

**MINUTES OF THE TE ROOPU TUPU TAHI HUI HELD ON
TUESDAY 20 JULY 2010 IN ROOM 1, SEMINAR CENTRE,
BRAEMAR CAMPUS, NELSON HOSPITAL AT 10.00AM**

Chair

Carol Gowan

Present

Lorraine Eade, David Hough, Lynda Sigglekow, Hilary Genet (NMDHB); Cheryl Thompson (SF Marlborough); Moira McLeod, Peter Rees (Te Ara Mahi); Michele Parkin (Consumer Representative, Marlborough); Susan O'Connell (SF Nelson); Warren Sadd (MH Consumer Advocacy); Jos van der Pol, Pat Duffy (Health Action Trust); Jo Johnson (Te Whare Mahana); Lois Millar (St Marks); Rob Somerville (District Inspector); Katrina Mark (CARE Marlborough);

In Attendance

Gaylene Corlett (NMDHB)

Apologies

Carmen Lynskey, Ron Keown (Richmond NZ); Sarah Preece (Mental Health Support Services); Janie McIntyre (Gateway Housing Trust); Martin Kane (Nelson Bays PHO); Rachel Davis (Te Awhina Marae)

Karakia:

David Hough

1. Welcome and Introductions

Carol welcomed everyone to the meeting.

2. Presentation – John Peters, CEO of NMDHB

John Peters, Chief Executive of Nelson Marlborough DHB presented to the meeting on the new NMDHB Executive Leadership Team structure.

The current structure has been in place for 5 years. The decision behind the restructure was not that the current team has failed but is about recognising the evolution of what is happening in the area of provision and oversight of services, not just locally but internationally. It is important to note that the DHB is in a different environment to what they were in 5 years ago. There are challenges from a number of areas like funding, change of government etc. There has not been a funding cut in health, but a significant change in structure around funding to the extent that in previous years the DHB has enjoyed between 6-8% pa of increases. This year NMDHB received just an increase of just under 2%, of which 0.9% has been allocated for demographic growth (ie, only allowed to be used for additional number of people in the district. Noting the population of Nelson Marlborough grows at about 0.8% each year, the increase will be required for this growth). The biggest challenge to the DHB around funding is that our costs keep increasing more than the increase. However, we must bear in mind that some government departments received no increase! The increase received by NMDHB is not enough to cover our financial growth.

With the current national trend being more patient focussed, the new structure for NMDHB will be looking at working better with providers and the source of provision of service. That means we need to work differently in how we work together. Second component to include is that if we are going to manage a number of things, not only patient centred, then we are keen to get greater engagement from clinicians than we have had in the past.

The new team will be:

- One source of truth, one system of care
- Focussing services on the patient/client
 - o service providers working together across the care continuum
- Clinical leaders from hospital and community involved at highest level of decision making
 - o both strategic direction and operations
- Service delivery at the executive level
 - o service directorates responsive for services across the district-
- Providing support for the three service directorates through:
 - o Clinical Support Services Directorate
 - o DONM, CMO. DMH & WO, Director of Allied Health
- Marlborough
 - o to inform, facilitate and participate
- Corporate Support structure:
 - o GM Strategy and Planning
 - o GM Corporate Services
 - o GM Workforce and Organisation Development
 - o Chief Executive's Office

See pages 4 and 5 of attached presentation for flow charts.

Mental Health providers will come under Community Based Directorate.

Each directorate is set up by a trio of equals; a service director who is full time and two clinical directors - one from specialist services and the other from community or primary. Not sure at this stage the degree of their positions (ranging from 0.1 to 0.4 FTE each)

Important to understand that Clinical Directors are not representing their speciality, eg clinical director medical/surgical - if that person happens to be a surgeon, that person is not there representing orthopaedic surgery but there representing the medical/surgical directorate. This means there will be 10 clinicians sitting around the ELT table monthly that can give views on the topics of discussion with a focus that ensures there is working together across the patient care continuum and across the organisation. Each will have delegated powers – high level of decision making delegation for budgets.

