

# Primary Health Organisation Group (GPHO)

Wednesday 11 November, 2009

12 noon to 4pm


Building 2, Manukau Boardroom

Minutes	Actions by
<p><b><u>Welcome &amp; Apologies</u></b></p> <p><b>Present:</b></p> <p>Allan Moffitt (AM) –Chair, Sam Cliffe (SC), Loretta Hansen (LH), Neil Woodhams (NW); Ross Smith (RS); Wayne McLean (WMcL), Manu Sione (MS), Mike Lamont (ML), Tina McCafferty (TMC), Karyn Sangster (KS), Denise Kivell (DK), Jennie Auton (JA), Kim Buchanan (KB) Mark Vela (MV), Esther Blomfield (EB), Siobhan Matich (SM),</p> <p><b>Apologies:</b></p> <p>Pam Montford (PM), Dolly Rewha (DR), John Cosgriff (JC), Lael Meredith (LM), Bernard Te Paa (BT), John Savory – replacing Ian Johnson as Pharmacy Rep.</p>	
<p><b>1a. Previous Minutes</b></p> <p>The previous minutes from GPHO held on 14 October 09 were accepted as true and correct record.</p> <p><b>Agreed - ML</b></p> <p><b>Seconded – LH</b></p> <p><b>Matters arising</b></p> <p>After hours – TMC reported there had been no official release yet. Service specs have been issued and some queries which have been addressed. A key issue was that the A/Hr service would actively not seek to enrol patients referred or attending from another practice.</p> <p>Pandemic – SC to follow up with Ron Dunham who was to check on current state of the MoH review and send through information.</p> <p>Flu vax – noted that H1N1 will be included in the Flu vax for 2010, do we have the dates it will be available? AM said to assume the usual dates will apply but will find out if any changes are proposed.</p> <p><b>Action –</b></p> <p><b>Check on current state of review</b></p> <p><b>Confirm details for 2010 fluvax</b></p>	<p>RS (for SC)</p> <p>AM</p>
<p><b>1b.Arising from Action List</b></p> <p><b>29. Quality Strategy</b></p> <p>AM noted that meetings were set up but then cancelled. The plan is ambitious and AM has agreed to meet with each PHO to ensure it is reflected in each PHO's plans.</p>	

<p>Important that 'business as usual' continues alongside EOI etc.</p> <p>AM seeking advice on what to do – don't want to 'flog a dead horse'.. We need to meet 2009/10 commitments but concerned about capacity. Suggestion that we look for 2-3 areas which are also likely to be the focus for EOI planning.</p> <p>Noted that PHO business plans are coming in – a few more to come.</p> <p><b>80. B4 Schools</b></p> <p>SC provided an update for the meeting.</p> <p><b>82. ASH rates</b></p> <p>AM reported that data is available and a pack will be put together. Some local data sent out yesterday (10/11) by Sharon and the national data does not align possibly due to some coding changes.</p> <p><b>102. Work Programme</b></p> <p>TMC gave an outline of the work programme priorities being Long-term conditions, Acute demand management, IT and Workforce.</p> <p>Acknowledged that the EOI business case will take time and resources to develop. Question around what happens with the DAP in the meantime – the 6 national health targets will continue but expecting some flexibility around the other stuff (ML). Noted that the Primary Care Plan also ends in June 2010.</p> <p><b>GPHO rep on CPHAC</b></p> <p>RS reported there were now two nominations to be forwarded to SC.</p> <p><b>Action –</b></p> <p><b>ASH pack to be put together</b></p> <p><b>Nominations to be forwarded to SC</b></p>	<p>AM</p> <p>RS</p>
<p><b>AGENDA</b></p>	
<p><b>2. Laboratory Update</b></p> <p>Johan Vendrig reported that QSTAT was in week 9. A six week summary report had been released however GPHO members had not seen it. Johan to provide copies.</p> <p>Working on a number of issues. Quality and Safety has two work streams</p> <ol style="list-style-type: none"> <li>1. Audit process – equivalent to IANZ Accreditation process. Completed, waiting on the report to sit down and discuss with Labtests. List of 25-30 corrective actions from the audit process</li> <li>2. QI Team – working on list of 50 QI improvements – 58% implemented.</li> </ol> <p>QSTAT will step back to weekly reviews. Labtests now reporting on Quality Performance Indicators.</p> <ul style="list-style-type: none"> <li>- complaints down significantly (80-100 last week). Don Mackie to review and see if the complexity/seriousness of the complaints is also down.</li> <li>- complaints about the collections centres and staff down. Audit also shows an improvement in this area</li> </ul> <p>NDSA will publish QPIs next week on internet. C-M will download and send out to PHOs</p>	

