MINUTES OF THE MEETING OF THE
NORTHLAND DISTRICT HEALTH BOARD

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

COMMENCING AT 11.10AM

PRESENT

Sally Macauley (Chair)
John Bain
Craig Brown
Sue Brown (Deputy Chair)
Debbie Evans
Denise Jensen
Libby Jones
Colin Kitchen
June McCabe
Gary Payinda
Sharon Shea

IN ATTENDANCE
Nick Chamberlain, Neil Beney, Margareth Broodkoorn, Meng Cheong, Andrew Mardon, Mike Roberts, Jeanette Wedding, Pip Zammit, John Wansbone (part), Karen O'Keefe (part), Scott Wilson (part), Kathryn Leydon, Sarah Hunt (notes)

APOLOGIES
No apologies

FIRE PROCEDURES
The fire exits were noted

REGISTER OF INTERESTS
The Register of Interests was noted

Debbie Evans - delete Community Organisation Grant Scheme and Springboard Trust from the list of her interests.

ATTENDANCE REGISTER
Register was noted.

At lunch the Board will tour the Dargaville Hospital facilities.

1. BOARD MINUTES

1.1. Confirmation of Minutes 10 April 2017

IT WAS MOVED THAT the minutes of the meeting held on 10 April 2017 be accepted.

MOVED John Bain: SECONDED Libby Jones **CARRIED**

1.2. Matters/ Actions Arising

1.2.1 CRAB Data

- There is an update to CRAB which will be implemented soon, which will show ethnicity data.
- Noted issue with WebPAS data.

1.2.2 Neighbourhood Healthcare Homes Update

- Paper was taken as read.
- Gives a summary of how Neighbourhood Healthcare Homes (NHH) works, how it frees up time and what other outcomes are achieved.
- A number of patient benefits that have been outlined.
- Practices that are implementing this are already seeing massive changes.
- **A3 diagram of NHH Programme Logic to be circulated to Board members, with a hard copy handed out at the next meeting.**
- Noted the Programme Logic is not in an RBA framework, however there is an evaluation programme built into the framework.
- Every change won't be measured in the same way across all practices, however most patients will be aware there are changes.
- 15 practices applied, have taken up 6. This year there is to be a second EOI phase and expect another 10 practices to begin.
- A number of components already underway independently by practices waiting to become a NHH.
- Extra funding available through capitation to ensure GPs are not financially adversely affected.
- Don't know that all practices will ever be NHHs. Business case approved by the Board was for 3 years and will cover approximately 140,000 patients (out of 170,000 population in Northland). Voluntary change.
- RBA Champions to apply an RBA lens to the evaluation of the NHH programme.
- A query and some discussion occurred on how to sustain this programme post end date.

1.2.3 Privacy laws and phone messages

- What level of phone message can be left on a patient phone?
- Looking at the level of detail that can be sent without it breaching the Privacy Act.
- Identify the level of training that is required/ given.
- Consider an opt out clause at registration, provision of an email address to send information, that the patient agreed to, that isn't ethically compromised. Some concern raised about this, taking into consideration patient state of mind at the time of registration.
- Issue around collecting email addresses (WebPAS).
- **Report to be provided to the Board detailing current practice, possible solutions and implications.**

2. QUALITY & SAFETY GOVERNANCE REPORT

2.1. Summary Report – April 2017

Chief Medical Officer spoke to the report, which was taken as read.

Key Issues and Discussion Points

- The number of adverse events and number of SAC2 events has been high.
- Medication errors and falls are two key areas that are trending up. Due mostly to system errors, analysis shows things that haven't been done, process not completed in a timely way, assessment that hasn't identified something. Always room for improvement. Impact of the busyness and increase in numbers of patients being seen.
- With the number of processes that are involved ticking off medications, there are significant opportunities to miss something.
- Understanding some of the issues better, however don't have solutions yet.
- No issues around incompetence identified.
- Every serious event is analysed through a SEA – Serious Event Analysis. Concern around practice is always raised and addressed. Low blame culture (not no blame) means we look at process issues first.
- Busyness and interruptions are two human factors that are key for increasing rate of errors and mistakes.
- Discussion occurred around Health & Safety, and whether it involves staff or whether it is anyone coming into the environment.
- Would like to put more focus and discussion onto the Patient Stories in this report. Use patients as another checkpoint for quality. Balanced opportunity to allow all people to be part of the equation.
- HDC complaints – often these aren't upheld. 3 in March are still in the process, no results back yet. Reassurance – DHB fluctuate between being 2nd and 4th best in the country in having fewest complaints being raised.
- Patient Experience – commentary of Partners in Care. What has been found is that terminology may be confusing. Intention was to engage with family and partners. Believe the reported result may be due to having terminology wrong. Consider and acknowledge negative aspects to partners in care as well. Some of the issues are the 4 bed rooms.
- Falls data and quality markers. Should be Oct to Dec 16 in the report.
- Assessment data has dropped, siting at 69% where previously 75%.
- Care plans being completed have increased, tracking upwards.
- A lot of work is being undertaken in terms of assessing health outcomes and quality and safety markers – a way of seeing how well we're doing.
- Falls data by comparison with other DHBs is good – 0.8 per 1000. There will always be patients falling, but working to mitigate falling with harm.
- Falls group and pressure injury group – vulnerable patient group. Combining those groups and will develop assessment tools. Embarking on contract with ACC looking at falls programme and focussing on strengths and balancing programmes in the community. Strong Multi-Disciplinary Team approach. Fracture liaison nurse to support those who are falling and the frail elderly programme.