Below this level will be specialist directors.

Corporate/support structure is GM Strategy & Planning, GM Corporate Services, GM Workforce and OD Support and CE Support. CE Support is EA to CEO and Board Secretary. IDSS sits on CE Support line.

A partnership agreement on core accountabilities has been developed for the directorates between the service director and the two clinical directors of each directorate to ensure responsibilities are covered.

It is noted that the new structure is more complex than we have at present, but it is about working to achieve some of the things we are looking to do, eg one source of truth, one system of care etc.

Questions:

How are you going to retain the smallest of the clinical director roles? John – will be a challenge which is why we have not said what they will be at this stage. Each of the service directorates will have that responsibility themselves because they will carry the budget so if it starts at 0.3FTE then need more time and have the budget can increase the time.

Process around IDSS and its future – what is the influence of those people involved in the service in deciding the future? John – it will sit under the CE Support to allow a better approach for engagement of those involved in IDSS. Recommendations will then go to the larger service delivery group and then to the Board. Will be able to focus on projects outside of the day to day running of IDSS.

Timing? John – positions have been advertised with over 80 applications being received which is taking time to work through. Currently shortlisting. Positions of Board Secretary, GM Strategy & Planning, GM Workforce and OD have not changed, also DoMH and DONW also remain. New structure to be in place by 1 September.

DHB has gone through 360 degree of change – clinical directors will have some business background. Across the country talk about the number of DHBs we have – what would be the impact on this if they decided not to have a DHB here? John – will not find a DHB in the country that does not agree 21 DHBs are too many. All would support some sort of careful regionalisation of this. Current government have said they will not look at DHB structure in this term. John thinks whichever government gets in will look at number of DHBs. Nationally are already starting to look at regionalisation of Finance and HR services.



ELT Structure
Presentation - Rev 2

3. Minutes of Previous Meeting

The minutes of the meeting held on 1 June 2010 were accepted as a true and correct record.

4. Matters Arising from Previous Minutes

Nil.

5. Issues, Information and Celebrations

Carol informed the meeting of Support Learn Grow programme which is a NMDHB initiated programme for literacy and numeracy support for community support workers. Any issues with literacy with clients can contact Jill Kersey, Wellcare, 35 Nile Street, Nelson. Phone 03 539 4444, mobile 027 288 8967 or email Jill.Kersey@wellcare.co.nz

DHB

Merrill Brunt has resigned from DHB – all focus groups are on hold until replacement in place. A card for good wishes will be available at the next meeting for TRTT members to sign.

SF Nelson

Held a successful mid winter Christmas dinner at Nick Smith's rooms for about 40 people – family and service users.

Matariki celebrations at mental health unit was a great evening.

6. Workforce Development

Health Action Trust conducted a four day advocacy course attended by 15 people. Some confusion as in workforce calendar has three dates – have had training others need to be removed. If funding can be found they will run a 60 hour peer support and advocacy full course later on this year.

MH101 – blueprint for learning – medical health first aid training. Two training sessions held in Nelson funded by the MoH. A training session may be held in Marlborough in August. It was noted these sessions will not be advertised as they are for those that did not attend last time. Contact Hilary Genet for more information.

Compass Seminars run a number of seminars – one on Preventing Suicide coming up in August by John Henley from UK. David Hough has asked if he would come to Nelson. Has said yes but for a fee – need 40 people paying \$195 each. David needs to know whether people are interested by midday tomorrow. About 9 interested so far. Contact David Hough if interested.

7. Reports from Cluster Groups, Special Interest Groups, Other Networks

Motueka MH

Last meeting discussed TOR. Main focus is on support services directory in Motueka. In process of getting noticeboard made and put up (funded by TDC). Next meeting will look at getting a group together to prepare something for Mental Health awareness week.

