


# Clinical Advisory Group (CAG)

## Minutes

Of the meeting held on Wednesday, 21st April 2010, Meeting Rooms 1&2, 19 Lambie Drive at 1800 - 1930 hrs

Agenda Item		ACTION
<b>Present</b>  <b>In Attendance</b> <b>Apologies</b>  <b>Minutes of February 2010 meeting</b>	Peter Gow, (Chair), Michael Clark, John Savory, John Roke, Tina McCafferty, Soli Henare, Pam Williams, Sam Cliffe, Denise Kivell, David Hughes, Jenni Coles, Analosa Ulugia-Veukiso  Val McCullough Don Mackie,  Passed as true record	
<b>Welcome to Analosa Ulugia-Veukiso</b>	Peter and Soli introduced and welcomed Analosa to the group. The group introduced themselves then Anaolsa gave an overview of her journey leading to this position	
<b>Role of Quality Unit</b>	<ul style="list-style-type: none"> <li>• Forms part of discussion on providing governance for quality improvement activities across the organisation both provider arm and community</li> <li>• Looked at various groups/meetings to see what representation each meeting had</li> <li>• CAG seen as ideal forum to provide this</li> <li>• Discussion currently stalled and thus further discussion would be premature</li> <li>• A representative from the Quality Unit would be useful to attend CAG</li> </ul> <b>CAG support the above occurring.</b> Action point: David to discuss with the Quality Unit the nomination of a representative.	
<b>CAG ToR</b>	Approved as written	Val to place on SouthNet
<b>DSP Review 2006 – 2011</b>	DSP distinguishes what ought to be done versus what can be done. Final DSP to be sent to MoH by November. <b>Key Components of DSP</b> <ul style="list-style-type: none"> <li>• Strategic Direction</li> <li>• Health needs assessment and the operating environment</li> <li>• Strategic objectives and actions</li> <li>• Performance indicators and targets</li> <li>• A 10 year financial plan</li> </ul> <b>Key Considerations for Review</b> <ul style="list-style-type: none"> <li>• The NZ health and disability strategies</li> <li>• Alignment with Govt strategic direction including the Minister’s expectations, Ministerial Review (Horne) Report</li> <li>• Health needs assessment</li> <li>• Achievements and progress in the previous three years</li> <li>• Regional Services Planning and Regional Asset Planning</li> <li>• Changing Models of Care and Service Configuration</li> <li>• Keeping our strategic ‘Shape’ – Triple aim</li> <li>• Affordability</li> </ul> <b>Government Priorities</b> <ul style="list-style-type: none"> <li>• Global Fiscal Crisis: Living within our means</li> <li>• Better, Sooner more Convenient – policy focus on strengthening services</li> <li>• Priorities: hospital productivity, clinical leadership, workforce retention, primary care, improving service and wait times</li> </ul> <b>Approach and Timeframes</b> <ul style="list-style-type: none"> <li>• Plan review phase (April – June 2010)</li> </ul>	

