


# Clinical Advisory Group (CAG)

## Minutes

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

Agenda Item		ACTION
<p><b>Present</b></p> <p><b>In Attendance</b></p> <p><b>Apologies</b></p> <p><b>Minutes of June meeting</b></p>	<p>Peter Gow (Chair), Michael Clark, John Roke, Soli Henare, Pam Williams, Sam Cliffe, David Hughes, Analosa Ulugia-Veukiso, Gary Jackson, Paula Nes, Karyn Sangster, Campbell Brebner, John Savory,</p> <p>Pam Montford (notetaker for Val McCullough), Dana Ralph-Smith (for Jenni Coles), Lynanne Stanaway, Pauline Hanna</p> <p>Don Mackie, Nua Tupai, Denise Kivell, Martin Chadwick,, Allan Moffitt, Jenni Coles;</p> <p>Passed as true record</p>	
<p><b>Introductions</b></p>	<p><b>The Chair welcomed Dana Ralph-Smith, Pauline Hanna and Lynanne Stanaway to the meeting</b></p>	
<p><b>AGENDA</b></p>		
<p>1.</p>	<p><b>Family Violence/Child Abuse Screening training</b> - Dana Ralph-Smith for Jenni Coles</p> <p>In 1994, family violence was estimated to cost NZ society up to \$5.3 billion each year.</p> <p>Objectives of the Violence Intervention Programme (VIP) are</p> <ul style="list-style-type: none"> <li>• To establish and develop a VIP focussed on identification, assessment and referral of child and partner abuse for designated areas in the DHB (Women’s Health, Mental Health, EC and Child Health). This programme also includes elder abuse.</li> <li>• To implement the VIP in alignment with Family Violence Guidelines, MOH (2002)</li> <li>• To work with the National VIP Programme Manager and Ministry funder AUT evaluation team to assess health care providers responsiveness</li> <li>• To ensure the DHB programme meets the requirements of the VIP audits</li> <li>• To work collaboratively with referral agencies and community organisations</li> </ul> <p>Two of the key issues from CMDHB perspective</p> <ul style="list-style-type: none"> <li>• We were identified as an outlier as per the MOH audit results</li> <li>• Our training was identified as too long (2 days)</li> </ul> <p>It has been indicated the next MoH audit will occur in March 2011.</p> <p>Key Learning to improve success and sustainability</p> <ul style="list-style-type: none"> <li>• Access the National Coordinator to allow support to develop resources, policies and procedures that support staff prior to training on screening</li> <li>• Ensure staff resources are put in place before any roll out of screening</li> <li>• Access the National Train the Trainer package that will train</li> </ul>	 <p>VIP Presentation CAG v2.ppt</p>

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	<p>a number of staff to support sustainable training and provide further support for staff during screening.</p> <ul style="list-style-type: none"> <li>• Set up e-refresher training and coordinator support to allow efficient use of staff time and also give staff more opportunities to ask questions where there is no obvious appearance of violence.</li> <li>• Ensure community agency links</li> </ul> <p>Next Steps</p> <ul style="list-style-type: none"> <li>• MoH will look at primary care to establish where this screening education programme can take place.</li> <li>• Support and infrastructure to do a similar thing and start to have conversation.</li> <li>• 85% of staff training before roll out screening programme (can take 2 years)</li> </ul> <p>Concern tabled by Michael Clark that release of information has stopped going through to GPs. Dana commented that there had been an interim decision made to stop information going through. There is a need to ensure that information that is issued is accurate and current.</p> <p><b>Action</b> <b><i>HIC has on agenda for further discussion and will report back after receiving report from Ethics Committee – first draft to be circulated to CAG when available for consensus</i></b></p>	
	<p>Noted Peter advised that there was a consumer workshop at Greyhound Function Centre organised by the National IT Board on the future of Health enabled by Information for anyone interested in attending.</p>	
<p>2.</p>	<p>Dr Wrong Discharge Letters – Dr John Roke Concern tabled that communications to GPs are misdirected at times which occurs when our PIMS system contains either an incorrect GP or no GP for a patient. There are some 104,721 patients without a known GP and recent identification has shown some 90,000 patients who had a non-active GP in PIMS. The GP has now been changed to Dr None. In order to try to increase notifications of errors from GPs we have introduced a statement onto EDS's and clinic letters requesting the GP to notify us of misdirected communications which has resulted in a noticeable increase in such reports.</p> <p>Errors by clerical admission staff have also been noted, and to avoid fallibility of human performance a suggestion was made that the PiMS GP record could be downloaded from the national database.</p> <p><b>Action:</b> <b>October CAG update</b> <b>Campbell to produced a Policy and Procedure</b> <b>Update PIMS – work off PHO register</b></p>	<p>Val to note Campbell</p>
<p>3.</p>	<p><b>Pharmacy – Managing the Growth of Close Control Prescribing</b> CAG was requested to</p>	

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	<ul style="list-style-type: none"> <li>• Note the impact of increasing use of close control on dispensing volumes, particularly of stat medicines.</li> <li>• Note that prescriber/pharmacist intent to supply free compliance packaging is a key driver of weekly close control</li> <li>• Provide feedback on the guidelines for weekly close control including <ul style="list-style-type: none"> <li>○ Are the guidelines clear, reasonable, clinically appropriate</li> <li>○ How should they be implemented</li> <li>○ Will they help contain the use of close control in the absence of more specific regulation under the Pharmaceutical Schedule</li> </ul> </li> <li>• Give a view on whether CMDHB should consider funding some level of compliance packaging and how it might determine eligibility for subsidised blister packaging within an affordable budget.</li> </ul> <p><b>Action:</b>  <b>Guidelines supported in principle for weekly close control prescribing (but not at the expense of blister packaging) with the proviso that the guidelines would go out to primary care for wider discussion and any concerns to come back to CAG for resolution and sign off</b></p> <ul style="list-style-type: none"> <li>• <b>Sam/Lynanne to send out around primary care for comment</b></li> <li>• <b>Lynanne to be invited back to CAG for further discussion once people have had time to feed back their comments</b></li> </ul>	<p>Sam/Lynanne</p> <p>Val</p>
4.	<p><b>Dashboards – presented by Pauline Hanna</b></p> <p>Note was taken of the Dashboard Reports that are produced for the Community and Public Health Advisory Committee (CPHAC) and discussion took place on the types of reporting that can be provided by Gary’s team</p> <p><b>Action:</b></p> <ul style="list-style-type: none"> <li>• <b>CAG to look at specific contract data of value to this group</b></li> <li>• <b>Sam to review linking in with EOI and BSMC</b></li> <li>• <b>Pauline Hanna to circulate the high priorities and accountabilities on clinical indicator reports in the first instance to Peter Gow, Allan Moffitt, Campbell Brebner and Sam Cliffe</b></li> <li>• <b>CAG to review three monthly for progress</b></li> </ul>	<p>All</p> <p>Sam Pauline</p> <p>ALL</p>
Next Meeting	18 August from 6pm to 7.30pm sIn Meeting Rooms 1& 2 s Counties Manukau DHB, 19 Lambie Drive, Manukau	
Agenda items for August meeting	<ul style="list-style-type: none"> <li>• <b>Family Violence – release of information to practices update</b></li> <li>• <b>Wrong Discharge Letters – October CAG update</b></li> <li>• <b>Managing the Growth of Close Control Prescribing Update</b></li> <li>• <b>Dashboards data requirements update</b></li> </ul>	