Clinical Council

Summary of June 10th 2015 Meeting

Previous Business:

Clinical Council Terms of Reference – these have been published on MIDAS and have been placed on the Clinical Council webpage.

Advance Care Planning – A working group has now been established and has met. The working group has ensured greater district-wide representation.

Urgent Interim Works Dunedin Hospital – It was noted that the Project Team is now in place. Also emphasised has been the need to involve all clinical teams and engage all clinical staff in the process (not just those in the immediate areas subject to the immediate redevelopment).

Private Practice, Secondary Employment and Other Business Activities Policy and Guidelines – Letter has been sent to John Pine with the feedback from the Council regarding this policy and the need for it to be consulted on by clinical staff.

Not for CPR Policy – Further to the decision that in light of case of *Tracey v Cambridge University Hospitals NHS Trust* that we should reconsider the content our Not for CPR Policy, and the information we provide to patients regarding Not for CPR processes - a working group should be formed to look at this topic and that the Chief Medical Officer should set up and resource the working group – This item will now go to Mr Richard Bunton, as Acting CMO, for his management.

New Business:

Discharge Summaries – Access by Community Care Providers.

Craig MacKenzie, Manager of Pharmacy, Dunedin Hospital, presented a proposal entitled "Discharge Summaries – Access by Community Care Providers". The proposal requested that the Clinical Council support a change to current policy that would allow access by Community Care Providers (in particular Community Pharmacists) to the Discharge summary *on request*.

Current policy does not permit access by Community Pharmacists to the Discharge Summary (also known as the Electronic Discharge Summary). In terms of medications, there continues to be discrepancies between the discharge summary, the discharge prescriptions and the most recent inpatient medication chart despite the introduction of MedChart.

Often, the medication changes are documented on the Discharge Summary and this information is then useful for the Community Pharmacies to determine whether any change to medications are intentional changes vs. unintentional changes (errors). Without access to the Discharge Summary trying to establish the actual correct medication regimen is very complicated and can take considerable time to resolve. It also involves the in-hospital teams for clarification.

It was decided that the proposal will be taken to the Medical Directors for their consideration.

Redevelopment Update

Lexie O'Shea and Dr Pim Allen led a discussion on the redevelopment process and principles. It was noted that there is a **single stage business case** in development currently. This involves urgent cases. The team are currently applying for finance from the Ministry of Health. This will be implemented *from decision* in 2015-17. It involves ICU, endoscopy suite, mental health, audiology, and deferred maintenance.

There will need to be a **full business case** for Clinical Services Building redevelopment. This involves a full business case process using the better business case model (i.e. as described in "Better Business Cases – Investing for change" Treasury, New Zealand Government). The process takes 2-3 years. The principle in clinical service planning is "function before form".

First step: what principles will we use? If we have to balance two equally "good' matters – what framework will we help us decide? Do we really understand and support the meanings (e.g. "best for patients" – according to whom? On what criteria? The patient in front of me or the population?

Request for the Clinical Council thoughts on: *Who should be involved? What kind of process should be followed?*

We need a set of principles. The principles need alignment to our values. These will be especially useful for work across different professional groups (needs to be inclusive so everyone can have input). Also need a framework for using the principles.

Principles focus on the whole and determine the mode of care:

- *Systems approach;*
- *Learn from lessons from previous work done*.

It was noted that we will be tested against what Canterbury has already done. National context/regional context – *how does it meet our strategic plan?*

It was proposed that the Capital Development Team will come back to the Clinical Council and discuss: *Structure; Process;* and *Timeline.*

That the Clinical Council advise how it engages with clinicians and clinical staff. Need principles to facilitate agreement over decisions with "everyone sitting at the table".

Also need to consider consumer (patient and disability service consumers) engagement in the process – value on patient time (e.g. are patients willing to travel to Dunedin for a procedure?). Need to engage disability groups in the process.

**PLAN: Workshop on set up principles – involve interested parties and people.

Quality and Patient Safety Update

Leanne Samuel presented an update on current activities in Quality and Patient Safety. This involved summaries of a number of examples of the use of A3 methodology to define how well services are doing. Quality process measures were also tabled. It was decided that the information is very useful and should be presented quarterly to the Clinical Council in a dedicated session.

Carole Heatly, Chair