2.2. Reducing Medication Errors

Karen O'Keefe, Improvement Advisor, Medicine, Health of Older People, ED & Clinical Support Service presented.

- How do we know we are safe? Current systems – policy, review of incidents, audits for reliability, looking for things that go wrong and try and mitigate these.
- Reporting culture
- Types of errors that are seen – administration, prescribing
- Learning from incidents

- Incidents of concern – double dosing, wrong patients, Patient Controlled Analgesia (PCA), IV infusions. Reliability issues. Complicated patient management issues.
- Gaps or challenges in our systems or ability to move to Safety II – Information system availability, availability in hard barriers, safe system design, availability of data to support improvement
- Current medication safety infrastructure: NDHB, Medicines committee, ward based pharmacist, clinical pharmacist facilitator
- Medication safety improvement projects
- The big 5 of safe medication management – Antibiotic Stewardship, Safely identify patients and their Allergies and Adverse Drug Events (ADEs), Polypharmacy, Safe management of medications during transition of care, Safe management of high risk meds
- Safe use of Opioid project, national project. Information found in coding data, allowed understanding of level of adverse events in the population. Focussed on post op patients and learnings from that.
- Issues identified - Opioid Induced Ventilatory Impairment (OIVI) events in the post op patient occurring on a regular basis (average between events 9 days); Event occurring in a younger patient group than expected (under 50s); 70% in women; OIVI events often occurring shortly after return from Post-Anaesthetic Care Unit (PACU); almost all on a PCA; Frequently had an early trigger event
- Key changes implemented – Screening, different opioid use, change how people were looked at in recovery, sedation score monitoring.
- Still working with Health Quality Safety Commission.
- Partnering with patients and helping staff to have the right conversations with patients on pain management is an important component.
- Update requested for 2018 programme.

3. CHAIR'S REPORT

The Chair spoke to her report, which was taken as read

IT WAS MOVED THAT the Board receive the Chair's report.

MOVED Debbie Evans: SECONDED Craig Brown **CARRIED**

4. CEO'S REPORT

The CEO spoke to his report, which was taken as read

Key Issues and Discussion Points

- The CE is meeting with Ministry of Education asset disposal team. Formally indicated that NDHB would be interested in taking over ownership of The Pulse.
- Tai Tokerau indigenous health system hui occurred. Further discussion to occur between Maori providers and Iwi. Piece of work around primary care single entity going very well. Not quite what the Board envisaged but could go further than what we envisaged. Some of the indigenous health system could be channelled through this new entity. Opportunity to have broader, more system approach to whole of community. Drive a focus and desire to lift game across the whole system. Meetings are very demanding but have moved into a collaborative approach.
- Better public service targets. Part of the suite of 10 targets, still have immunisation and others but keeping kids healthy and healthy mums and babies added to those.
- Publicity recently around Vaxxed movie. Organisation is completely supportive of Dr Lance O'Sullivan. Misinformation needs to be challenged. Decline rates have never been higher at

15%. Very difficult to address with social media being so prolific. Board members to keep giving personal stories, keep giving positive outcomes. Experience of Somali community in USA in 2004 and drop in vaccination rates noted.

- Availability of acute theatres – plan to be presented to the Board in the near future.
- Tobacco control. There is a reporting process around the requirement for 5% by 2025. One of the most effective interventions we could have. CE to keep Board updated on progress.

IT WAS MOVED THAT the Board receive the CEO's report.

MOVED Debbie Evans : SECONDED Craig Brown **CARRIED**

5. DECISION PAPERS

There were no papers for consideration.

6. SYSTEMS PERFORMANCE

6.1. Health & Safety Report

Paper was taken as read.

6.2. Health Targets

Paper was taken as read.

6.3. Finance Report

The Chief Financial Officer spoke to the Financial Report. The report was taken as read.

