Clinical Council

Summary of October 31, 2016 Meeting

Discussion regarding job-sizing.

Council was reminded that job-sizing is a process specific to Senior Medical Officers (SMOs) and is a provision contained within the collective agreement contract for that professional group. It was noted that there appeared to be a hiatus in progressing job-sizing within Southern DHB.

The related issue of service sizing was also raised. This is a distinct process in which the capacity of a service to deal with the demands being placed upon it is assessed. There is a large number of services that have indicated a wish to be subject to service sizing but currently no agreed process to undertake these reviews. It was suggested that job sizing was only one issue that was unresolved and that the allocation and use of non-clinical time by SMOs was similarly overdue for resolution.

Council advised: that they wished this matter to be raised with the Chief Executive, that there was a need to have a process for determining required clinical time at a service level, that there were risks to clinical engagement and morale if job sizing was not undertaken in the near future, and that inadequate clinical time was a direct risk to patient safety.

Presentation by Sapere on Detailed Clinical Services Plan

David Moore from Sapere attended to discuss the Detailed Clinical Services Plan. David noted that there was a workshop that evening regarding the Plan and that the workshop would look at what Dunedin Hospital could be and the challenges. He noted the limitations of the Dunedin Hospital Ward Block reflected in its build design. Flexibility in the build is needed with a focus on patient flow across the system. It was also noted that the greatest cost to the DHB is labour and second to that is technology. Sapere are expecting submissions on the Detailed Services Plan on what the Hospital could be.

The architects have estimated that it will take seven years to build the new hospital with an upper limit of 10 years. A document in this regard will shortly be released. Assumptions include what the hospital system will look like and how primary care interfaces with secondary care. David stated that Service Reviews needed to be taken off the table and reviewed separately for ORLHNS, Ophthalmology and for Mental Health Addictions and Intellectual Disability. There was discussion as to the role of the Clinical Council in this process. This was felt to be at the level of setting principles relating to service design and providing an overall view at a health system level. This is similar for the Community Health Council's role but from a complementary perspective.

Intensive Care Unit/High Dependency Unit Clinical Sponsors Report

Professor Barry Taylor noted the complexity of the work undertaken in this project and thanked Leanne Samuel and those on her team responsible for the work.

Stranded Patients Report

It was noted that 'stranded patients' are those with an extended stay in hospital and who contribute disproportionately to bed occupancy in general medical and surgical settings. There

are identified risk factors associated with an increased likelihood of patients becoming stranded.

Work undertaken by the Health Roundtable has identified a number of underlying issues with systems of care that are amenable to change and that can reduce the numbers of stranded patients while also improving their care.

The Council had a brief discussion on the extent of this issue within the District and what measures should be directed to solving this issue locally. Concerns were raised and discussed regarding the quality of the data and that the data were observational and so raised a number of hypotheses as to underlying causes rather than pointing directly to solutions. Nonetheless the questions arising were the start of formulating a problem statement and programme of work.

Dr Keith Reid, Chair