
WANGANUI HOSPITAL CLINICAL REVIEW

Report to
Whanganui District Health Board &
Ministry of Health

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EXECUTIVE SUMMARY

1. This external review of clinical quality in the Wanganui Hospital was prompted by three highly publicised episodes of patient injury, and separate public allegation of unsafe clinical practice
2. Reviewers interviewed hospital staff and individuals external to the hospital during April – June 2007
3. Clinical practice at Wanganui Hospital is not unsafe.
4. Clinical quality systems in place for Wanganui Hospital are comparable to other New Zealand hospitals; the level of safety is acceptable and compares favourably with other hospitals.
5. There is ample room for clinical quality improvement at Wanganui Hospital but the gap between current state and ideal is similar to that seen throughout New Zealand.
6. Absence of delays in patient access to acute surgical treatment results in better patient access in Wanganui compared with metropolitan hospitals.
7. Three patient injury incidents at Wanganui Hospital publicised in the last 12 months (but occurring 2004-06) when reviewed had no similarities and did not reflect a current safety problem.
8. Reviewers report opportunities for clinical quality improvement brought to their notice by those interviewed.
9. 80% of the senior medical workforce at Wanganui Hospital are fully qualified specialists.
10. There is a stable and well qualified nursing and midwifery workforce
11. Sustainable medical workforce recruitment into unstable areas (O&G and General Surgery) requires new models of secondary service delivery.
12. Reviewers make the following recommendations:

Recommendation 1: that confidential verbal reference checking be included in the standard recruitment process for SMOs.

Recommendation 2: that the Credentials Committee further refine within speciality categories, e.g. core and non-core approach as begun in medicine.

Recommendation 3: That the DHB introduce immediate short term measures to remedy the transcription timeframe deficiencies

Recommendation 4: that fitness to work policy and decision-making be reviewed, including access to resources for expert assessment.

Recommendation 5: that expert advice including consumer input be used to put in place laparoscopic tubal ligation quality audit.

Recommendation 6: that a Quality Framework describing strategy and structure be developed.

Recommendation 7: that management structures and reporting at governance level be altered to integrate clinical governance.

INTRODUCTION

Wanganui Hospital provides secondary services to the population of the fourth smallest DHB in New Zealand, a population of 63,000. Neighbouring DHB's regions are also rural each with hospitals offering secondary services. WDHB is the largest employer in Wanganui which has a population of 39,990. Compared to the New Zealand average the district has more Maori, more young people under the age of 15 years, more older people, a high deprivation overall, and a projected decreasing population. This results in the second highest level of funding per head of population of all the DHBs. Against this background the WhDHB has major recurring problems: difficulty in retaining senior medical staff in key roles, and difficulty in living within its means without financial deficit.

In the last 12 months there have been three highly publicised episodes of suboptimal clinical care at Wanganui Hospital. The combination of this and public allegations of unsafe clinical practice precipitated this clinical review.

REVIEW PROCESS

The reviewers were selected by of the MOH on advice from the sector. They agreed to conduct a review and produce a report according to the Terms of Reference (Appendix i)

The reviewers visited Wanganui Hospital April 24 – June 06 2007. Interviews were conducted with hospital staff, DHB staff employed in the community, PHO staff, ex-staff members, community representatives, and individuals. Reviewers informed participants that the review process was confidential, that the review findings would be published as a public document, and that notes taken and documents supplied to the reviewers in confidence would be destroyed. Secretarial services used in the report production were independent of the MOH and WhDHB,

The question of clinical safety was central to each interview. In addition a structured interview format was used for Heads of Department to systematically examine their clinical quality systems. Interviewees were selected from all departments including those with positions of responsibility plus a sample consisting mainly of nurses and some junior doctors well-placed to observe and comment candidly on clinical quality and safety issues. In addition all senior management staff, clinician members of the WhDHB Board and the Chair and Deputy Chair of the WhDHB Board were interviewed.

It was not practicable or indeed within the scope of the review to conduct a comprehensive consumer satisfaction survey of Wanganui Hospital services. However, reviewers sought views of experienced clinicians in the community, some consumer representatives, and some public critics of the DHB services who requested to be heard.

As far as humanly possible the reviewers maintained an open mind throughout the interview process, followed principles of natural justice in not accepting uncorroborated evidence and took an inquisitorial approach to uncovering unsafe clinical practice.

The review panel received and/or requested a number of documents listed in Appendix iii. In addition reviewers were shown various internal memos and letters, and received letters from staff and members of the community.

Following completion of the interviews a draft report was shown to the Steering Committee for comment. Minor errors of fact and improvement for clarity were noted by the Steering Committee. The reviewers incorporated most of this feedback in this final report presented to the MOH and WhDHB on 28/08/07.