8. Collaboration and Consolidation

Te Whare

Have lost DHB funding (0.5FTE) so looking at opportunities to continue the services they deliver by collaborating with other agencies in Golden Bay. Response Fund looking at developing a proposal that will be self sustaining for the Bay. Te Ara Mahi offered their assistance in collaboration for services in Golden Bay.

Te Ara Mahi has retained space in Motueka Gateway facility, but have down sized in Richmond. Noted Tudor Street office is not manned, use room as needed, and Richmond office is only open on Thursdays.

WINZ Community link – set of offices in Blenheim that can be used by community free of charge. Community agencies working together in Marlborough. Contact Cheryl Thompson.

Te Ara Mahi – ACC building in Nelson on ground floor has seminar room which is free to community groups to use. Need to take own cups, tea and coffee etc.

9. Mental Health Planning and Funding Report

Report noted.

TRTT Annual Workplan

Discussion held on integrated client pathways and sharing of information. Need to be careful of what information is available electronically that may breach privacy of clients. Agreed the best pathway forward is to find out about the national project first and see how that will filter down to a local level. Lorr to report back next meeting. Agreed integrated client pathways and clinical coverage to be incorporated into one and scoped out more. Agreed take out best practice as we do it anyway in the TRTT forum. Agreed to combine Models of care, packages of care. Discussion held on show case of mental health NGO/specialist mental health services/voluntary/community groups to the General Practice sector. Suggested link in Sport Tasman for Mental Health awareness week. Lorr to change action plan as suggested above and to link into Mental Health awareness week – showcasing through a MH expo. Lorr to talk to Alison and Martin about best way to get GPs to work with community groups. .

SIRMHN

Thank you for contributions for regional models of care discussion. Noted the Workforce (Let's get Real) DVD is available free from Te Pou website.

Suicide Prevention

Noted the five pilots for suicide prevention have received MOH funding for a further two years. Also noted that Southern DHB and Canterbury DHB have joined the other piloted DHBs, making a total of 7.

Workforce Calendar

Send any training to Lorr for inclusion in calendar. When attending First Aid courses attendees must let Lorr know if they are not going to attend (part of the agreement with L&D). Noted research section added to calendar – let Lorr know if this is useful. Lorr to zip to see if this assists. Mention of linking into funds from NBPHO through Jane Kinsey for workforce development. Noted Lorr has spoken to Jane and needs further discussion to clarify as funding has to be applied for.

Alcohol and Liquor Advisory Council

Facilitation of LOAD forums will be held quarterly by P&F. Will be held locally. ALAC sending Lorr LOAD database then will set up meeting. Jim Hauraki will attend first meeting.

Primary Mental Health

NMDHB, Nelson Bays PHO and Kimi Hauora Wairau PHO met with MOH to discuss the opportunities for being a National Demonstration Project as part of the Better, Sooner, More Convenient/integrated family health systems development.

Systemic Recovery Indicators

Lorr is putting in a submission from P&F. Discussion held on whether TRTT would put in a submission or whether NGOs would put in individual submissions. There are nine categories of questions where they ask for a yes, no, comment or change.

Discussion held on the definition in the Plan on clinical recovery, personal recovery and family/whanau recovery. Jos mentioned that from feedback of service users, they dislike the word 'recovery' – would rather use the word 'discovery of new life'.

Recovery is considered a provider word. Agreed that wording around Personal Recovery is acceptable. Wording "... opportunities for people to facilitate their transition to a meaningful life" – what is meaningful! Should state a meaningful life as it means to the service user. Agreed providers to do own submission to MHC.

Websites

Due to time restraints it was agreed to look at websites at the next meeting.

10. Any other Issues

Nil.

11. Next Meeting Topics

Please forward any topics for the next meeting to Carol or Gaylene.

Close:

David Hough

Meeting closed at 12.30m.

The next meeting will be held on Tuesday 31 August in the Admin Meeting Room (old Board room), Wairau Hospital, Blenheim