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	<ul style="list-style-type: none"> <li>• Plan consultation Phase (July – early Sept 2010)</li> <li>• Plan finalisation and implementation phase (Oct – early 2011)</li> </ul> <p><b>Plan Review Phase</b></p> <ul style="list-style-type: none"> <li>• TiDT and Delivering the Triple Aim</li> <li>• Organisational vision/mission/values</li> <li>• Strategic priorities including outcomes</li> <li>• Service Plans including those developed since 2005</li> <li>• Health needs assessment</li> </ul> <p><b>5 Workstreams of Delivering the Triple Aim</b></p> <p><i>Population Health</i></p> <ul style="list-style-type: none"> <li>• Service Integration and whole system delivery (Sam Cliffe)</li> <li>• Population Health &amp; Child Health (Gary Jackson)</li> </ul> <p><i>Patient Experience</i></p> <ul style="list-style-type: none"> <li>• Secondary Care Quality Improvement Plan (Mary Seddon)</li> <li>• Primary Care Quality Improvement Plan (Allan Moffitt)</li> <li>• Design for Safety (Ron Dunham)</li> </ul> <p><i>Cost and Quality</i></p> <ul style="list-style-type: none"> <li>• Accounting for Patient Safety and Quality Improvement Savings (Ron Pearson)</li> </ul> <p><i>Strategic Capacity development</i></p> <ul style="list-style-type: none"> <li>• Leadership Development (Geraint Martin)</li> <li>• Centre for Health Services and Innovation (Geraint Martin)</li> </ul> <p><i>Health Equity (Bernard Te Paa)</i></p> <p><b>Plan Consultation Phase</b></p> <ul style="list-style-type: none"> <li>• Written and verbal submissions</li> <li>• Public meetings: <ul style="list-style-type: none"> <li>○ By Localities</li> <li>○ Maaori, Pacific and Asian</li> </ul> </li> <li>• Meetings with staff groups across the DHB</li> </ul> <p><b>Plan Finalisation Phase</b></p> <ul style="list-style-type: none"> <li>• Ongoing communications to promote plan and monitor implementation</li> </ul> <p><b>Communications</b></p> <ul style="list-style-type: none"> <li>• SouthNet</li> <li>• Newsletters</li> <li>• Staff/team meetings and forums</li> <li>• Community Panel</li> </ul>	
<p><b>CMDHB Approach to Health Equity</b></p> <p><b>David Hughes</b></p> <div style="text-align: center;">  <p>Health Equity presentation</p> </div>	<p>Health Equity Group chaired by Bernard Te Paa  Been presented to a number of stakeholder and leadership meetings. Feedback will shape future of health equity strategy.</p> <p><b>Background</b></p> <ul style="list-style-type: none"> <li>▪ In 2009 <ul style="list-style-type: none"> <li>– The health environment was subject to significant change, internally and politically</li> <li>– The ‘Better, Sooner, More Convenient’ paper set the scene for structural change in health</li> <li>– The organisation was strengthening the focus on ‘Quality’ and confirmed our commitment to ‘Triple Aim’</li> <li>– Budgets became tighter</li> </ul> </li> <li>▪ CMDHB needs to make important decisions regarding its future <ul style="list-style-type: none"> <li>– Quality of information?</li> <li>– How we make decisions and prioritise?</li> <li>– The desired results?</li> </ul> </li> </ul> <p><b>Mandate and Vision</b></p> <p><b>Our Mandate:</b></p> <ul style="list-style-type: none"> <li>▪ NZ Health &amp; Disability Act 2000</li> <li>▪ To work to improve the health and disability outcomes of our population and reduce disparities between groups</li> </ul> <p><b>Our Vision:</b></p> <ul style="list-style-type: none"> <li>▪ To work in partnership with our communities to improve the health status of all, with particular emphasis on Maaori and Pacific peoples and other communities with health disparities</li> </ul> <p><b>Purpose</b>  To further embed ‘Equity’ into all CMDHB activities</p> <p><b>What do we mean by Equity?</b></p>	