CLINICAL QUALITY SYSTEMS

OVERVIEW

Wanganui Hospital has participated in the Quality Health New Zealand accreditation process and is currently fully accredited. The reviewers noted that when last surveyed the deficiencies were not substantial and were being acted upon.

Overall the reviewers found the aggregate of clinical quality systems in place throughout the hospital to be very comparable with similar sized and larger sized hospitals in New Zealand. There is a view that hospitals are essentially dangerous places. The very low rate of patient injury seen in New Zealand hospitals in the reviewers' experience does not support that view. The reviewers found Wanganui Hospital's patient incident rates to be comparable with other New Zealand Hospitals.

Undeniably the sector as a whole has room for improvement in hospital quality standards. There are pockets of excellence in other secondary and tertiary hospitals throughout New Zealand that all DHBs including Whanganui could emulate.

AUDIT AND CONTINUOUS QUALITY IMPROVEMENT

Overall, clinical audit at Wanganui Hospital is not emphasised. Resources that have been previously attached to this area have tended to be downgraded with time. The Clinical Quality and Risk Advisor role has reporting and incident investigative responsibilities, and on occasions may be involved in the auditing of clinical activity.

The innovative role established three years ago of a 0.4FTE SMO as the Clinical Audit Co-ordinator, was reduced following review to 0.2FTE. It remains at 0.2FTE currently. An audit culture was introduced as result of this role and subsequently clinicians are engaging more in audit activity than previously. Another outcome of this appointment was the setting up of the Otago surgical audit system for general surgery and orthopaedics. This system of auditing surgical outcomes at individual surgeon level is well established throughout New Zealand. Apparently it continues to function in general surgery but due to a shortage of clerical staff resource has been discontinued in orthopaedics.

The undertaking of a large one year audit that examined the peri-operative phase of total joint replacement is to be commended. The study involved orthopaedic surgeons, anaesthetists and physicians examining transfusion rates and resulted in a change of practice that showed at re-audit 6 months later a significant reduction in cardiac events from 11:115 to 3:165 patients. This audit demonstrates completion of the CQI cycle.

Wanganui Hospital is no different from many clinical settings where it is difficult to persuade busy clinicians to conduct audit without assigning time and resources. The reviewers felt that for clinical staff in general but SMOs particularly, non-clinical time was poorly defined and poorly allocated for the purpose of clinical audit and for the consequent work required to implement the improvement changes that audit reveals.

The clinical audit commentary column in the DHB news has lapsed.

Another effective local clinical audit reported to the reviewers was the regular review of child and adolescent dental clinical outcomes resulting from audit of school dental service x-rays.

Universal throughout all departments was a well-established series of clinical case review meetings, pathology and imaging review meetings. These include strong elements of peer review amongst the medical staff and in some areas the excellent opportunity for multidisciplinary clinical discussion.

The increasing requirements of SMOs by their professional Colleges for participation in quality assurance hospital activity including clinical audit was noted by the reviewers.

In common with most New Zealand hospitals, the majority of clinical audit activity within Wanganui Hospital was not visible at an organisation-wide level. Comparatively little systematic audit of clinical outcomes or surveillance using clinical indicator methods is undertaken.

PEER REVIEW

The Wanganui Hospital approach to doctors' peer review via scheduled clinical case review meetings is well structured and organised in the larger departments (Mental Health, General Medicine, General Surgery, Orthopaedics, Anaesthesia Intensive Care, and Emergency Department). In addition to case management and informal audit functions, these meetings provide participants with inter-clinician comparison of approach to clinical problems.

These opportunities are not available at Wanganui Hospital to doctors in 'single specialist' subspecialties (Oral Health, Imaging, Ear nose and throat, rheumatology, geriatrics, etc), but all these individuals reported to the reviewers the detailed arrangements they had in place with colleagues adjacent to their region mainly in Palmerston North or Taranaki, or at a more distant tertiary DHB. The 'large' departments at Wanganui are, however, still small with 2-6 SMOs. Some of these departments had poorer collegial / peer review arrangements outside Wanganui Hospital than some of the solo specialists.

The reviewers felt that there was a clear need overall to widen and consolidate the collegiality / peer review arrangements for SMOs at Wanganui. This topic is intimately connected to the size of sub speciality medical groups, and the geography and pattern of service delivery. This topic and possible solutions is taken up elsewhere in this report.

The reviewers uncovered an exception to effective clinical case discussion and peer review in the General Surgery department. Bitter internecine behaviour of longstanding has destroyed previously effective professional processes. These processes are now beginning to be re- introduced

CRITICAL INCIDENT REPORTING AND RESPONSE

Wanganui Hospital has a good system of incident reporting (approximately 40 incidents per month, not all clinical). Reliable systems are in place for answering and responding to complaints and also compliments, however, the newly introduced electronic recording system (Riskman Incident Reporting Software, Enable Risk Management) for the reporting of incidents needs further staff training.

