Clinical Council

Summary of August 29, 2016 Meeting

Update from the Commissioner Team – Graeme Crombie, Deputy Commissioner and Jane Wilson, Implementation Manager, Commissioner's Office

An update was provided to the Council on the following topics:

- Lakes District Hospital - Sapere Report has been sent to Chairs of the Rural Trusts.
- HealthConnect South – This is in-play; stage 2 with HealthOne at end of next month.
- Interim CEO – Chris Fleming is currently overseas and Lexie O'Shea will cover this role until he starts. A Human Resources Recruitment Company has been retained for the search for the substantive appointment. The Clinical Council will be involved in the process.
- This Quarter – Performance – Key targets from Ministry of Health; currently we are in the middle of DHBs. At the end of June the DHB was ahead of budget by a small amount.
- Budget for next Financial Year – The number has been agreed with the Ministry of Health and awaiting sign off from the Minister of Finance and The Treasury.
- At the end of September the Commissioner Team will be providing an update to staff on 'where we are at'; follow up with patients listening clinics and staff interactions.
- Audiology/Gastroenterology/ICU/HDC re-developments are all progressing.
- The Minister of Health recently visited Clutha Health First and the new Training Centre in Southland was well received by him.
- Graeme noted that it will be the 150th anniversary of Dunedin Hospital on its current site soon and this will be celebrated.
- Southern Future – Governance Group. It was noted that Michael Collins, Executive Director of Organisational Development and Performance, commences employment in his role soon. Dr Angela Pitchford is to retire from Deputy Commissioner role.

Presentation and Discussion on "A Values based approach to Service Development"

Mr Richard Bunton presented *Dealing with Service Demand Pressures in a Value Based Way -*

Owning our future values:

- Visibly lead the Southern DHB plan;
- Patients are at the centre of everything we do;
- Actively build capacity and/or capability;

- Ensure fair access across the district;
- Ensure Maori health and wellbeing is integral to planning and service delivery;
- Focus on a district wide network of care;
- Develop and enable clinical leadership.

It was noted that the issue is that currently the DHB, in particular the provider arm, is overwhelmed with requests for Job Sizing and service expansion. Taken in isolation each of these many requests are not without merit and have often taken a considerable amount of time to work up. The current way we do job sizing is about individuals and not focused on the system of care (or model of care).

A new approach to the process was suggested to include:
- A commitment to continuous quality improvement and patient safety;
- Take a long term view of decision making;
- Be transparent in our decision making;
- Be visible and connected to our staff;
- Be in the community;
- Build one source of the truth;
- Invest to save.

The current process does not include what other members of the team might contribute to care if working at the top of their scope.

Advice was requested on the principles to support teams who are doing more work than they are resourced to do. Whilst staff may choose to do more work than they are resourced we need a way to reduce the burden including:
1. Reduce service level;
2. Co-design services;
3. Improve efficiency;
4. Continue for a limited period of time while the above are being worked on.

It was noted that we need to:
- Respond promptly to requests;
- Outline the expectations;
- Be clear – who are the decision makers;
- Understand that there will always be commercial imperatives;
- Understand there will always be political imperatives.

The Role of the Clinical Council:
- Provide analysis and advice regarding requests;
- Take an overall DHB view; as opposed to service focused view, when assessing such requests;
- Help the DHB to prioritise such requests.

Principles to agree on:
- That provide guidance for assessing requests;
- That guide a “warrant of fitness” before investing in additional resources?
- That make saying ‘no’ appropriate;
- That can help teams to work with managers in a more positive way.

Discussion:

It was suggested that the job/service sizing is a symptom and that we currently provide too wide a range of services in too many places to too many people. We have a fixed income; how do we pull that in? What is the role of the Clinical Council in this?

It was suggested that there needs to be a more specific relationship between the provider and funder arms; Planning and Funding to provide the picture and then the Clinical Council

validates that or challenges it. We need a set of principles that the Clinical Council can agree on and that people believe in and are trusted.

It was noted that the Medical Engagement Group had raised these types of issues two years ago and that they have not been advanced.

It was suggested that draft principles be developed and brought back to the Council.

Proposal re Trauma Service and Registry in Southern DHB

Mr Mike Hunter presented this item.

Mr Hunter noted that there has been a history of failed endeavours at this DHB in regard to establishment of a Trauma service. There was increased momentum 3-4 years ago with Ministry of Health guidelines. Dunedin Hospital and this DHB are standout in the country for not having achieved a viable Trauma Service and Registry.

Mr Hunter noted that this was the sixth iteration of the business care and that the evidence shows that 30% mortality can be reduced by an expanded service to that of 11% or in some cases even less. It is also evident that a trauma service promotes consistency of practice.

After discussion those present were in the affirmative for the recommendation that a Southern District Trauma System be established, and to that end that the CEO:

1. approve establishment of a Southern Trauma Project Executive Group to oversee establishment and initial development of a viable and credible Trauma Service;
2. approve establishment of new positions for key Trauma personnel (and associated plant) to enable the collection of Trauma data that will both meet the mandatory requirement to submit a major Trauma data set to the National Registry (overdue from June 2015), and the data collection on all admitted trauma patients that is needed to commence Trauma Quality Improvement in the Southern District;
3. agree that ongoing funding for current or additional resource and/or regional personnel will be contingent on cost/benefit analysis at 12 months from Project start.

Dr Keith Reid, Chair