MINUTES OF THE MEETING OF THE
NORTHLAND DISTRICT HEALTH BOARD
HOSPITAL ADVISORY COMMITTEE

HELD ON MONDAY 29 MAY 2017
COMMUNITY SERVICES CONFERENCE ROOM, DARGAVILLE HOSPITAL

COMMENCING AT 9.00 AM

PRESENT

John Bain (Chair)
Sue Brown
Debbie Evans
Denise Jensen
Libby Jones
Sally Macauley
Gary Payinda

IN ATTENDANCE

Nick Chamberlain, Neil Beney, Margareth Broodkoorn, Meng Cheong, Ian McKenzie, Andrew Mardon, Andrew Potts, Mike Roberts, Jeanette Wedding, Pip Zammit, Kathryn Leydon, Sarah Hunt (notes)

Craig Brown

FIRE PROCEDURES

The fire exits were noted

APOLOGIES

Nil

CONFLICTS OF INTEREST

The Chair reminded Board members that in keeping with agreed protocol, conflicts of interest should be declared on a meeting-by-meeting basis as issues arise

Debbie Evans advised to remove Community Organisation Grant Scheme and Springboard Trust from the list of her interest.

1. COMMITTEE MINUTES

1.1 Confirmation of Minutes 10 April 2017

It was moved that the minutes of the meeting held on 10 April 2017 be approved

MOVED Libby Jones SECONDED Debbie Evans CARRIED

1.2 Matters/Actions Arising

1.2.1 Choosing Wisely Initiative – Presentation Dr Mike Roberts, Chief Medical Officer

- Developed in North America. Considered one of the useful ways to reduce waste in healthcare and get best values for the dollar.
- Important to understand how to use programme in Northland.
- What is low value care – Care of little or no value to patient; costs do not provide proportional benefits; risk of harm exceeds likely benefit as seen by patient.
- Factors that encourage over intervention – fee for service healthcare'; concern over errors of omission; patient perception that "more must be

better"; misunderstanding of risks by clinicians and patients.

- Looked at percentage of GPs reporting the amount of medical care their patient receive is "too much" or "much too much". Discussed large amount of unmet need in NZ.
- Choosing wisely – health professional led; collaboration between health professionals and patients; shared decision making. Patient making the choice that is right for them.
- Sharing expertise – clinicians and patients.
- Wasted money on investigations is significant in Northland.
- Choosing wisely in Northland – in-patient blood testing for surgical patients; pre-dialysis discussion with renal patients. Developing patient decision aids for Northland. Will start in Renal but will be rolled out more widely in time.
- Patient decision aids will possibly assist with compliance (with medication for example) when patients can see the benefits.
- Worth looking at GP prescribing habits? Have the data on that and investigations done. Significant differences in utilisation, but also differs depending on population. Now have a pharmacist facilitator working with GPs in some areas.
- Discussed last year of life patients. Advanced care planning will be key, discussions to be had with GP and those discussions then shared across the hospital.
- Regional Health Care Planning Group. Strategy being released around last days of life and utilisation of healthcare resource. ACPs, Advanced Directives and conversations that need to occur with families and aged care facilities.
- Education of people in those positions that need to have the conversations.
- Decision cannot be made based on money alone. Needs to be done in conjunction with those things that the patient finds benefit from.

2. CHAIR'S REPORT

There was no Chair's report

3. GENERAL BUSINESS

3.1 Utilisation of NDHB's Oral Health Service

- The paper was taken as read.
- Oral Health services encompasses pre-school, school based, adolescent and hospital services. 43,000 people in the 0-17 year old age group.
- Community dental is a user pays service.
- Only 72% of eligible preschool children enrolled. Work being done to increase that, however until 85-90% enrolment then don't believe stats will change.
- Will be some change in the future given preventative initiatives in place, however largest factor will be fluoridation in the water supply. There has been a large body of work done, however still some way to go.
- Enrolment occurs at birth. ¼ of children are registered however not accessing care or utilising service. Parent might engage initially, however may subsequently query the value before kids have teeth. Pre-teeth training is very important.
- Rely on Well-child providers and Maori providers to provide education in that space.
- Looking at various options to break the cycle. Midwives have a huge part to play. About connecting the whole system to encourage engagement.
- Are all midwives now experts on prenatal oral health? Good percentage are, however some don't agree with the initiative. They contract with the NDHB so make it compulsory to have that education.
- In future would be helpful to see graphs that show percentage, rather than number of children seen.
- DHB holds contract for 0-12 year olds. That contract ends and another starts at the end of that time, which is also open to private practitioners. People have to re-enrol