Reportable events discussed later in this review were first identified by the incident reporting system in a timely way. The close connection between incident reporting and senior management knowledge and response in Mental Health was more evident than in the other clinical areas.

In retrospect, some staff felt that non-clinical management staff were not alerted early enough to recent major clinical safety incidents by senior clinical staff.

COMPLAINTS MANAGEMENT

Reviewers formed the view that the complaints service received and handled consumer complaints properly, and appropriate changes were made in response to complaints. The reviewers also met dissatisfied consumers who had been or still were complainants of the DHB. Some had entrenched grievances that also involved other health agencies such as ACC, HDC and some had an added political component to their complaint.

The reviewers felt the overall effectiveness of the complaints process was not in question. The independent view of Consumer Advocacy Services in comparing Wanganui with other North Island DHBs was that it performed equally well in the area of complaint management and there had been a reduction in mental health complaints for Wanganui compared to previous years.

The organisational culture of acceptance of the patients' right to complain was largely evident, however, some exceptions were shown to reviewers.

COMMUNICATIONS

Notwithstanding the adequate performance of the hospital in critical incident reporting and response to these incidents, the reviewers concluded this was still an area of opportunity for improvement. This is based on a partial disconnection detected between clinical and managerial staff and a disconnection exposed in the organisational structure. This is exemplified by the routine monthly reporting of clinical incidents and complaints to the Board being relayed by a corporate manager, not the clinical heads of the organisation.

The opportunities for improvement lie in management and clinician culture change to remove the "them and us" barriers. These barriers would be more easily overcome by organisational acceptance at all levels of a mutually agreed common vision for quality improvement.

DHB staff were extremely defensive about complaints, however, the reviewers felt this was not surprising given the events of the previous 12 months. During that period the Communications Manager position had remained vacant for about 8 months with some of the gap filled by an outside consultancy firm. There was a strong view from staff at all levels in the organisation that the DHB responsibilities for good public communication with the community was not being met.

CREDENTIALLING OF SMOS

APPOINTMENT PROCEDURES FOR SMOS

The head of department arranges with the relevant service manager and Human Resources Department for local and international job advertising to occur once a vacancy has been recognised. Frequently there is only one candidate therefore short listing is not required. The HOD conducts an interview which is often via the telephone. Registration status is checked with the Medical Council of NZ. The candidate must be either a vocationally registered specialist or a specialist requiring supervision.

All this information is then considered by the Credentials Committee. This includes the Curriculum Vitae and two up-to-date written references supplied by the candidate. If doubt exists a further confidential reference may be requested, pursued by the HOD. Confidential verbal reference checking is not routinely undertaken.

The Credentials Committee confirms that the candidate is appropriate and whether or not supervision is required. In the latter case the HOD determines the scope of practice.

Process for DR H who had tubal ligation operations which failed: The procedure above was followed, and Dr H was one of the first to go through this particular component of the credentialling process. All reference checks were made. However, the candidate had not passed the O&G Specialist exam, did not meet New Zealand requirements for vocational registration and required supervision by a fully registered O&G specialist. This was undertaken by the HOD Dr S.

The reviewers understood the credentialling process to be relatively new in the Wanganui Hospital (introduced by 2000) and considered it to be an entirely reasonable process to ascertain the good standing, registerability, and appointability of SMO recruits. Following Dr H's appointment the HOD assessment and allocation of scope of practice turned out to be rigorous. Neither process could be expected to uncover the subsequent failure of technical performance of this surgeon since the deficiency subsequently uncovered was not due to lack of training or previous experience.

CREDENTIALLING STATUS OF SMOS

Wanganui Hospital employs about 60 doctors of whom currently 51 are SMOs, and of these 40 are fully qualified and vocationally registered specialists. The remaining 11, referred to as "Medical Officers" work in a specialist scope, under supervision of a specialist. They have elected not to take higher examinations, but nevertheless are highly experienced senior clinicians. All 51 SMOs have had their specialist or Medical Officer scope of practice defined by the Credentials Committee. Scope is limited to defining only the subspecialty (e.g. medicine, anaesthetics, psychiatry etc). At this stage in its development the Committee has not sought to define clinical privileges within speciality scope except for some sub categories in the medicine scope (echocardiography, endoscopy, and rheumatology). The Credentials Committee intends to introduce more detailed within-speciality privileging. The reviewers did not examine the credentialling of locum SMOs but recognised this is a difficult area and often relies on accepting the credentialling qualifications already allocated by other New Zealand hospitals.

Wanganui Hospital has a solid base for further refining their credentialling processes to a stage similar to many hospitals throughout New Zealand. Further refinement and the publishing of the credentialling status of the large skill asset residing in the SMOs (e.g. on the hospital website) will add to community confidence in their hospital. Furthermore a stocktake of the skill mix detailed credentialling provides can assist broad regional service planning inside and outside the DHB boundaries.

