MidCentral Hospital & Specialist Services 90-day action plan:Q2 2024/25

A Acute flow

Relevant plans: Acute Flow Improvement Plan, Health Target Plan

Focus for Q2 24/25	Actions and timeframes	Rationale	Measures of success	Responsibilities	RAG Rating
(1) Acute Flow Standards.	1.1 - Socialise the finalised **Acute Flow Standards** with all senior and operational leaders to disseminate and champion the achieving of standards. (October). 1.2 - Conduct the **self-assessment audit** and formulate the corresponding improvement plan based on the findings, with an initial emphasis on inpatient standards. (October).	The Standards set out expectations to manage acute flow along the patient journey from the emergency department to inpatients to discharge, as experienced by the patient.	• Self-assessment audit completed.	Actions are ultimately owned by Hospital & Specialist Services' Group Director of Operations for MidCentral. Execution of actions is principally supported by Hospital Performance team with support from Te Whatu Ora Improvement - Planning, Funding and Outcomes. Specialist support will be provided by Jo Gibbs.	↑
(2) Reducing average length of stay in hospital.	2.1 - Identify interventions to reduce **avoidable hospital admissions** (Standard 1.4). (November). 2.2 - Establishment of Multi-Disciplinary Team (MDT) **rapid rounds** on acute wards to coordinate the patients' plan for their stay and expedite the addressing of identified barriers to said plan. (October – November). 2.3 - Review whole of **hospital discharge processes for medically optimised** patients to meet expectations set out in the national Acute Flow Standards (Standard 6.8). (December).	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. • Increase in SSED for admitted patients.		↑
(3) Improving timely discharge from inpatient hospital wards.	3.1 - Review current **MAPU Model of Care** to align with the national Acute Flow Standards (Standard 6.2). (October – November). 3.2 - 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) (October onward). 3.3 - Create a **discharge lounge** to assist in the flow of patients identified for discharge that day (October). 3.4 - Create opportunities for **Early Allied Health Supported Discharge** (December). 3.5 - Continue current **Time Of Day discharging** initiatives to enhance patient flow, reduce length of stay, improve patient satisfaction, increase operational efficiency, and lower per patient costs. (Standard 6.9). (Ongoing)	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. • Utilisation of discharge lounge		↑
(4) Improving safe, timely management of non-admitted patients.	4.1 - Extend ED **work area out of hours** into fracture clinic to enable improved treat and discharge performance. (November – December). 4.2 - Implement **onboarding procedure** for distribution of risk for corridor patients, underpinned by existing My Next Patient and Over Census procedures. (December) 4.3 - Progress the associated model of care for the completed **Children's area within the Emergency Department** to provide a safe area of assessment and treatment for identified patients. (November)	MidCentral's overall SSED performance will be hindered in meeting interim target without focus on treated and discharged patient cohort. This is crucial for enhancing patient outcomes, reducing hospital congestion, and ensuring efficient use of healthcare resources.	• # of patients discharged from ED via fast track. • Increase in SSED for non-admitted patients. • % children seen in 6 hours		↑

B Clinical leadership & culture

Relevant plan: Culture Improvement Plan

Focus for Q2 24/25	Actions and timeframes	Rationale	Measures of success	Responsibilities	RAG Rating
(5) Setting clear expectations about values-led behaviour: bringing Te Mauri a Rongo (the Health Charter) to life.	5.1 - 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 November). 5.2 - 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' (December). 5.3 - Require all staff to complete a new national **eLearning module** on Te Mauri a Rongo (from November).	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.	↑
(6) (Re)establishing trust with medical staff.	6.1 - Strengthen channels for **meaningful clinical leadership 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 October). 6.2 - 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 October). 6.3 - Establish **regular SMO Clinical Lead meetings** to ensure effective communication, coordination, and alignment of goals across different areas of the organisation. (October onwards). 6.4 - Ensure all Clinical Leads undertake **regular 1:1 meetings** with their respective Clinical Executive to provide a dedicated time for personalised feedback, professional development, and open communication, allowing both parties to discuss goals, challenges, and progress in a focused setting. (October onwards)	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. • Improvement in relevant Ngātahitanga Pulse Survey scores.		↑
(7) Building psychological safety across the organisation.	7.1 - Pilot the **Respect at Work programme** to enable staff to resolve interpersonal difficulties and address poor behavior on the ground, in real-time, supported by relevant training (eg active bystander workshops) (September onwards). 7.2 - Implement the **Respect at Work programme** progressively across MidCentral. (from December). 7.3 - 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)(November).	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 Respect at Work programme. • Establishment of resolution pathways. • Staff utilisation of new resolution pathways. • Improvement in relevant Ngātahitanga Pulse Survey scores.		↑

C Quality & safety

Relevant plan: Quality and Safety Improvement Plan

Focus for Q2 24/25	Actions and timeframes	Rationale	Measures of success	Responsibilities	RAG Rating
(8) Understand and identify any opportunities for improvement from recognised mortality reporting data platforms.	8.1 - Complete deep dive review into Te Tahu Hauora | Health Quality Safety Commission **Quality Alert for 30-day mortality rate** of Status two and three patients who do not wait (DNW) to be seen by a clinician when presenting to the Emergency Department. December) 8.2 - As part of the aforementioned deep dive review and understand the Mortality Four data identified by **Health RoundTable**, (December).	Hospital mortality rates can be useful indicators of quality of care, but careful statistical analysis is required to avoid erroneously attributing variation in mortality to differences in health care when it is due to differences in case mix.	• Mortality rates (both in hospital and 30-day mortality) are within normal variation of other district hospitals.	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.	↑
(9) Agreeing MidCentral's current, and future, models of care for acutely ill and deteriorating patients.	9.1 - Conduct a **clinically-led review of MidCentral's current model of acute care** with relevant clinicians, via a facilitated-process (October onwards). 9.2 - Establish **clear clinical pathways for the ED, Coronary Care Unit, Higher Dependency Unit, and Intensive Care Unit**, and corresponding clinical governance mechanisms (November - December). 9.3 - 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 (December).	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).		↑