MidCentral District Health Board

Minutes of the Health & Disability Advisory Committee meeting held on 4 September 2018 2018 at 9.00am at MidCentral District Heath Board, Board Room, Gate 2, Heretaunga Street, Palmerston North

PART 1

PRESENT

Karen Naylor (Chair)
Diane Anderson (Deputy Chair) (part meeting)
Dot McKinnon
Adrian Broad
Barbara Cameron
Ann Chapman

Brendan Duffy
Oriana Paewai
Barbara Robson
Vicky Beagley
Anne Kolbe (part meeting)

IN ATTENDANCE

Kathryn Cook, Chief Executive
Barb Bradnock, Senior Portfolio Manager, Strategy, Planning & Performance
Chiquita Hansen, CEO, Central PHO
Claire Hardie, Acting CE, Cancer Screening Treatment & Support
Craig Johnston, General Manager, Strategy, Planning & Performance
Cushla Lucas, Operations Executive, Cancer Screening, Treatment & Support
Dave Ayling, Clinical Executive, Primary, Public, Community Health
David Sapsford, Clinical Executive, Acute and Elective Services
Debbie Davies, Operations Executive, Primary, Public, Community Health
Gabrielle Scott, Executive Director, Allied Health
Jan Dewar, Acting Executive Director of Nursing & Midwifery
Jeff Brown, CE, Women & Children's Health (part meeting)
Judith Catherwood, General Manager, Quality & Innovation
Lyn Horgan, Operations Executive, Acute and Elective Services
Marcel Westerlund, CE, Mental Health & Addictions
Paul Joice, Medical Head ORL Services and Chair, Optimise Programme
Sarah Fenwick, OE, Women & Children's Health
Stephanie Turner, General Manager, Maori & Pacific
Vanessa Caldwell, Operations Executive, Mental Health & Addictions
Wayne Blisset, Operations Director, Maori & Pacific Health

Carolyn Donaldson, Committee Secretary

Other Staff: 15
Public: 2
Media: 1

The Board Chair, Dot McKinnon, opened the meeting welcoming members to the new look committee meeting. She thanked Diane Anderson and Brendan Duffy for the work done as the past chairs of the predecessor committees, and explained leadership of the new committee would be undertaken by Karen Naylor.

1   ADMINISTRATIVE MATTERS

1.1   Apologies

An apology was received from Michael Feyen.

1.2   Late Items

There were no late items.

1.3   Conflicts and/or Register of Interests Update

There were no conflicts of interest or updates to the register of interest.

1.4   Minutes of the Previous Meeting

It was resolved:

> *that the minutes of the previous meeting be approved as a true and correct record.*

Recommendations to Board

It was noted that the board approved all recommendations contained in the minutes.

1.5   Matters Arising

There were no matters arising from the minutes.

Stephanie Turner entered the meeting.

2   QUALITY IMPROVEMENT

2.1   Clinical Governance & Quality Improvement Report

The General Manager, Quality & Innovation spoke to this report, outlining the format it would take in future. Current reporting would expand and develop with more ownership from within the clusters.

A member asked for clarification of what was meant by complaints requiring extension letters, and also who was having the falls - whether it was people who had been assessed and had plans, or other people. A response about the falls could be provided in a later report.

In relation to serious adverse events reporting, the member said her expectation was that board members would continue to receive reports at a similar level as previously in part two of the meeting, as there were issues that could not be discussed in part one

that the Board had knowledge and insight to for which board members were responsible and accountable, eg corrective actions from reviews, coroner's requests, ACC treatment injuries etc. Management explained the extension letters related to complaint letters and extensions that were sent prior to a full response. MDHB was required to respond within 15 working days of receiving a complaint. If this was not possible, then a letter requesting an extension was required. The General Manager said she would like to report on both of these measures by cluster, so that members knew how the responses were doing in terms of responding in a timely manner.