Recommendation 1: that confidential verbal reference checking be included in the standard recruitment process for SMO's.

Recommendation 2: that the Credentials Committee further refine within speciality categories, e.g. core and non-core approach as begun in medicine.

SUPERVISION OF NON-VOCATIONALLY REGISTERED SPECIALIST SMOS

The airline analogy of one qualified specialist (airline captain) supervising another slightly less qualified specialist (co-pilot) usefully applies to vocationally registered specialist and specialist medical officers. Medical supervision is not, however, side by side in the cockpit but at the level of case discussion and review, with prior agreement and understanding of the core scope of practice in which the medical officer practices medicine independently. Non-vocationally registered medical officers fall largely into two

groups – those who aspire to specialist status, and those who do not. While the supervisory responsibilities are the same, they are generally less arduous when applied to “non-training” specialist medical officers with a well-defined and constant scope of expertise. Supervision of aspiring specialist medical officers who are preparing and sitting local specialist exams and may have many years of independent specialist practice outside of New Zealand and skill levels very similar to the supervising specialist can make supervision more difficult.

The reviewers were impressed by the extent to which the supervision model worked successfully in the hospital especially in psychiatry where there are 10 specialists and 6 non-vocationally registered specialist medical officers.

Supervision of Dr H who had tubal ligation operations that failed: The reviewers examined the supervision of Dr H, a non-vocationally registered O&G specialist in considerable detail. Initial assessment of competence was undertaken by the supervisor Dr S. Dr H was taken systematically through the basic core O&G surgery operations, first assisting the supervisor and then performing the procedures unassisted but observed by the supervisor including level 1 and 2 laparoscopic procedures. It was agreed that level 3 laparoscopic work and more complex pelvic floor operations would not be included in his scope of practice. However, the performing of tension-free vaginal tape operations was subsequently added to the scope as Dr H’s skill in undertaking these was evident. Clear competence was demonstrated with obstetric procedures and supervision included weekly case review with Dr S and the Midwifery Manager. Reviewers heard details of the constructive feedback Dr H received in areas of decision-making and personal interaction. Clinical skills were closely observed by midwifery and operating room staff and technical competence was never an issue.

The underlying issue of the desirability of an SMO workforce of fully qualified specialists only is achievable in tertiary DHBs who generally have a choice of candidates when recruiting to SMO roles. Small provincial DHBs have pragmatically employed specialist Medical Officers as preferable to leaving positions vacant. Yet Wanganui has achieved an SMO workforce that comprises 80% of vocationally registered specialists. These concepts are discussed in a later section.

CONTINUING PROFESSIONAL EDUCATION

The reviewers gained the overall impression that the DHB was meeting its obligations in providing time out and resources for continuing professional education for the clinical staff. Medical staff describe the convoluted approval process but no other difficulties in planning conference leave or the equivalent were uncovered. However, the DHB has no systematic approach to providing management training to nursing staff taking on new supervisory and managerial roles.

It appeared to reviewers that in general the opportunities for CPE existed and were taken up.

CLINICAL QUALITY SYSTEMS: CONCLUSION

The organisation needs to refresh its approach to quality.

The various activities and gaps in activity need to be referenced to a broad Quality Framework, a framework that links to an integrated governance structure that includes clinical governance.

Recommendation 6: that a Quality Framework describing Strategy and Structure be developed.

COMMENTARY ON CLINICAL QUALITY AND SAFETY ISSUES

OVERVIEW

The review found that clinical practice at Wanganui Hospital is not unsafe, and the level of safety is acceptable and comparable with the majority of New Zealand's public hospitals.

The community should have confidence in the safety of Wanganui Hospital because it has competent, well-trained and experienced staff, excellent equipment, and systems that tend to minimise the chance of human error and system failure that could cause harm to patients.

Compared to metropolitan hospitals, Wanganui has higher quality care in some areas due to absence of delays (for example surgical treatment of fracture or appendicitis).

Undeniably there is room for clinical quality improvement in Wanganui Hospital but the gap between current state and ideal is similar to that seen throughout New Zealand.

Three major incidents of public concern reported in the last 12 months (loss of patient referral letters in Central Records, undiagnosed pericardial effusion, failed tubal ligations) which resulted in harm to patients were examined as a part of this review. In addition to these, the reviewers also examined 5 other clinical incidents producing potential or actual patient injury, and which were the subject of clinical review at Wanganui Hospital in the last 3 years.

From the issues raised at interview and examination of the reportable events just described, reviewers were able to identify potential safety issues. All of these related to the potential impact of deterioration in SMO staffing levels from the current safe level.

