patient of repeated visits</li> <li>• Patient expectations <ul style="list-style-type: none"> <li>- Want to see a Specialist</li> <li>- Expect any Dr to be able to refer them</li> </ul> </li> <li>• Degree of information sharing</li> </ul> <p><b>Possible Solutions</b></p> <p>Virtual consults</p> <ul style="list-style-type: none"> <li>• 1 on 1 advice for GPs. Targeted, but time consuming</li> </ul> <p>GPwSI consults</p> <ul style="list-style-type: none"> <li>• GP with Special Interests running ENT, Gynae clinics</li> </ul> <p>Increased access to Consultants on call</p> <ul style="list-style-type: none"> <li>• Paeds/Medicine/O+G at present</li> </ul> <p>Healthpoint as IT forum</p> <ul style="list-style-type: none"> <li>• Referral guidelines, blogs, noticeboard</li> <li>• Web teaching videos</li> </ul> <p>Departmental input into CMEs</p> <p>Enhanced access to community radiology</p> <ul style="list-style-type: none"> <li>• Eg u/s for gallstones, heavy menstrual bleeding</li> <li>• Appropriate triaged access to diagnostics.</li> <li>• Long wait times. Demand exceeds contracted delivery.</li> <li>• Issue re income streams.</li> <li>• IT system can't cope &gt;6/12. Archaic manual system.</li> </ul> <p>E referrals</p> <p>Wider sharing of patient information</p> <ul style="list-style-type: none"> <li>• Sharing of GP records; commercial/privacy barriers</li> <li>• Reducing barriers to Concerto access</li> </ul> <p>PHO initiatives</p> <ul style="list-style-type: none"> <li>• Encourage dialogue between Clinical Directors in DHB and PHOs</li> </ul>	
<p>CMDHB Planning and Funding</p> <p>Sam Cliffe</p>	<p>The key focus areas for the Board and Senior Management team for the next 12 months are:</p> <p><b>Health Information Management</b></p> <ul style="list-style-type: none"> <li>- Have Regional Information Strategic Services Plan (RISSP).</li> <li>- Transfer of Care summaries, E records appear on the cusp of improving communication between primary and secondary care.</li> <li>- Won't have huge amount of money to invest either locally, regionally or nationally.</li> <li>- Prioritised list for capital spend for IT activity due end of week.</li> </ul> <p><b>Quality and Patient Safety</b></p> <ul style="list-style-type: none"> <li>- Bottom up ground swell of activity</li> </ul> <p><b>Sustainable Cost Containment</b></p> <ul style="list-style-type: none"> <li>- 7% growth this year</li> <li>- 3-4 % growth over next year or two</li> </ul> <p><b>Capital Planning</b></p> <ul style="list-style-type: none"> <li>- \$208 million to build new clinical services block – phase two of a several phase capital plan going out to 2025</li> <li>- Chances of further \$s next year - very slim</li> </ul> <p><b>Changes to National Policy</b></p> <ul style="list-style-type: none"> <li>- Potential Primary Care structural changes - unknown currently</li> <li>- The MoH may down size keeping policy and regulatory functions but there may be changes to overseeing and monitoring of performance.</li> </ul> <p><b>Regional Activity Changes</b></p> <ul style="list-style-type: none"> <li>- Lots of activity both clinically and management wise but unsure how exactly things will look at this stage</li> </ul> <p><b>Clinical Networks</b></p> <ul style="list-style-type: none"> <li>- Have a couple of networks that aren't really functioning as networks but as</li> </ul>	

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	<p>groups of people coming together to do pieces of activity e.g. Mental Health and cancer network. Not truly networks nor clinically driven either</p> <ul style="list-style-type: none"> <li>- Lot of work to be done on Clinical Networks</li> </ul> <p><b>Workforce Development</b></p> <ul style="list-style-type: none"> <li>- Have some major issues.</li> <li>- MoH have pulled back national control of work force development from DHBNZ 8-9 months ago. Nothing forthcoming to date from this</li> <li>- DHB getting to where this needs local progression</li> </ul> <p><b>Clinical Leadership – In Good Hands</b></p> <ul style="list-style-type: none"> <li>- Capacity development around clinical leaders</li> <li>- Policy from Government states clinicians need to increase taking a lead in clinical settings, joint decision making and being there at highest possible levels of decision making</li> </ul> <p><b>Primary Care Reconfiguration</b></p> <ul style="list-style-type: none"> <li>- Minister of Health made it clear there will be changes to Primary Care</li> <li>- Will be fewer PHOs</li> <li>- Not just devolution of few additional FFAs and GPwSIs procedures but fairly large transfer of cash, resources, accountability and responsibility to Primary Care from Secondary Care settings.</li> <li>- Positivity around discussion of devolution-opportunity to do things better for the benefit of patients, the term “devolution” i.e. money transfer, may not be the most constructive way to look at future requirements for best practice</li> <li>- Current structures don’t allow us to devolve things to their full potential</li> <li>- Our current structures in primary care aren’t there in terms of the organisations and the governance structure that is.</li> <li>- Governance structure not at fault. Is probably the number, critical mass capacity doesn’t allow devolution to the extent that both the primary and secondary sector would want.</li> <li>- Need to think about what Minister wants and what he would support us doing</li> <li>- Need to come up with a model of care and what we would want to be purchasing.</li> <li>- Very little money to fund changes</li> </ul>	
<p><b>Standing Agenda Items</b>  <b>Community Panel - TanuToso</b></p> <p><b>Community Panel Review Update - Soli Henare</b></p>	<p><b>As per Community Panel Minutes</b></p> <ul style="list-style-type: none"> <li>- Small team leading review</li> <li>- Identified a number of questions relating to the ToR</li> <li>- Liz Stewart undertaking the actual review</li> <li>- Review report will be presented to the Community Panel before going to the Director Service Integration along with Community Panel comments</li> <li>- Final report will be made publicly available</li> <li>- Suggestion that the good work of the community panel should be celebrated by using report as the basis of an article in NZ Medical Journal or similar publication</li> </ul>	
<p><b>Other Busines</b></p>	<ul style="list-style-type: none"> <li>- Next Single Theme Meeting topic is ‘Obesity and related issues’ Sept 10<sup>th</sup></li> <li>- Possible future topic suggested “Poor performer or difficult/bad health practitioner”. The more we can understand what leads that behaviour to the DHB as a bad or poor performer is driven by things like they way they are funded, how busy they are, staff recruitment, workforce and all sorts of issues intrinsic to the way that person practises rather than an uneducated poor quality doctor. Some solid work around this would flag many issues that would be key to FAMA, recurrent admissions and acute acuity issues.</li> <li>- Don offered to present on Integrated Clinical Governance at Aug meeting</li> </ul>	
<p><b>Next Meeting:</b></p>	<p><b>August 19th 2009 ♦ 1800 - 1930 hours</b>  ♦In Meeting Rooms 1&amp; 2 ♦ Counties Manukau DHB, 19 Lambie Drive, Manukau</p>	