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	<ul style="list-style-type: none"> <li>▪ The meaning of words like 'equity' matters because meaning determines what actions are considered necessary to address the issue, which in turn determines how resources are allocated and how 'success' is measured</li> <li>▪ Equity in health implies that everyone should have a fair opportunity to attain their full health potential</li> </ul> <p><b>Why should we consider this?</b></p> <ul style="list-style-type: none"> <li>▪ An equity approach to health 'recognises that not everyone has the same level of health or level of resources to deal with their health problems and it may therefore be important to deal with people differently in order to achieve equal outcomes'</li> <li>▪ The aim is not to eliminate all health differences so that everyone has the same level of health, but rather to reduce or eliminate those which result from factors which are considered to be both avoidable and unfair.</li> </ul> <p><b>Why else?</b></p> <p>Te Tiriti o Waitangi is the founding document of Aotearoa New Zealand. It establishes a relationship 'akin to partnership' between the Crown and Rangatira, and confers a set of rights and obligations on each Treaty partner. The two peoples are Tangata Whenua, Maaori, and Tangata Tiriti, all other non-indigenous people groups in Aotearoa New Zealand, so a Te Tiriti approach to equity is about giving all people groups the opportunity for good health</p> <p><b>Health care equity as part of health equity</b></p> <ul style="list-style-type: none"> <li>▪ <b>Health Equity approach</b> <ul style="list-style-type: none"> <li>- Recognises that health is more than health care, includes addressing determinants, positive aspirations not just fixing gaps</li> </ul> </li> <li>▪ <b>Health Care Equity</b> <ul style="list-style-type: none"> <li>- Attempts to change those things over which health sector has direct control</li> <li>- To match services to level of need, with services taking into consideration social determinants of health as well as clinical need, and favouring more disadvantaged groups</li> </ul> </li> </ul> <p>A CMDHB approach to Health Equity means</p> <ul style="list-style-type: none"> <li>- working towards Health Care Equity and</li> <li>- working with inter-sectoral partners to influence the social determinants of health, and so contribute to health equity</li> </ul> <p><b>Implementation</b></p> <ul style="list-style-type: none"> <li>▪ Example: Review of a contracted programme <ul style="list-style-type: none"> <li>○ Current targets set on historical basis, with incremental increases on past achievement</li> <li>○ Consequently current targets for coverage lower for Maaori and Pacific, despite higher prevalence of disease and poorer outcomes</li> <li>○ What would taking a stronger equity approach mean?</li> <li>○ What might be the implications for prioritisation, workforce, measurement of progress, service development?</li> </ul> </li> <li>▪ What would implementation of a more explicit equity approach for CMDHB look like in your part of the world?</li> </ul> <p><b>Questions we might ask</b></p> <p>Scenario</p> <p>DNA after seemingly successful engagement</p> <ul style="list-style-type: none"> <li>▪ What could individuals do?</li> <li>▪ What could teams/services do?</li> <li>▪ What could the DHB as an organisation do?</li> <li>▪ What could the DHB do with its collaborative partners?</li> <li>• Participation, consumer involvement, community engagement - is this a part of 'Equity'?</li> <li>• What kind of infrastructure, processes are needed to support you to further embed equity in your work?</li> <li>• Can you think of any unintended consequences?</li> <li>• What other examples have worked or not worked?</li> </ul> <p><b>Discussion Points</b></p> <p>Is this Maaori specific or Maaori Pacific?</p> <p>Less emphasis on target and greater on need</p> <p>Target those who get most benefit or greatest need</p> <p>Where is starting point?</p>	