ISSUES RAISED

MR CLIVE SOLOMON

Mr Solomon, a specialist general surgeon and elected member of the Whanganui District Health Board since December 2004 publicly announced his resignation from the Wanganui Hospital staff in November 2006. His reason for resignation, widely quoted in the local and national media was "I would support this hospital as long as it was safe. I no longer believe this to be the case." "I believe patients are at risk. I cannot continue to provide a service in this environment." At that time the context was of an imminent critical shortage of O&G Specialists, and vacant SMO positions in general surgery. There had also been a recent crisis in paediatrics, however, that was being resolved.

The reviewers considered the contingency plan for the absence of O&G specialist cover over a period of several months. General surgeons were included in this contingency plan. The implementation of this contingency plan and the clinical safety outcomes were analysed. The professional approach of a very experienced midwifery team in the hospital that linked well with other midwifery services in the district was evident. The emergency transfer arrangements were appropriately used.

Wanganui Hospital delivers about 670 babies per annum and the other two rural birthing units bring this total to 800 per annum. During the 6 month period with low or no specialist obstetric cover at Wanganui Hospital 66 women were transferred out of the DHB of whom 10 would have been transferred anyway. Caesarean section rates,

intervention rates and, complication rates remained unchanged during this period. The reviewers found no instances of unsafe practice. The midwifery view was that the transfer plan kept women safe although it did introduce a level of disruption for the women and their families.

The reviewers could find no evidence of the maternity service being unsafe at any time.

DHB AND PRIMARY CARE STAFF

While the reviewers were unable to identify clinical areas that were unsafe, staff were quick to point out activity that would benefit from quality improvement. The review could not systematically search for all possible opportunities and this section merely serves to include legitimate quality concerns expressed:

- The philosophy of patient assessment at the hospital front door is not defined and clear to all involved. The ED model of single point of entry for inpatients, ED assessment of undifferentiated patients, inpatient team assessment of differentiated patients, the roles and responsibilities of junior staff making these assessments and senior staff supervising them all need to be clarified.
- The general anaesthesia rate for cataract surgery has improved dramatically; however, the rate should continue to be improved upon. I.e. reduce further.
- Diagnostic ultrasound access for general practitioners is viewed as suboptimal.
- The GP Liaison role is vacant and needs to be filled promptly in the light of the value this role achieves in other DHBs.
- Letter transcription service for hospital doctors' correspondence with primary care clinicians does not meet required standards of timeliness. Hospital doctors and GPs were highly critical of delays which can be measured in weeks in some instances.
- Specialist dental cover for ED and inpatient acute admissions for severe dental conditions is incomplete. The reliance on ad hoc arrangements should be re-examined.
- Further training should be made available in the new electronic reportable event system for front line clinical staff
- More effort in hospital / primary care communication is sought by GPs and hospital doctors. Hospital acknowledgement of primary care referrals better referral letter content, electronic discharge letter implementation discharge planning and plan communication all need improvement.

COMMUNITY REPRESENTATIVES AND INDIVIDUALS

In various ways all those interviewed in this group expressed a lack of community confidence in the hospitals' Board and its management. A perception exists that vulnerable community members particularly the elderly, were frightened that they might not be meeting capable staff or medical staff who were not credentialled, and held the misconception that all foreign medical graduates were not specialists. A community representative of the elderly had no safety issues with the hospital, rather the reverse and was very complimentary of services provided. However, some examples of poor

discharge planning were noted and a general concern about the lack of community input into the prioritisation of secondary service delivery provision in the district versus out of the district was raised as an issue. One result of the latter is that the provision of volunteer transport service for the elderly to early morning clinic appointments in Palmerston North is experiencing some difficulty.

The reviewers also met several complainants with valid criticisms of DHB performance. Some of these related to issues highlighted in the previous paragraph or to instances of poor "customer service", and another related to an on-going personal grievance. None of these complaints were resolvable by the reviewers or the review process.

COMBINED WARD

The new combined medical / surgical ward continues to cause anxiety to managers, nursing, and medical staff, despite the successful merger. The model of care involves very short patient stay and high turnover. The proposed nursing skillmix has not been achieved in practice.

This is a critical high risk area requiring good teamwork. The anxiety relates to teamwork and skillmix. The reviewers were impressed by the achievements and consider it now timely for the hospital to review the current HCA / EN / RN skillmix against the original proposal, and seek further teamwork initiatives from staff.

REPORTABLE EVENTS REVIEWED

THREE PUBLISHED CASES RESULTING IN PATIENT INJURY

- 1. Patient Referral Letters Lost in Central Records Department:** In this case the insidious performance breakdown of an individual in a clerical role responsible for processing patient referrals remained undetected by immediate superiors for some time. The system failure in detection is the critical failure in this incident. The effect of 166 unprocessed patient referrals was a significant delay in assessment and treatment. Once discovered the referrals were speedily dealt with and the causes for the failure to detect a distressed employee were investigated in depth. The treatment delays could potentially have adversely affected clinical outcomes in a small proportion of these patients. There have been no significant clinical issues arising thus far. However some harm was caused by the delays in processing because of the fear and anxiety imposed on the individual patients affected.