<p>(SC)</p> <p>ML asked about waiting times – JV advised the accuracy of the wait times has been raised with Labtests. Relies on Admin staff being available and only report during the peak times of 7-11am. Labtests are proposing a 5-stage improvement process including e-tagging and looking at staff utilisation.</p> <p>Clinical error rate (wrong person, result, reading) – JV reported this is hard to measure. Can report the data entry errors – currently 3.5%.and working to get &lt;3%. Hampered by a lack of 'standards' in this area.</p> <p>JV reported a new CEO has been appointed – Greg Marshall, ex SCL Labs, a sports physician.</p> <p>Question about whether the testing itself is correct – JV advised there are some reference range differences as a result of different methods and machines. Labtests have been asked to communicate these through the e-updates.</p> <p>SC asked about the complaints 'fatigue' issue and whether audits have picked this up? JV advised it is hard to pick up what is not happening but GPs have been asked for specific examples. Discussion about whether NDSA could do reports by PHO showing PHO/Practice variance?</p> <p>NW asked does the complaints process pick up the cause of the problem i.e. is it the practice or Labtests? Do some GPs have the majority of complaints, are some GPs looking for problems? JV confirmed that some practices do have a higher level than others, E.g. Hospital forms are not done correctly.</p> <p>PHO feedback was requested</p> <ul style="list-style-type: none"> <li>- TKOH – still some work to do to rebuild trust</li> <li>- TP – still getting complaints; a long way to go.</li> <li>- ProCare – seems quieter now; fatigue maybe a factor</li> </ul> <p><b>Action –</b></p> <p><b>CMDHB will download and send out reports to PHOs</b></p> <p><b>Also check if NDSA can do reports showing PHO/Practice variation in complaints</b></p>	<p>AM</p> <p>AM</p>
<p><b>3. SmokeFree update</b></p> <p>Tracey Barron (TB) joined the meeting to discuss the Tobacco Control Programmes and Services overview/stocktake paper.</p> <p>Questions raised about the numbers attending training (KB) and the general absence of numbers (\$s) in the paper (MV), SC offered to add dollars, noting the bulk of the contracts are directly funded by MoH.</p> <p>Question also raised about the evidence supporting the funding and whether Ingrid could source this?. WMcL responded that it would be inappropriate to make assessments on a contract or have a regional discussion without the contracted parties at the table.</p> <p>SC confirmed this is the intention of the next stage – the paper is a desk-top stocktake only and no judgments have been made on any of the contracts or use of the funding.</p> <p><u>Health Promotion update</u> – TB noted there is only one PHO response to come in and MoH have also provided a comprehensive list. In terms of the effectiveness of the</p>	

<p>programmes, looking at a 'toolkit' for providers to evaluate their own contracts. CMDHB will also do their own contracts.</p> <p><u>Resource to Support Primary Care to Deliver and Document SmokeFree ABC - MV</u> tabled a paper noting the Smoking Cessation Working Group were keen to reward outcomes and to encourage GPS to engage with patients. There was also an indication from Serena at DHBNZ that the 2<sup>nd</sup> set of PPP indicators could include SmokeFree. Concern that the data needs to be tidied up before that can happen and the paper addresses this also.</p> <p>The proposed funding split is that 40% of the funding goes to the six PHOs representing 20% of the population. Suggest they get together to use the same IT person to do the work as the three larger PHO have own IT resource.</p> <p>Discussion around the target for GP/PN training and that it should also include CHWs.</p> <p>MV noted the PPP issue is premature as it has not been discussed by the PPP Governance Group. AM agreed there was a risk around the funding.</p> <p>KB noted that ProCare had been funded to develop IT tools which could be shared – Ingrid meeting ProCare on 12 November.</p> <p>NW asked what the process is for agreeing read codes. AM replied the list has been in place since 2003 but may be different to the codes proposed for PPP.</p> <p>KB asked about practitioners already trained by Heart Foundation? – TB advised that so long as there is a paper trail and the training is accredited then no problem.</p> <p><b>Action –</b></p> <p><b>Tracey Barron to add dollars to stocktake paper.</b></p> <p><b>GMPHO to agree and confirm the allocation of the \$100k funding.</b></p>	<p>TB RS</p>
<p><b>4. PCD update</b></p> <p>Sarah Tibby joined the meeting.</p> <p>1.1 Long Term Conditions Programme – 2<sup>nd</sup> month of –ve growth and some growth in numbers within the caps. Will discuss with individual PHOs</p> <p>1.4 Diabetes data now submitted to PPP</p> <p>1.5 A request for data from Claire O'Brien – refer separate paper. Some confusion around the nature of the study as Primary Care clinics are already Nurse-led so what is the difference? AM suggested that DK contact her directly to discuss.</p> <p>No objections to accessing data however. Approved but concerns noted about project design.</p> <p>1.6 Request for data from Doone Winnard and Gary Jackson for NZMJ paper.</p> <p>The requested anonymised data dump was approved. Some discussion about what inequalities are costing the DHB with NW noting Gray's estimate fo \$40m for Maori alone – could be as high as \$50-100m across the entire DHB.</p> <p>SM also suggested that the pharms issue be widened for the study – not just the ACE inhibitor but the 3 components of the 'polypill'</p> <p>1.7 Diabetes Get Checked quarterly report</p> <p>The report was noted. Data issues with Retinal Screening need to be corrected. The % is of those identified as having Diabetes. The issue of eligibility and scanning passports</p>	<p>DK to contact Claire</p>