at that time which causes a degree of fragmentation at that point. Most parents don't realise there is that switching point. Doing a lot of education and following up adolescents.

- Going to a dentist is discretionary. When economy is going well dentists don't want this contract. Dentists also don't follow up the way the DHB does. Consider that dental treatment now is unaffordable for many people.
- Availability of appointments for private dentist is also a key barrier. From a National perspective the number of dentists per capita in Northland is good. What we see in Northland is that a number of dentists are towards the end of their career so no longer working full time.
- There is no after-hours dentists anymore – default provider is DHB.
- System in place with WINZ offices. Someone can ask for $40 to access care (part payment for community services card) and they'll be provided with that.
- If a person turns up at ED from ACC, do ACC pay? Depends on the sort of accident as to who deals with it, however there is a payment from ACC.
- Dental Therapists can do so much in NZ which is fantastic, however amount of severe distress in children is still shocking. DHB doesn't have enough therapists to service whole population of adolescents.
- One issue is there aren't enough therapists to provide the service, another is also the follow up and administration time required. Is there a roll for NDHB with that? Oral Health promoter started some months ago who will be looking at this.
- Public Health nurses are already pivotal in schools
- One of the better services which is a whole system approach. Continuous improvement. Education is key, however not just about choice, needs something more forceful in terms of legislation.

4. SYSTEMS PERFORMANCE

4.1 Operational Report

- During March a new Patient Administration System (WebPAS) was implemented across the hospital. Huge project, may years in the planning, relatively expensive. Some data reporting problems subsequently so some omissions in the report. Caveat around report until that settles down.
- Some uncertainty around data in March. Will need another month before there is reliable data.
- Tumanako occupancy good.
- Bay of Islands Hospital is consistently showing increased ED presentations.
- No falls reported during March.
- Regained ESPI compliance for elective surgery in March.
- Growth in acute activity, cancer treatment in March, reflected in financials for the month.
- Considerable drop in colonoscopies. There is not a high variable cost in colonoscopies so no financial benefit in doing this. Recognise there could be considerable downstream costs as a result of delaying treatment.
- Discussed possibility of having a Sunday theatre. Substantially more expensive than having another in the hospital for weekday clinics.
- Auckland are doing nurse led endoscopies. Northland will go there, once there is a credentialed endoscopy suite. Training programme in place in Auckland which Northland can access when ready to go. Some significant resistance from gastroenterologists nationally. Alternatives to colonoscopy tend to be resisted.
- Anticipate that at the end of current quarter will be close to 85% target for Faster Cancer Treatment.
- MRI stats well below target. In March did highest number of scans since recording started, however still didn't reach target.
- CT scans have doubled in 5 years. Consistent high growth in CT. Patients can get CT and MRI privately in Whangarei, some do choose this option however still a significant waiting list.
- Critical constraint for number of scans possible is radiologist staff – reporting of the

scans takes the time. Only a few minutes to do the scan but an hour or two to report it. Currently have 2 vacancies for radiologists.

