MidCentral Hospital & Specialist Services 90-day action plan:Q1 2024/25

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1 Acute flow

Relevant plan: Acute Flow Improvement Plan

Focus for Q1 24/25	Actions and timeframes	Rationale	Measures of success	Responsibilities	RAG Rating
(b) Reducing average length of stay in hospital.	• Finalise **standard operating procedures re holding orders**, which enable the safe transition of eligible patients from ED to inpatient beds in advance of/until formal admission is completed by the relevant speciality (NB: research shows that holding orders are associated with a decrease in length of stay, without increase in measures of under-triage [admitting patient to ward bed when higher care is necessary] or over-triage [admitting patient to ward bed when discharge from ED is appropriate) (August). • Work with the **national Clinical Leader for Acute Care** to identify further opportunities to reduce inpatient length of stay (eg use of 'waiting for what' procedure to identify and escalate discharge blockers) (August).	MidCentral's hospital flows when hospital occupancy is between ~92-95%. Ensuring occupancy remains in this range requires reducing patients' length of stay, to the extent appropriate.	• Reduction in average length of stay. • Reduction in time from ED referral to ward transfer. • # of patients transferred under holding orders. • Increase in SSED for admitted patients.	Actions are ultimately owned by Hospital & Specialist Services' Group Director of Operations for MidCentral. Execution of actions is principally supported by Hospital & Specialist Services' Delivery Unit. Support will also be provided by Service Innovation & Improvement. Specialist support will be provided by Jo Gibbs.	
(a) Improving timely discharge from inpatient hospital wards.	• Ramp up the **'2 before 10' initiative**, which requires inpatient wards to identify 2 x patients suitable for discharge before the start of the next (morning) shift and discharge them by 1000 (July onward). • Ensure that clinicians are **rounding on patients suitable for discharge first** to speed up discharges (unless there are medically unstable patients that need to be attended to) (July onward). • Institute **criteria-led discharge for inpatient specialties,** with specific focus on use during weekends (August). • Build **operational cadence** to drive performance improvement. • Create a **discharge lounge** to assist in the flow of patients identified for discharge that day (September). • Create opportunities for **Early Supported Discharge** (September).	Bringing forward MidCentral's average time of day discharge, and increasing the rate of weekend discharging, is critical to freeing up inpatient beds for patients to 'flow' into.	• Reduction in average time of day discharge. • % discharges before 1000. • Increase in weekend discharge rates. • # of patients discharged via criteria-led discharge. • Utilisation of discharge lounge		
(c) Diverting and discharging patients direct from ED.	• Increase **use of ED redirects**, such as issuing practice plus (same day, after hours service) vouchers (July onward). • Trial the use of a **Nurse Practitioner with the ED wait room** to run a 'fast track' (ie assist with treatment and discharge of low acuity patients) (July). • Extend ED **work area out of hours** into fracture clinic to enable improved treat and discharge performance. • Complete the **Children's ED** build and progress associated model of care.	Reducing pressure on MidCentral's ED via safe redirection of patients to alternative care settings frees up capacity to treat and discharge patients direct from ED and attend to patients requiring admission in a timelier manner.	• % of ED redirects. • # of patients discharged from ED via fast track. • Increase in SSED for non-admitted patients.		