<p>to verify was discussed.</p> <p><b>Action –</b></p> <p><b>DK to contact Claire O’Brien</b></p>	
<p><b>5. Asian Health Plan</b></p> <p>Kawshi De Silva presented the Integrated Asian Health Plan and asked PHOs for their input and comments on the draft plan. The plan is due to go to CPHAC in November.</p> <p>AM referred to pages 66 and 75 where specific feedback is required from PHOs.</p> <p>LH noted that EastHealth already have an Asian Health Plan, are happy to be involved but felt that they do not get good data from the DHB on Asian health – not broken down into sub groups.</p> <p>MV noted it was unclear from the plan what we are specifically being asked to address. Primary Care programmes are available to all regardless of ethnicity.</p> <p>TMC noted this was similar to internal feedback and the question has been raised should we add Asian Health targets into CCM like we have for Maori and Pacific?</p> <p>AM felt the key thing to answer was – what are the 3-4 things you can do to address Asian Health, with no more money!</p> <p>JA note that most complaints relate to the style of communication and that there are access issues once enrolled/.</p> <p><b>Action –</b></p> <p><b>PHOs to provide feedback to KS</b></p>	 <p>GPHO-presentation 10 November.ppt</p> <p><b>GMs</b></p>
<p><b>7. HRC Feasibility Study</b></p> <p>KS spoke to the paper HRC Feasibility Study.</p> <p>Some preventable diseases are weighted 20 to 100x greater for disadvantaged children, usually Maori or Pacific.</p> <p>The paper advocates an evaluation of an extension to the school clinic which has shown good results for Rheumatic fever – a 30% reduction. In C-M there are 500n children with RF representing a high cost on health.</p> <p>AM noted that cellulitis also a major cause of ASH rates along with respiratory disease.</p> <p>Noted there will be some issues to work through about the role of the GP versus school clinic. The study is dependent on HRC funding. SC added we are also looking for some MoH funding.</p> <p>WMcL agreed in principle but wanted to know who the service deliverer will be?</p> <p>ML asked how the dots will be joined to the EOI process. AM proposed it is not a Year 1 EOI activity but to make the project team aware of it.</p> <p><b>Action –</b></p>	

<p><b>8. Financial Situation – Thriving in Difficult Times</b></p> <p>Presentation by SC gave the wider context from the impact the recession has had on the NZ economy and Treasury forecasts, and that radical transformational change is needed. C-M needs to “work with PHOs and providers as this problem is too big for us to address on our own”.</p> <p>Discussion raised the following issues</p> <ul style="list-style-type: none"> <li>- What is the impact of this on the EOI process?</li> <li>- Minister looking for savings from Primary Care but too many DHBs and funding silos</li> <li>- Primary Care agreed on reduced FFT if the sector did away with FFT – didn't happen. Some contacts had FFT automatically added.</li> <li>- openness and transparency appreciated</li> <li>- did not get fair chance to participate last time around things like FFP.</li> <li>- \$s to PHOs wont be sustained at current levels</li> <li>- has C-M considered use of external consultants to make the hard calls?</li> </ul> <p><b>Action –</b>  <b>SC asked that members ‘mull it over’ until the next meeting</b></p>	<b>GMs</b>
<p><b>9. General Business</b></p> <p><b>EOI Process</b></p> <p>DK gave a brief report on her involvement with the EOI Evaluation process noting that workforce was emerging as the key factor to be addressed in Business Cases. Each approved EOI has been given some direction. Whanau Ora was also shown to be not widely understood.</p> <p><b>CCM High Needs</b></p> <p>NW noted that an interim report had just been received, not yet evaluated. Meeting with Deloitte in next couple of weeks.</p> <p><b>Sonia Vangessel’s work (AM)</b></p> <p>This work is about the impact that the Primary Care Strategy has had at C-M. Looking at the KPIs now.</p> <p><b>Action –</b>  <b>Paper for next meeting</b></p>	<b>SV</b>
<p><b>10. Next Meeting – 9 December, 2009</b></p>	