- Queried outsourcing of radiology reads. Use Australia currently, very expensive. Approximately 6 years since last tested the market, will reconsider this now.
- ACC imaging is generally done privately.
- Consider what is causing the demand increase. Choosing Wisely will help to address this - consider whether the pathways are driving some of the demand. Very high cost to the service.
- HOP service – dip in outpatient contacts. Service is financially well under budget to offset medical service. Making revenue from ACC, do charge them for patients in the rehab ward. Safe use of opioid has been significant project – continuing to implement. Will be very valuable moving forward looking after patients.
- Medicine. Shows YTD growth in Acute case weights of 19%. Seeing more patients with complex dementia coupled with delirium, very hard to manage. Watch budget is significantly increasing - 20,800 watch hours so far this year.
- Queried developing a skilled nursing facility as currently admitting frail elderly on revolving door. What is the breakeven point to have DHB skilled nursing facility? Evidence is the patient stays longer so net gain is nil. Cost of setting up a step down bed is still a bed – all the fixed costs remain the same – some of the personnel costs might be slightly down. Biggest argument is bed availability to avoid bed blocks.
- What percentage of admissions come from rest homes which could be avoidable? **Advised that Audit completed this week so can report on that shortly.**
- Investment needs to be upstream to support people in their homes even more. Some proposals currently being considered. Considerable work being done around community support but still some way away from a resolution.
- Renal growth in both Whangarei unit and across Northland. Looking to contain that. Haven't been successful shifting to home based dialysis
- ED is particularly busy.
- Good paper in NZ Med Journal showing benefits of the 6 hour stay target.
- Mental health very busy. Finance showing positive variance, predominantly due to vacancies, however vacancies create risk in terms of service coverage. Vacancies variance offset by cost of locums. SMO recruitment is improving. Showing some revenue from new contracts.
- Methamphetamine joint venture going well, gaining local publicity, positive experience. Police take interest in involvement and early intervention.
- Developing business case for community mental health facility in Whangarei.
- Model of Care work is reaching completion of phase 2, lines up well with work that Chief Medical Officer is doing with Choosing Wisely.
- Wait times are currently 3-6 weeks. There will be contact with that person even if psychiatrist is not available for some weeks. Northland are in line nationally with wait time targets.
- District Hospitals –trend showing ED events at Bay of Islands increasing, Kaitaia decreasing. Considerably over budget in Districts – mainly due to locums and Kaitaia working on new scopes. There is now also an additional doctor on the team in Bay of Islands. Dargaville have now employed a second full time SMO. Working towards shift roster in Bay of Islands – progressing that, considering after hours cover, looking to have this implemented in the next few months.
- Paediatrics – looking at 120% utilisation in neo natal unit – concerning, risk mitigation in terms of staffing. Quality improvement are looking at readmissions – co-designing that with primary care – to address high use patients.
- Trialling filling prescriptions before discharge to be able to give them to families when they leave.
- Dr Roger Tuck retiring. Some vacancies to fill on that team.
- 3 young people reported with rheumatic fever this year. Doing root cause analysis currently to identify why. Some GPs not following guidelines for pathway.
- WebPAS issue is a one off issue. However, do have stable Concerto now as a result. Much better system, just ironing out glitches now.
- Audit NZ and known issue there. Internal audit are looking at it now. WebPAS has reporting issues that need to be ironed out, when that is done will inform controls

moving forward. Data is there but not the reports. Ministry are very aware of current reporting issues.

- This system improves control significantly. Lot of issues have arisen from previous system and mapping that to the new system. Ministry also changed some of their reporting systems over that period as well.

4.2 Financial Report

- Taken as read
- This is the result to the end of April.
- Received funding envelope. Will be presented in public excluded Board meeting.
- Believe the end of year result will be a deficit of $1M compared with annual plan of $2M surplus.
- The Chief Financial Officer has signalled this forecast to the Ministry in April. They are aware of this possibility.
- Rate of growth of expenditure on oncology drugs has more than doubled year on year. Difficult to know an exact figure due to rebating. Budgeted $3M, spent nearly $6M. DHB has no control over this spend. Not just the cost of the drug, also requires additional staffing to support administration. NDHB has a larger number of patients with cancer when compared to other DHBs of this size.

5. NEXT MEETING DETAILS

The next meeting will be held at 2.00pm, Monday 10 July 2017, in the Tangihua Room, Tohora House, Whangarei

There being no further business the meeting closed at 11.05am.

Confirmed that these minutes constitute a true and correct record of the proceedings of the meeting.

CHAIR **DATE**