Radical changes have been introduced to the referrals process as a result and it is highly unlikely the same or similar referral losses could occur again. Coincidentally, just prior to this incident an independent external audit of workplace leadership and management: (communication, conflict management, and participation) had been commissioned. As a result of this audit, workshops were held to support and improve performance in these areas. The reviewers heard favourable reports of these workshops from staff.

In many ways the incident had a positive internal impact and was the driver for considerable improvement in processes. However, the perception of the reviewers is that the handling of external communication regarding the event did not fully explain the incident and systems failures to the community.

- 2. Missed Pericardial Effusion, HDC investigation:** The HDC report on the 2004 case was published in April 2007. The publication date coincided with the initiation of this review.

The case (05 HDC14141) is summarised by the HDC as follows:

Wanganui Hospital – Emergency Department – inadequate communication between doctors in relation to patient referred to hospital by general practitioner

In early 2004 a 52 year old woman with possible cardiac symptoms was referred by her general practitioner to Wanganui Hospital three times over the course of eleven days. The level of concern the general practitioner held about the patient's condition was not fully understood by the hospital doctors. On all three occasions, the patient was investigated in the Emergency Department and discharged with a diagnosis of viral illness. On each occasion the general practitioner was unaware that the patient had been discharged until informed by the patient's husband. Tragically, the patient died at home the day after her final discharge. The post-mortem found the cause of death to be heart failure resulting from cardiac tamponade secondary to massive pericardial effusion.

The Commissioner considered that, overall, the assessment and management of the patient by the individual hospital doctors was appropriate. However, reaching the correct diagnosis was compromised by poor communication between the hospital doctors, and with the general practitioner, and inadequate discharge information. It was held that the hospital breached Right 4(5) of the Code, and the Commissioner recommended that the Whanganui District Health Board undertake a review of the management of referral and discharge information, and a review of the timeliness of its radiology services.

Given that the case had occurred 3 years ago the reviewers throughout their inquiry were interested in what had happened in the DHB since then to remedy general practitioner / hospital communication and timeliness of radiology services (bearing in mind that the HDC recommendation above has not been available over that period).

The case raised the issue of the use of ED as a patient assessment area as noted above in the commentary on clinical quality and safety issues.

Firstly on the question of radiology, reviewers were of the opinion that the 5 year contract commencing 21 May 07 with Pacific Radiology Limited will enable the identified service shortfall in radiology to be substantially if not completely rectified. (We would expect this to also resolve other concerns quoted to reviewers: limited access by hospital clinicians to interventional drainage procedures, and concern from general practitioners about both the level of service and timeliness of diagnostic ultrasound.)

The subject of primary care / secondary care communication was widely canvassed by the reviewers. There was universal agreement that there is room for improvement in the communication between hospital teams and primary care teams over individual patient management,. This seemed mainly in the area of written material as picking up the phone for urgent problems was described as commonplace.

Except in Mental Health, which uses a more advanced typed discharge format, the rest of the hospital appears to largely rely on a hand written self carboned triplicate form, one copy of which is posted to the patients' general practitioner at the time of discharge. This is a distinctly second rate system which is gradually being replaced throughout New Zealand hospitals with an electronic version. The new system has the potential to eliminate the two major safety issues of legibility and timeliness of communication.

A dictated discharge summary letter from hospital clinician to general practitioner commonly follows the handwritten discharge note in some departments, but following outpatient clinic consultation this is virtually the only form of communication. Transcription typing accuracy was thought to be quite accurate; however intense frustration was voiced both by general practitioners and hospital doctors at the completely inadequate timeframes offered by the transcription service. Hospital clinicians were severely hampered during patient follow up visits even at 2 and 4 week intervals due to the absence of their own dictation about a patient's previous visit.

Recommendation 3: that the DHB introduce immediate short term measures to remedy the transcription timeframe deficiencies

In a small community reviewers expected personal relations between hospital clinicians and GPs to be at the level of personal acquaintance, and while this was confirmed by many of the long standing hospital doctors it was not necessarily the case for the many new recruits. An area of difficulty for GPs was communication with the rapidly changing junior doctor pool and some issues with English as a second language were described to reviewers.

The reviewers felt that this whole area of doctor collegiality needed some solid work from all sides.

It was not within the brief of this review to examine the clinical information management system except in so far as there were safety issues. The only concerns have been detailed above. However, the reviewers were struck by the lack of development of electronic Clinical Information Systems and assessed Wanganui Hospital as being 1-2 years behind other secondary DHBs and 2-4 years behind New Zealand tertiary hospitals. (A possible exception to this generalisation is the Mental Health clinical information system). This issue is both a symptom of and a limiting factor contributing to the present difficulties in "regionalising" secondary service provision across the wider region.