Other comments noted the continuing struggle to achieve the hand hygiene target; where reporting on linkage with outside groups would occur, good information and graphs in the report, and an encouragement to expand the markers to include issues the clinical leads felt were important. Management acknowledged the various comments, noting that the clinical governance framework was still under development. The difficulty patients faced in asking a clinician if they had washed their hands was acknowledged. Management advised more patient education was required so people knew when clinicians should wash their hands. This issue would be covered further during patient safety week, which would focus on hand hygiene.

It was resolved:

that the Clinical Governance and Quality Improvement report be noted.

2.2   Optimise, Medimorph and Takatu Programmes of Work (Francis Group)

This report provided an overview of the programmes, details around the initiatives and results to date. There had been some quite positive outcomes. Clarification of the term "stranded patient" was provided, with Management explaining the term referred to long-stay patients. Twice weekly morning meetings were held to discuss problems with patients in hospital, and to put in place measures to move them faster than they had perhaps been moving. Management also clarified the reference to patients being identified on theatre lists – every effort was made to not defer patients if they had been deferred previously, so these patients were identified on theatre lists.

Presentation
Dr Paul Joice (Chair, Optimise Programme) then gave a presentation on the Optimise work. The presentation covered the background to the work, goals, timeline, workgroups and workstreams, outcomes of the Perfect Day "Beta Testing" Group testing, standardising elective list construction, creating consistent teams, identifying factors impacting on the flow through the acute theatre and exploring solutions to address those issues, developing a system to collect and report perioperative data, and rewriting the master grid (master theatre schedule) which supported the timely delivery of the required volumes of elective and acute surgery now and in the future. The presentation concluded with what went well, what went poorly with the project, and what the future work would cover.

In concluding the address, Dr Joice noted there was not enough theatre capacity for the work. As a result of the programme, the issues were understood better, a production plan had been created, and a working structure for continuing the improvement had been created. Issues could be addressed, eg the availability of Information Systems, the number of change management projects occurring at the same time and the resultant "engagement fatigue", and the continued involvement of all groups including management to achieve desired outcomes. He said there was a need to continue the work but the issues would have to be addressed, ie resourcing the IT department

sufficiently, and theatre capacity. There were not enough theatres, but this was a complex problem to resolve.

Dr Joice acknowledged the work of the Francis Group, who he felt acknowledged the issues at the beginning of the programme, as MDHB were using the theatres to full capacity so there was no easy solution. They were very impressed with the engagement of the organisation.

In relation to the concept of the value of surgery, Dr Joice said the onus was on surgical services to demonstrate what they were doing was correct. It was difficult to come up with a figure showing savings.

A member asked if the presentation could be included in the minutes. Management advised it could be put on the ShareNet website.

The presentation concluded with Management noting they were committed to the programme, and any sense of disengagement in moving to business as usual was unintentional. The project had to deal with many years of history and resource issues. However part of the process had been to be open and equitable in how theatre resource was used. It was also noted that the Board had given a commitment to an 8th theatre mid-2020.

The meeting took a five minute break following this presentation.

On reconvening, the presentation from the uru Rauhi – Mental health and Addictions Cluster was made.

4.1   Uru Rauhi – Mental Health and Addictions Cluster Report/Presentation

Presentation

A presentation was made to the Committee by many of the key community groups working with this cluster. The presenters were Richard McLevy, Chris Hocken, Roger Mcleod, Leilani Maraku, Vic Rogers, Luke Rowe, Marcel Westerlund, and Richard Atkinson.

The Operations Executive, Mental Health and Addictions Cluster, introduced the speakers. Dr Caldwell said the presentation would show highlights of the challenges faced and provide examples of changes being made. A handout was also circulated giving a snapshot of services available across the region.

The following points from the presentation were noted:

- Communications – improve communications
- Priorities – there are too many suicides each year
- Physical health of patients is really important and will improve mental health
- A unifying language was necessary
- Innovation – have to be smart in using resources eg basing staff in ED, or using modern technology if unable to travel
- Were disease focused, but need to focus on well-being. Formerly it was a medicine model but was now a recovery model.
- Ten Commandments of service users and whanau covering early intervention with children, better links/connections between services, good information sharing, community strength, system follow up, complaints listened to, family whanau based care, respite care, admission criteria, and barriers to access.