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	<p>What criteria would you base service delivery on?            Not everyone has ability, resources, or desire to achieve health equity.            How do you define need?  <b>Action Point; All users databases need to be populated with updated information</b></p>	
<p><b>BSMC DAP</b>  <b>Sam Cliffe</b></p>	<ul style="list-style-type: none"> <li>• Oct 09 3 coalitions of PHOs submitted proposals to MoH to implement BSMC</li> <li>• Primary Care asked to step up to challenge</li> <li>• 3 business cases approved to be developed. These cover all PHOs in greater Auckland region bar one.</li> <li>• In March the business cases submitted to expert group within MoH to make recommendations on progress then proceeded to the Minister.</li> <li>• Auckland metro covered by business cases but Minister not convinced progress being made fast enough, strong enough, robustly enough, detailed enough, specifically enough.</li> <li>• 3 DHB CEOs and Chairs to be held accountable for outcomes</li> <li>• CMDHB CEO/Chair appointed as leads of Chairs and CEOs to drive this process within a month to produce a commonly consistent district annual plan for Primary Care for BSMC, a district annual plan insert to go to the MoH around BSMC with focus on Diagnostics, POAC, increased access to after hours services, clinical pathways, clinical networks, reduction in backlog of first specialist assessments in hospitals, increase in minor surgery in general practice. Wants this across all three business cases but dialogue across 3 DHBs hasn't been happening</li> <li>• Directive from Minister has placed a huge amount of work within a tight timeframe.</li> <li>• Positive of this is it focus's mind</li> <li>• Negative side – rushed and may miss something obvious and people needing to be involved</li> </ul> <p>Minister met with individual business cases and DHB partners to give his feedback</p> <ul style="list-style-type: none"> <li>• DHB documents sign-off – Minister likes it and says get on with it</li> <li>• National Maori PHO Coalition – of grave concern, all over the place, no framework for implementation, concept great. How will it happen?</li> <li>• Alliance Health Plus – 3 PHO coalitions given green light to go ahead. July 1<sup>st</sup> 3 PHOs joining into 1 to form a pan Auckland cross DHB PHO for Pacific people.</li> <li>• GAIHN – All 3 DHBs covered with 11 PHO consortiums. No clarity on how to be governed, no clarity on how Clinical input will be sought or gained, no clarity on how it will sit along the other 2 coalitions?</li> <li>• Commitment by DHBs to achieve</li> <li>• Over next 10 days expect implementation plan for business cases to be submitted to MoH.</li> <li>• DHBs have to ensure synergy and alignment between 3 business cases</li> </ul> <p>Big Issues Outstanding</p> <ol style="list-style-type: none"> <li>1. Lack of informed clinical buy in, engagement, process. Leadership needs remedying</li> <li>2. Governance – 3 coalitions will have their own governance. The only 1 that has some governance currently is Alliance Plus PHO.</li> <li>3. Cross boundary PHO policy/contract mechanisms – to be made less bureaucratic.</li> <li>4. Alliance Contracting – form of contracting used in construction and transport. Form of contracting based on high trust, in it to win it, share winnings/losses, don't walk away – alliance of people/entities working towards common objectives and how to get there. Will this work in health? 1<sup>st</sup> July expectation we will start to use this. Unlikely to happen in this timeframe</li> <li>5. Trust – a lot of what we are about relies on trust and faith</li> </ol> <p>Need to establish clinically led business board to oversee and direct the business cases that directs the involvement of GPs, PHO managers, DHB clinicians, collaborating to making things work</p> <p><b>Feedback, Discussion</b> Peter</p>	

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	<p>Need more detail            What are we doing about change management?            Now have a work plan with some details            New relationships need to be developed            Tina            Barriers to clinical engagement – trust and relationships</p> <ul style="list-style-type: none"> <li>• Need to ask what is the win win and how do we get there?</li> </ul> <p>Michael            Too conceptualised            Need clinicians to come up with the solutions            Goodwill from clinicians too make this happen but flawed. Designed to break down relationships/trust            List is good but how do we deliver it?            List outcomes we want then work out how we achieve them            Timeframes too tight            John            Regional group to discuss things only way to get there.            Need to get clinical people involved            Pam            No engagement with nurses. We will keep doing what we do            Denise            Whole sector in rapid change. Big challenges. Have hope we will get there            Integrity of how metro Auckland operates in the future is being watched closely by rest of country            Michael            Bizarre that Primary Care heads are not being held accountable rather than the DHB heads.            ToR            What can we (CAG) do with BSMC?</p> <ul style="list-style-type: none"> <li>• Useful discussions asking/responding to difficult questions</li> <li>• Appropriate clinical input</li> <li>• Increase mana/kudos of this group in DHB to be group of its title</li> <li>• Honest brutal challenging and constantly coming back to DHB and each other as to how we can do things differently but we need to have a higher profile. Not sure how we do this.</li> </ul> <p>Action Point            Ask CMO to be part of this group and take back information to clinical meetings</p>	
<b>Standing Agenda Items</b> <b>Community Panel - Soli Henare</b>	Not given this month due to run over of time.	
<b>General Business</b>		
<b>Next Meeting</b>	<p style="text-align: center;"><b>May 19<sup>th</sup> 2010 ♦ 1800 - 1930 hours</b></p> <p style="text-align: center;"><b>♦ In Meeting Rooms 1 &amp; 2 ♦ Counties Manukau DHB, 19 Lambie Drive, Manukau</b></p>	