


Clinical Advisory Group (CAG)

Minutes

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

Agenda Item		ACTION
Present In Attendance Apologies	Peter Gow (Chair), Allan Moffitt, Michael Clark, John Roke, Soli Henare, David Hughes, Analosa Ulugia-Veukiso, Campbell Brebner, John Savory, Martin Chadwick, Sam Cliffe, Karyn Sangster, Jenni Coles, Gary Jackson Val McCullough, Tanya Maloney, Tina McCafferty, Sue Hallwright, Kris Vette, Andrew Stacey, Geraint Martin, Jonathan Gray, Marlene Van Hooven, Bernard Te Paa Don Mackie, Denise Kivell, Nua Tupai, Penny Impey	
1. Minutes of Oct Meeting Action Plan Update	Passed as true record. Pharmacists Access to HbA_{1c} Results via TestSafe Repository The agreement was yes we will open up HbA _{1c} but when we start moving towards clinical documents, EDSs etc being available more consultation will be undertaken with the community seeking feedback on appropriateness re the acceptance of clinical documents being available wider than simply primary care itself. Looking at clinical documents going on TestSafe approximately the middle to end of 2011.	
2. POAC Campbell Brebner	<ul style="list-style-type: none"> ▪ POAC Maori utilisation not as high as would have liked ▪ Completed some analysis which is hoped will reassure us to some extent and might make us rethink whether the indicator used on the dash board is appropriate or needs rethinking ▪ 21% of POAC patients under 5s are Maori ▪ 22% of CMDHB under 5s are Maori ▪ 5-15 age group tracking close but gap increase as age increases. ▪ Quite a dramatic number of older people using POAC ▪ POAC figures as compared to ASH figures indicate we are lagging behind for Maori. Looking at developing an alternative group of ICD 10 codes that better reflect what POAC can do. Hopefully when we re-analyse the data using these codes the areas will come together ▪ Utilisation rates per 1000 patients over 5 years - there were 424 Maori under 5 POAC patients in 5 years and 8536 Maoris under 5 so utilisation per 1000 is just under 50. Utilisation for other (European, Asian etc) is lower than 40. Utilisation rates for Maori are high except for this age group. 	
3. Crossing the Chasm in four leaps: A call for a health plan Ko Awatea Geraint Martin, Jonathon Gray  Crossing a Chasm in Four Leaps	Key Points <ul style="list-style-type: none"> ▪ Manukau a City of the Future - will reach the size of Hamilton ▪ Designing the future is a positive not a passive act : hope is not a plan ▪ One size will not fit all, but one method will ▪ Peripheral changes will not deliver ▪ We must change the game radically to succeed: Ko Awatea a place where we can bring together the best international thought, the best of our own practice and our own incredibly creative minds to find solutions to the problems we are facing in quality improvement, population health, in clinical leadership and workforce development and innovation and how we deal with health inequalities. It is a place where we need to come to synthesise the best knowledge with the best practice to ensure we have the best outcomes 	