3. **Failed Tubal Ligations:** This case was drawn to public attention in 2007 with the announcement that the HDC office would conduct an investigation into failed tubal ligation sterilisation procedures performed on women at Wanganui Hospital by a single surgeon.

The case falls within the Terms of Reference of this review. The detailed HDC investigation report is expected late December 2007. This review process is entirely different from the HDC process, particularly the use of content experts and a legal framework. Hence the reviewers' opinions below should be viewed as complimentary to the future HDC investigation report.

Dr Hasil was a Czech trained Obstetrician Gynaecologist who emigrated to Australia with his family. He occupied senior registrar positions in O&G for some 6-7 years; however, he had failed attempts at the O&G specialist qualifying examination.

He accepted a post as a non-vocationally registered specialist Medical Officer in O&G and moved to Wanganui without his family in order to give him time to study. The reviewers have commented elsewhere that the appointments process and its review by the Credentials Committee was appropriate.

Indeed this applicant for an O&G specialist position that had been vacant for some years looked the best on paper for a long time.

Dr Hasil started work in August '05. The reviewers have commented previously at the detailed personal evaluation of his competence undertaken by the supervising O&G specialist on his arrival and the establishment of his scope for working independently in core O&G. His gynaecology surgery and obstetric technique were closely observed by midwives and nurses, as was his patient evaluation technique in the outpatient department. No technical skills were lacking. More than one observer described his operating speed as "fast" and sometimes "a bit rough" but perfectly competent. He was affable and co-operative and his direct "European" manner was accepted by staff.

In March '06 he was called in to the maternity unit to perform a surgical episiotomy repair, a task he performed well. However the midwife and the patient's mother smelt alcohol on his breath, and reported this. The disciplinary process appeared to be that he was taken aside, referred to his GP, and given a warning. Money problems, family problems, and a resort to alcohol subsequently came to light.

A second incident occurred on a Monday morning (October 2006) a staff nurse reported Dr Hasil was incoherent on the telephone when reminded he had a patient to see in outpatient clinic. On arrival he was noted to have alcohol on his breath. The Service Manager thought he was unfit to work therefore he was immediately suspended from duties. The DHB referred him to the MCNZ and the process of investigation by them was implemented. While he was on leave the failed tubal ligations came to light. Concern was raised by social workers who in a short space of time had been referred four women with failed tubal ligation who subsequently became pregnant. They were requesting termination of pregnancy. Given that Wanganui Hospital performs about 40 tubal ligations per year this failure rate seemed abnormal. Audit connected these cases to Dr Hasil. Dr Hasil remained on leave until his resignation, has subsequently left New Zealand, and was not available to be interviewed for this review.

The first failed tubal ligation operation occurred in September '05 prior to the first detection of his drinking and an awareness of his stressed personal circumstances. He went on to perform a further 3 faulty tubal ligation operations before the October incident. Dr Hasil was on sick leave from October 2006 until he resigned in March 2007. None of these failures were known to hospital managers or to the O&G specialist supervising Dr Hasil at the time of his suspension. Once it was known that a problem existed the DHB quickly identified all the potentially effected tubal ligation patients, who then underwent investigation of tube patency and if needed repeat surgery.

This review did not examine the extent of injury to all of the women involved, given the HDC investigation. However, on two other aspects reviewers did form a view:

Firstly, on the evidence presented to us Dr Hasil was trained and competent to perform tubal ligation laparoscopically. Tubal clipping is an easy operation to get wrong if the operator is not paying attention and not correctly tracing the fallopian tube. This surgeon knew how to do the operation but wasn't doing it correctly. The reviewers speculate this was likely through inattention, distraction by personal stress and perhaps haste.

This was the failure of an impaired physician. If his problems had preceded his shift to New Zealand then reference checking might have uncovered it. If it followed his arrival then the appointments process becomes irrelevant.

The reviewers felt that it was only because of the small size of Wanganui that the tubal ligation failures were detected at all, and would likely have remained undetected had this incident occurred in a larger metropolitan centre with multiple separate private and public providers.

Secondly, there is the question of the detection and suspension of an impaired doctor, which as this case shows, can be extraordinarily difficult.

In retrospect, removing Dr Hasil following the first alcohol incident would have prevented around four further failed tubal ligations, and the need to investigate several additional women for this possibility.

The opinion of the reviewers is that the original assessment of fitness to work was inadequate.

Good performance in staff reports of Dr Hasil's first few months work, an explanation by him for a minor incident of alcohol on his breath are probable factors contributing to the decision he should remain working.

Alcohol in the workplace is never trivial. Suspension on sick leave pending independent reports confirming physical and mental fitness to work is the standard.

Had this process been followed in this case it is possible that unfitness to work would have been detected earlier and subsequent patient injury prevented. However, it may have returned him to a workplace with highly structured support and surveillance that would not have detected careless tubal clipping. The lack of a more formal fitness to work process in this case may not have prevented subsequent events.