- WAIROA – the holistic wellbeing across the wellbeing continuum and life course with a focus on flourishing individuals, whanau, communities and environments.
- Housing support – connect and communicate – build trust
- Tararua College project, working with 45 people has improved attendance at school
- Crisis events – numbers have grown from 52 per month in 2015 to 245 per month in the first six months of 2018. Also managing 100 non urgent referrals per month. Complexity of presentations and acuity is increasing. People are distressed as an outcome of social determinants, eg lack of housing.
- Drivers of inequities – health system, workforce issues, exposure to known risk factors, psychotropic medication, socio-economic status, adverse childhood experiences.
- Horowhenua Adult Mental Health Services have been integrated with Adult Maori Mental Health Services and Older Adult Mental health Services, and will shortly move into new premises with onsite integration with the primary iwi health provider, Rangitane. There will be a solid multidisciplinary team process with a single point of entry for the three services, ie service users only tell their story once. There will be an integrated administration system with files stored together in one place. The crisis/duty assessment will be completed by one duty team across all three services.

At this point, discussion returned to order paper item 2.2 to conclude discussion on that item.

2.2   Optimise, Medimorph and Takatu Programmes of Work (Francis Group)

Management advised the Healthy Ageing and Rehabilitation Cluster had a programme of work around the expected early discharge (ACE – Acute Care of the Elderly) model. It would ensure services were in place to support better support the frail elderly population.

Bed modeling – this work would look at where improvements could be made. No particular area was being considered at the moment, rather the whole hospital and how the number and location of beds could be configured more effectively.

Information systems – given the workload of this service and the importance of information like length of stay data for managing beds, Management were asked if consideration could be given to generating daily reports on length of stay. Management advised when the Alcidion MIYA reporting system commenced it would provide this type of information. The CEO also advised that whilst the implementation of the WebPAS system had involved a lot of work for information systems, WebPAS was now settling down.

The Chair referred to the level of investment in these programmes and the benefits from them, noting that some benefits were about patient experience and therefore could not be clarified in dollar terms. However she felt it would be useful to identify the cost savings which have resulted, such as the benefit of reduced length of stay. The CEO agreed advising this was reported back in the business improvement programme.

Diane Anderson suggested the second recommendation should be amended to reflect the morning's discussion regarding the cost and immediate and longer term benefits both qualitative and quantitative of the overall programmes. Management was urged to commit to ongoing engagement with clinicians to work toward reported project outcomes. The second recommendation was amended accordingly.

It was resolved:

> that the Committee:
> - *notes the Optimise, Medimorph and Takatu Programmes and progress*
>
> - *notes the cost and immediate and longer term benefits both quantitative and qualitative of the overall programmes and commits to ongoing engagement and reporting with clinicians to work towards the project outcomes.(Moved Diane Anderson/seconded Anne Kolbe)*

2.3 Cluster Alliance Groups

Management advised these groups would be set up relatively quickly, probably before the end of 2018.

It was resolved:

> that the Committee:
> - *endorse the formation of Cluster Alliance Groups based on standard terms of reference, to be led by the Clinical Executive of each Cluster, with the terms of reference to be co-designed with stakeholders.*
> - *endorse the Cluster Alliance Groups' Alliance Agreements being developed over time.*
> - *endorse the existing Clinical Network Groups transition into Cluster Alliance Groups, with the transition process to be managed by Cluster leads.*
> - *note the Integrated Service Model Transition Group has been extended to include oversight of Cluster Service Plans and related activities.*

3 EQUITY

3.1 Equity Targets – Update on MDHB's Progress

A member referred to the long standing inequalities experienced by the Maori population. He felt if the current bullying attitude continued, the issues would never be resolved. The General Manager, Maori & Pacific Health responded advising MDHB provided Treaty of Waitangi training, and Pae Ora cultural training and through that work brought the Treaty partnership to life to build understanding and confidence of staff.