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	<p>Raising the standard</p> <ul style="list-style-type: none"> ▪ We need to develop a compelling vision and delivery plan ▪ We need a standard to rally around <ul style="list-style-type: none"> - We will not change our behaviours, let alone the system - Tragedy of the Commons and Easter Island - Nothing by which to align, to practice by values, to build capacity or to lever change by ▪ Faced with a compelling case to mobilise for change we need to become Manchester United not our current best which is like watching kids play soccer in the park <p>A Vision</p> <ul style="list-style-type: none"> ▪ Moving the Sector to be clear on what it is aiming to do and where our focus is on the value we add <ul style="list-style-type: none"> - Value = Cost+quality+effective design Robert H Brook. The end of the quality improvement movement: Long live improving value. <i>JAMA</i>. 2010;304(16):1831-1832 - The “Big Dots” : “to move the needle” - Role of the DHBs as a system integrator - Both best and new practice - Build capacity and methodology : The need for a Brain <p>Using the campaign methodology <i>Adding Value to the health & lives of 1.6m New Zealanders</i></p> <ul style="list-style-type: none"> - Quality & Efficiency: <i>First do no harm</i> - Redesigning the system : <i>Adding life to years</i> - Reducing demand thru’ prevention: <i>Adding years to life</i> - Shared decision making: <i>Patient & family centred care</i> <p>What are the Big Dot Interventions to make these things happen?</p> <p>Campaign 1 : First do no harm <i>Aim : By 2015 we will be the safest healthcare system in Australasia</i></p> <ul style="list-style-type: none"> ▪ There are clear evidence based interventions which if systematically applied will <ul style="list-style-type: none"> - Save an additional 500 lives annually - Prevent 25,000 episodes of harm - Save money and free up capacity - Improve productivity <p>Campaign 2 : Adding life to years <i>Aim : By 2015 we will add x years of productive life to the people of the Northern region</i></p> <ul style="list-style-type: none"> ▪ This will be achieved by focussing on five conditions which if “best designed” would deliver a significant improvement to the health of the population, keeping citizens productive and learning and reducing demand for hospital services <ul style="list-style-type: none"> - Childhood mortality and morbidity - COPD/Asthma - CVD - Frail Elderly - Diabetes ▪ By delivering this we would also deliver the BSMC Business Cases <p>Campaign 3 : Adding years to life <i>Aim : By 2020 to increase y years of life in the Northern region by :</i></p> <ul style="list-style-type: none"> ▪ Reducing the risk of diabetes by removing 1 million (m) kg of fat from the Northern region by 2015 ▪ Reducing the number of cigarettes smoked by 1m by 2015 ▪ Reducing the number of alcohol related injuries by 50% <p>Campaign 4 : Shared Decision Making</p>	

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	<p>Aim : By 2015 to reduce demand by z for marginal treatment decisions by involving patients in decision making</p> <ul style="list-style-type: none"> ▪ International evidence in a range of elective areas ▪ Platform for health literacy : training the expert patient ▪ Patient and Family/Whanau Centred Care ▪ End of life care <p>How would we intervene</p> <ul style="list-style-type: none"> ▪ Condition ▪ Describe existing system <ul style="list-style-type: none"> - Cost - Volume - Outcome ▪ Clinicians to review ▪ Best practice, technical efficiency, reduce variation, marginal (dis) investment ▪ Quantify the outcome ▪ Intervention design ▪ Evaluate delivery <div data-bbox="454 795 1380 1512" data-label="Diagram"> <pre> graph TD DHB[DHB STRATEGY] --> Ko[Ko Awatea] Ko --> SP[Strategic Partners] Ko --> CF[Clinical Faculty] Ko --> LC[Local Capacity] SP --> CP[Centre for Quality, Centre for Workforce Development, Centre for Innovation & Research, Centre for Clinical Leadership, Centre for Health Intelligence] CF --> CP LC --> CP CP --> MI[Method, Capacity, Evidence, Evaluation, Innovation, Dissemination] MI --> SI[System Improvement] SI --> AP[Annual Performance] AP --> DHB </pre> </div> <p>Innovation “Activated Network” Culturum – people, system and network, leadership, culture change “Pipeline” Knowledge management, evidence/R&D pipeline, communications “Methodology for Change” Expert resource, QI, measurement, workforce and nurse development “Learning” Futurum - evaluation and joint research/PHDs</p> <p>How do we have the place at the middle of this to solve the challenges and lead change?</p> <p>Discussion</p> <ul style="list-style-type: none"> ▪ Forum being described has similarities in parts to the former Clinical Board being a focus group of clinical leadership and management bought together to problem solve but got bogged down in procedures, policy etc. Challenge to try and capture and keep going. 	

