Clinical Council

Summary of May 30, 2016 Meeting

Health Quality and Safety Evaluation Markers

Dr Nigel Millar presented this item. A data summary table was presented (Measures: Percentage of older patients assessed for risk of falling; percentage of those at risk with an individualised care plan; inpatient fractured neck of femur; hand hygiene audit; antibiotic dosing – major joint replacement; antibiotic dosing – major joint replacement; skin preparation – major joint replacement). It was noted that Southern DHB is at lowest end of ranking for most measures. Falls has been given due attention. It was noted that there may need to be more targeted communication regarding patient falls and falls prevention to Senior Medical Officers.

Intensive Care Unit / High Dependency Unit Redevelopment Update

Leanne Samuel presented this item and paper entitled Master Site Planning Stage 2; ICU/HDU Project: Clinical Sponsors Report – April 2016. PEER REVIEW - It was noted that a peer review report from Counties Manukau was received in April. THE MODEL OF CARE – The Critical Care Clinical Governance Group's Terms of Reference are being established. This group will oversee the activities and operating standards of all units in the district that provide critical care services.

Consideration of Draft Strategic Services Plan

David Moore, Sapere Research Group, presented this item. David noted that there were three pieces of work:

1. Southern DHB Strategic Services Plan (District-wide);
2. Detailed Services Plan for Dunedin Hospital;
3. Strategic Assessment (Capital business case) – the next step in the detailed business planning.

The next phase will be drafted within two weeks in which the detailed services plan will be described in contract and the next stage is the detailed plan – admission process in Dunedin Hospital. David noted:

- That there has been almost universal support for building strong primary care and for the need for more integration;
- Rural Hospitals – what can be delivered on these site?
- Gaps in the middle; need to build up clinical direction; retrieval service;
- Strategic direction – imaging;
- Strategic direction – hospitals; specialist vs. generalist; PMS/telemedicine; transparent relationship between DHB and University;
- Strategic direction – what the University sees as strategic for them.

There was discussion and questions including that this is an important document that needs to be distributed widely when it is no longer confidential.

Proposals for Review of Clinical Council Operations

The Chair presented a paper entitled "Proposals for Review of Clinical Council Operations".

It was noted that both the nature of the advice that the Council should aim to provide and the alignment of Council business with wider developments across the health sector, would benefit from further definition. Two areas where the Council operation could be modified to help assist this were outlined in the paper. These are:

1. *The Agenda setting process for the Council*

The proposal floated was that a small sub-group is established to oversee the agenda setting for Clinical Council meetings. The group will comprise representatives of the DHB Executive and from primary care. The group will generally operate virtually and by teleconference to achieve their purposes and will report to the Council at each meeting in the form of an Agenda and brief details of any matters referred to the Council but considered elsewhere.

2. *Developing Strategic Direction*

A half day 'face to face' meeting is held in about two months' time (date to be set) to: establish a workplan for the Council; review the performance of the Council to date and to identify areas for improvement; revise the terms of reference to incorporate agreed changes to the membership and the ways of working identified as a consequence of this review; and consider the resourcing required for the Council to act as an effective advisory body.

Council endorsed the proposals: That a sub-group of the Council be established with responsibility for setting the functions set out in the proposal; The proposed membership of the Agenda sub-group will be brought to Council for endorsement at its next meeting; That a half day face to face meeting is convened for the purposes set out above.

***Southern Future* – Verbal Update**

Jane Wilson, Implementation Manager, Commissioner's Office presented this standing item.

Jane noted that the current focus of the *Southern Future* project team has been to get the final summary feedback out. The documents are high-level summary documents and there are a further 700 pages of documents supporting these summaries (survey feedback, patient stories and feedback from staff and patient listening sessions). Key focus is now on developing action plans for the seven improvement priorities for patients and their family/whanau and the seven improvement priorities for teams/colleagues. The priorities were tested in the feedback session presentations and validated by participants as were the draft values. The draft values have now been adopted by the organisation. Under the priorities, the Project team have looked at other resources including other DHBs' information and literature on the topic.

It was recognised that the *Leading with Values* workshops were difficult for some to attend and that they may need to run shorter sessions. Dr Millar noted that the setting out to change culture is never an easy task and that in essence it is about what leaders do; that is change the culture by behaviour. Values have to be "lived", including being used in decision making processes. We have to reflect upon the values and behaviours in meetings and examine how we make the values real and used in everything we do.

Richard Thompson noted that this was a microcosm of overall work. The focus has been around discussion between patients and the DHB but has also been about staff and governance and clinical engagement. Richard posed the question of how they now take the feedback and the values to enhance the clinical engagement to take change forward. He noted that the Commissioners cannot make the changes; they can use confidence in discussions with Wellington, in removing waste not services, setting building blocks for staff to make good decisions; and to focus on strategic directions. Richard noted that clinical engagement has to flow out of the values work; how do we move from values to implementation? Dr Millar noted that this needs to be led together; doing it as one.

Jane Wilson noted the establishment of an organisational development and performance role currently advertised will play a key role in strengthening leadership development. She said that Clinical Council input was hugely valuable and necessary to influence change and organisational culture. Efforts are currently focused on setting up a Values Resource Toolkit accessible to all teams via SharePoint with some hard material resources available to support the Values roll out amongst teams (i.e. soft launch) rather than a formal Launch or 'top down' approach.

It was suggested that there needs to be more communication on who contributed feedback to the draft values and that there needs to be an action plan. It was also noted that the values are very broad and lack definition; we need to "land" the values and what we mean by them (e.g. what do we mean by "kind").

Dr Keith Reid, Chair