Key Issues and Discussion Points

- 10 months to April travelling with deficit of $271k compared with the budgeted surplus of $1m
- Main pressure is ED, surgical and oncology – drug spend is about $2m over budget. Hospital activity remains high.
- Forecast is potentially $1m deficit. This has reported to the Minister. Ministry will be in touch to discuss. Not in intensive monitoring.
- Funding envelope received. Presentation will be given in public excluded part of the meeting.
- Vodafone contract have resulted in savings of $10k per month, not per annum. Able to monitor and track phones to a larger degree than previously.
- Showing more FTEs than budgeted. Part of it is to do with acute volumes, part is how we budget vs actual and changes required through the year, includes annual leave accrual.
- Transfer to equity. DHBs funded on mix on Crown equity and Crown debt. In December Crown decided to swap all debt to equity, which means now pay 6% equity charge to the Crown. Part of new process of moving to full capital funding of public health sector. This year crown put aside $150M to fund investments, not allowed to borrow anymore. New equity for capital investments will attract 0% capital charge for first few years. Can sell and lease back significant parts of our clinical equipment fleet.

6.4. NDHB Funded Services Dashboard

The report was taken as read

7. INFORMATION PAPERS & Updates

7.1. Quarter Three 2016/17 DHB and PHO Health Target Results

The report was taken as read

8. NEXT MEETING DETAILS

The next meeting will be held at 9am on Monday 10 July 2017 in Tangihua Room, Tohorā House, Whangarei Hospital.

9. RESOLUTION TO EXCLUDE THE PUBLIC

Recommendation:
That the public be excluded from the following part of this meeting, under Schedule 3, Clause 32 of the NZ Public Health & Disability Act 2000 and in accordance with the Official Information Act 1982 as detailed in the table below;

Agenda item and general subject of the matter to be discussed		**Reason**	**Reference**
10.	Information Update 10.1 Regional Long Term Investment Plan Update	Commercial Activities: To enable the Board to carry out, without prejudice or disadvantage, commercial activities	9(2)(i)
11.	Confirmation of minutes for meeting held on 10 April 2017 – Public excluded session	For reasons given in the previous meeting	
12.	Decision Papers 12.1 Agreements for Specialist Palliative Care Services 12.2 Agreements for Support Services for Chronic Health Conditions 12.3 Community Pharmacy Contracts 12.4 Geneva Northlink Healthcare Agreements 12.5 Lease Agreement – Orrs Kaipara Pharmacies Ltd 12.6 NZHP Draft Annual Plan, SOE and SOI 2017/18 12.7 healthAlliance Procurement Agency	Commercial Activities: To enable the Board to carry out, without prejudice or disadvantage, commercial activities Negotiations. To enable the Board to carry out, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations)	9(2)(i) 9(2)(j)
13.	Information Reports & Updates 13.1 Project Office Report 13.2 Induction Feedback and Analysis 13.3 Funding Envelope Update 13.4 Presentation to National Capital Investment Committee	Commercial Activities: To enable the Board to carry out, without prejudice or disadvantage, commercial activities Negotiations. To enable the Board to carry out, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations)	9(2)(i) 9(2)(j)

14.	Risk Management/Initiatives	Commercial Activities: To enable the Board to carry out, without prejudice or disadvantage, commercial activities Negotiations. To enable the Board to carry out, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations)	9(2)(i) 9(2)(j)

IT WAS MOVED THAT the Board move into Public Excluded meeting

MOVED Debbie Evans: SECONDED Craig Brown **CARRIED**

10. INFORMATION UPDATE

The update was noted.

IT WAS MOVED THAT the Board move out of Public Excluded meeting

MOVED Debbie Evans: SECONDED Craig Brown **CARRIED**

7.1 Dargaville Hospital Model of Care Update

Presentation: Dr Scott Wilson, Clinical Lead, Dargaville Hospital

Key Issues and Discussion Points

- Background Check
- My role – relationship building, focus on patient centred care, integrated models, enhance the services offered at Dargaville.
- What we have been up to
- The team – up skilling personnel. Kaitaia advanced nursing sessions, in house education sessions, focus on critical debriefing, providing opportunity for practical skill development.
- Recruitment of second experienced specialist; involving our dual fellow GP colleagues; medical student involvement; registrar positions; physio/ Scott – sleep studies
- The gear – equipment. New NIV; updating resus equipment; standardisation of equipment; bedside iSTAT.
- Telehealth – iPAD pro – linked to allied health; VC clinic room, resus linked to ICU; virtual consults
- The Castle – resus room redeveloped, fit for purpose
- Facilities – IFHC meetings re-established, pharmacy coming on site, physio moved to allied health wing; Sleep study room.
- Where to next – Push on elective work – sleep centre/ detox; paediatrics; repatriation programme; modify admission hours – sustainability; Integrated out of hours call rosters; Dual training/ employment opportunities; enhanced telehealth opportunities.

IT WAS MOVED THAT the Board move into Public Excluded meeting

MOVED Debbie Evans: SECONDED Craig Brown **CARRIED**

11. CONFIRMATION OF MINUTES

The minutes were confirmed

12. DECISION PAPERS

The submissions were approved

13. INFORMATION UPDATES

The updates were discussed

14. RISK MANAGEMENT/ INITIATIVES

The issues were discussed

The meeting closed at 4.30pm

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

CHAIR _____ DATE _____