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	<ul style="list-style-type: none"> ▪ We don't have an accurate snapshot of where we are now and truly analyse what we do before we embark on how to plan the future. We constantly fail to capture the good we are achieving and we don't put a well costed look at where the gap is and what the failings are before we decide to move to the next step ▪ Easy in health to think that solutions come in evidence based medicine but reality is this is all very well in a controlled environment but actually when you interface with the community there are diverse ways of interacting with the medical profession and health care in general and we need to learn about what works for them and adapt everything for what is real for them ▪ Act local drive national ▪ Imagine, then plan, then deliver. Action comes from the arrows not the boxes. Flow comes from the in between bits ▪ Picture has to be changeable. As you transition through, it is all about relationships ▪ Importance of operational management important here. Can have great ideas but need a skilled manager to implement them ▪ From a regional perspective our space is hugely pregnant with potential. We need to create capacity that can be used elsewhere ▪ From the Maori perspective we need to capture innovative play makers amongst us. We are good at doing things for our community but we need to do things with our community. We need to maintain local focus, get representation right, more health equity talks taking place, or else we miss local wins ▪ From a Community Panel (CP) perspective in terms of Ko Awatea when we live in Counties Manukau (CM) we don't just use CM services. Resource needs to be shared regionally. Lot of focus on clinical improvement but where do the community and other players fit in? ▪ From a CP perspective how does patient and family centred care look? The CP have a slogan "nothing about us without us". How can we work along managers and clinicians to effect change? Change requires relationships ▪ Change methodology needs thinking about. How will Ko Awatea make change happen? Need to get involved in community, and primary care ▪ If Ko Awatea becomes hospital based then becomes a failure ▪ Need to be looking at big dot, whole system indicators which will ensure we focus on the right interventions to drive the solutions ▪ From a Pharmaceutical point of view community pharmacists are under utilised in the workforce. The remuneration structure partly contributes to that. The only thing you can quantify in a pharmacists day is the number of prescriptions they do. There are a lot of Brief Opportunistic Interventions (BOIs) which includes advising patients, referring patients to medical clinics etc. There are a number of Pharmacists who would be keen to pick up more clinical coverage. Pharmacists get the impression they are regarded as an expendable cost centre rather than a benefit centre. This is a hurdle that needs to be overcome. ▪ Need to remove waste - of duplication of processes. duplication of effort, lack of defined positions etc ▪ Need to decide who is going to drive and co-ordinate things to take things forward <p>To reflect: Jonathan is amazed by positive, energetic response to challenge. Has been a motivating response. Geraint - where to next? Nothing set in concrete yet. Need people built in to effect change – joint exercise. To achieve the things we are talking about we need to galvanise getting things right. Need to capture hearts and minds. We CAN DO THIS right across the system. We can be engaged in a positive revolution in health care. We can make the future a better more effective place.</p>	

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	Think over the next month how we can engage the wider group and at the December meeting combined with the Community Panel we can discuss the how.	
4. Community Panel Update Soli Henare / Anaolosa Ulugia- Veukiso	Community Panel topic for discussion The topic decided by the Community Panel for discussion at CAG's end of year meeting is, 'Better, Sooner, More Convenient', with the following questions posed by the Community Panel: <ul style="list-style-type: none"> • Does the community have a place in BSMC? • What is the place of the community in BSMC? • What plans have been developed by PHO's and DHB's for public consultation and communication of BSMC? Community Panel representative on CAG Analosa Ulugia-Veukiso was nominated to be the Community Panel representative. She recently resigned from the Community Panel due to other commitments, effective at the end of 2010. Paula Nes in conjunction with the Chair of the Community Panel and the Community Liaison Manager will re-convene to discuss the process for representation in 2011.	
5. General Business		
Next Meeting	15th December from 6pm to 7.30pm ♦ In Meeting Rooms 1& 2 ♦ Counties Manukau DHB, 19 Lambie Drive, Manukau	

ACTIONS REQUIRED SHEET

WHO	WHAT	BY WHEN
Gary Jackson Val	Dashboards Action Point: Recommend look at receiving report monthly and spend significant part of agenda on this 3 monthly	February, May, August, November
Val McCullough	Action Point : Invite Aaron Jackson to talk about the Medicines Reconciliation project	November Invite sent