2 Clinical leadership & culture

Relevant plan: Culture Improvement Plan

Focus for Q1 24/25	Actions and timeframes	Rationale	Measures of success	Responsibilities	RAG Rating
(a) Setting clear expectations about values-led behaviour: bringing Te Mauri a Rongo (the Health Charter) to life.	• Execute **communications strategy** about MidCentral's values and expectations of staff re how these are embodied via workshops, regular updates, and 1:1 meetings (from July). • Create a **values-led leadership toolkit** for people leaders, which includes practical examples of 'how to say yes', and 'if the answer is no – how to have that conversation, and why it matters' (July). • Require all staff to complete a new national **eLearning module** on Te Mauri a Rongo (from July).	Embedding values-led behaviour at MidCentral is foundational to facilitating a shift in culture – wherein 'culture' signifies *how* values are embodied through practices, process, and relationships.	• Increase in staff engagement with communications products. (eg weekly newsletters, intranet stories, videos) • Staff engagement in workshops (NB: mandatory for people leaders). • Majority % of staff having completed eLearning module on Te Mauri a Rongo. • Improvement in relevant Ngātahitanga Pulse Survey scores.	Actions are ultimately owned by Hospital & Specialist Services' Group Director of Operations for MidCentral. Execution of actions is principally supported by People & Communications' Organisational Culture and Development Team. Support will also be provided by the Chief Clinical Officer, and Interim Chief Wellbeing Officer. Relevant unions (eg Association of Salaried Medical Specialists) will be engaged throughout.	
(b) (Re)establishing trust with medical staff.	• **Close the loop on the Feb 2023 Culture and Climate Review** by communicating its findings and resultant/subsequent actions with the medical workforce and unions (July). • Strengthen channels for **meaningful engagement with RMOs and SMOs** to ensure open, two-way communication with leadership, and that information is received in a timely, direct, and appropriate way (from July). • Establish **regular support mechanisms** for RMOs and SMOs, including monthly online drop-in peer support groups, regular topic-specific sessions (eg on dealing with pressure, stress, and burnout), and using external providers for confidential, individual support needs (including profession-specific counselling services) (from July).	Changing MidCentral's culture requires buy-in from the medical workforce. MidCentral must demonstrate that it has heard their concerns, and that it's taking action accordingly.	• Improved RMO and SMO engagement via strengthened communications channels. • RMO and SMO participation in peer support groups. • RMO and SMO attendance at support sessions. • RMO and SMO uptake of external support services. • Improvement in relevant Ngātahitanga Pulse Survey scores.		
(c) Building psychological safety across the organisation.	• Launch the **Up Speak programme** to enable staff to resolve interpersonal difficulties and address poor behaviour on the ground, in real-time, supported by relevant training (eg active bystander workshops) (August). • Create **new pathways for resolution of grievances and employment-related issues**, encouraging issues to be resolved without escalation (where appropriate), via restorative options, or outside of MidCentral (as necessary)(August).	MidCentral needs to build an environment where everyone is accountable for their behaviour, and were speaking out about unacceptable behaviour is actively encouraged.	• Rollout of Up Speak programme. • Positive feedback on staff implementation of Up Speak strategies. • Establishment of resolution pathways. • Staff utilisation of new resolution pathways. • Improvement in relevant Ngātahitanga Pulse Survey scores.		

3 Quality & safety

Relevant plan: Quality and Safety Improvement Plan

Focus for Q1 24/25	Actions and timeframes	Rationale	Measures of success	Responsibilities	RAG Rating
(a) Reducing the number of long-waiters in the Emergency Department.	• Institute **Standard Operating Procedures re patients who wait >24 hours in the ED**, wherein such patients must be prioritised for the first bed that becomes available, an incident report must be completed, and a debrief must take place at the morning meeting (July onward).	It's unacceptable to have patients waiting in ED for a significant period of time without clinical justification. Setting clear expectations that this situation won't be tolerated is imperative.	• Reduction in # of patients waiting >24h in ED.	Actions are ultimately owned by Hospital & Specialist Services' Group Director of Operations for MidCentral. Execution of actions is principally supported by the national Clinical Leadership Team. Specialist support will be provided by Dr Andrew Connolly.	
(b) Agreeing MidCentral's current, and future, models of care for acutely ill and deteriorating patients.	• Conduct a **clinically-led review of MidCentral's current model of acute care** with relevant clinicians, via a facilitated-process (July - August). • Establish **clear clinical pathways for the ED, Coronary Care Unit, Higher Dependency Unit, and Intensive Care Unit**, and corresponding clinical governance mechanisms (September). • In concert with the aforementioned clinical pathways, agree the **purpose of each department/unit**, staff **roles and responsibilities**, **referral processes**, and **points of communication** within and between teams and services (September).	MidCentral's clinical pathways for acutely ill and deteriorating patients are not well defined. Reaching consensus among clinicians is critical to ensuring safe management of such patients and achieving hospital flow.	• Establishment of clear clinical pathways for ED, CCU, HDU, and ICU. • Agreement of associated responsibilities and processes. • Increase in appropriate use of units (eg having no patients discharged from direct from 'higher care' units).		

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