Management advised the third component, the Equity Toolkit, should be completed by December.

It was resolved

> that the Committee:
> - *note the progress update on the Equity Work Programme*
> - *note the integration of equity data into operational planning for the Cluster groups to develop meaningful measures of equity across the respective areas*
> - *note work is continuing on the Equity Toolkit to further support the organisation in the critical analysis of equity across the district.*

4   PERFORMANCE

4.1   Uru Rauhī - Mental Health and Addictions Cluster Report

Management advised the Zero Seclusion Governance Group would be undertaking a follow up visit on 1 October. Some in-house training was being undertaken to support that programme.

The issue of staff having difficulty attending training was clarified. This was due to the large number of vacancies and sick leave, and no back-fill being available to cover staff attending training.

The increase in the number of pieces of feedback received by the Marama Realtime process was noted. This could have been as a result of increased access through ipads and their location, thereby making it easier for people to provide feedback. Information on whether the feedback was positive or negative was unavailable at the meeting.

It was resolved:

> that the Committee:
> *endorse the progress made by Uru Rauhī - Mental Health & Addiction Services Cluster in 2018/19.*

4.1   Uru Matai - Cancer Screening, Treatment and Support Cluster Report

It was resolved:

> that the Committee:
> *endorse the progress made by Uru Matai - Cancer Screening, Treatment and Support Cluster in 2018/19.*

4.2   Uru Kiri Ora - Primary, Public and Community Health Cluster Report

Management confirmed the Health Care Home service was credentialed to enter homes.

A member expressed her continued concern regarding the Child Adolescent and Oral Health Service. She said she was getting mixed messages from reporting in the Finance, Risk and Audit Committee about dental chair utilisation and the workforce, and wondered if some clarification around this could be provided in the next report.

Diane Anderson and Anne Kolbe left the meeting.

It was resolved:

> that the Committee:
> *endorse the progress made by Uru Kiri Ora - Primary, Public and Community Health Cluster in 2018/19.*

4.3   Uru Arotau - Acute and Elective Specialist Services Cluster Report

It was resolved:

> that the Committee:

endorse the progress made by Uru Arotau - Acute and Elective Specialist Services Cluster in 2018/19.

4.4   Uru Whakamauora - Healthy Ageing and Rehabilitation Cluster Report

It was resolved:

that the Committee:
endorse the progress made by Uru Whakamauora - Healthy Ageing and Rehabilitation Cluster in 2018/19.

4.5   Pa Harakeke – Healthy Women Children and Youth Cluster Report

The Committee was advised there was an error in the first sentence of paragraph 5.1. The Ministry of Health Breastfeeding target was 76 percent, not 6 percent.

Management advised the voluntary bonding scheme had been successful in terms of retaining midwives but not very successful for medical staffing.

The contribution from Countdown was acknowledged.

It was resolved:

that the Committee:
endorse the progress made by Pa Harakeke – Healthy Women Children and Youth Cluster in 2018/19.

4.6   Regional Services Plan 2018/19 – Implementation

It was resolved:

that the Regional Service Plan update be noted.

5   POLICY & GOVERNANCE

5.1   Committee's Work Programme, 2018/19

Management noted there had been some timing issues with this meeting as a result of the lengthy presentations. This would be rectified. All reporting was tracking on time.

It was resolved:

that the Committee:
note progress being made in the delivery of the 2018/19 work programme.

6   LATE ITEMS

There were no late items.

7   DATE OF NEXT MEETING

16 October 2018 at 9.00am.

8   EXCLUSION OF THE PUBLIC

It was resolved:

that the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated:

Item	Reason	Reference
"In committee" minutes of the Health & Disability Advisory Committee meeting held on 27.7.18	For the reasons set out in the order paper of 27.7.18 meeting held with the public present	