The recommendation of return to work in 2 weeks in the October '06 Occupational Health fitness to work evaluation reported to reviewers, serves to reinforce the difficulty and uncertainty in this area.

Recommendation 4: that fitness to work policy and decision-making be reviewed, including access to resources for expert assessment.

Overall the reviewers concluded that for an impaired doctor to inflict so much patient injury undetected, is highly unusual.

Given that impaired gynaecologists can exist and that methods to detect accuracy of tubal clipping are not considered routine in New Zealand, and are not foolproof, this case should stimulate a rethink of quality controls for this procedure.

WhDHB can be criticised for its alcohol and fitness to work assessment process, but it cannot be criticised for using standard methods for appointment, competence assessment and supervision of a new surgeon.

The sole preventable element in this case is effective quality control of laparoscopic tubal clipping, sadly not available to the group of Whanganui women affected.

Recommendation 5: that expert advice including consumer input be used to put in place laparoscopic tubal ligation quality audit.

FIVE OTHER REPORTABLE EVENTS

Reviewers examined previous external reviews of clinical quality commissioned by WhDHB in Ophthalmology and General Surgery.

In Ophthalmology a well published case, the subject of HDC review was noted, along with the comprehensive 2006 review of the ophthalmology department by an experienced external ophthalmologist. Reviewers were satisfied with the attention being paid to the recommendations made and had no further quality concerns.

The remaining four cases all involved the general surgery department and relate to cases from 2002/2003, some of which have been extensively reviewed. All relate to patient incidents involving surgeons no longer employed by the DHB. Some cases involved patient injury which was dealt with at the time.

The striking lack of clinical leadership in the general surgery department since 2002 lies at the heart of these cases. The common root cause identifiable in all four cases was poor communication. Two cases did not cause patient harm although had the potential to do so had the communication barriers not been overcome.

The patients in these cases were not under the care of currently employed surgical staff and the review team felt that with one exception there were no ongoing communication issues between surgeons.

Reviewers were told that referral and transfer of care of surgical patients from the Wanganui private surgical facility to Wanganui Hospital is not occurring in a timely and appropriate way in all cases. Given current friction, it would be wise for the DHB to confirm that Wanganui Hospital is acting as the back-up for the private facility for medical and surgical complications, that the case-mix complexity admitted to that facility is appropriate, and that the inpatient medical and surgical teams understand their responsibilities to accept the transfer of patients from this facility.

One of the cases in this group of four is currently the subject of external review. Inability to internally review the case and the fact that external review was required attests to the level of dysfunctionality that has existed.

The reviewers' main concern is the need to develop a plan for redevelopment of the general surgery department as part of a wider regional group of general surgeons. This will allow subspecialisation, greatly improved collegial networking, cross referral and cross cover and a sustainable service model moving forward. For general surgery (and a number of other specialities) the degree of clinical cohesion needed to achieve completely regionally integrated practice will only be attained with the introduction of the concept of regional Clinical Directors.

FACTORS AFFECTING LONG TERM VIABILITY OF A SMALL PROVINCIAL HOSPITAL

Acknowledging the numerous other factors involved, the reviewers concluded that a critical viability issue for Wanganui Hospital is medical specialist retention.

The long term clinical and financial viability of Wanganui Hospital lies in its ability to retain a stable senior medical workforce and retain only those high acuity secondary services requiring inpatient facilities that are cost effective. These services should be placed within the wider context of WhDHB and its neighbours, i.e. collaborative secondary service provision with Palmerston North (Midcentral DHB) and to a lesser extent New Plymouth (Taranaki DHB).

Currently Wanganui Hospital has the most complete senior medical staff workforce that it has seen for many years. However, it still has two critical departments (general surgery, obstetrics) where temporary appointments make the situation unstable and untenable in the long term. The provision of acute inpatient services across a range of specialities for very few patients is very costly compared with larger hospitals. This is a major factor in the DHB's current financial position which is one of insolvency. Ironically, some of the same factors that create high hospital costs (high acuity specialities accepting acute admissions 24/7) are the same factors that make specialist medical practice unattractive (less than four specialists on a roster is largely unacceptable). Further elements of job satisfaction for specialists should also be attractive to the health system funder because they reduce costs: service delivery models that allow for medical subspecialisation, medical collegiality and peer review that accompany larger speciality groupings (across DHB boundaries that become irrelevant). Clinical quality at Wanganui Hospital ultimately depends on sustainable structures developed strategically with the support of all the regional health boards.

Visiting Wanganui Hospital the reviewers noticed examples in the areas of clinical governance, leadership, and service delivery models that appear to be actually or potentially counter productive to long term clinical sustainability.

The following is offered by the reviewers as a basis for wider discussion.

CLINICAL GOVERNANCE

In a DHB the Chief Executive and Board need to be confident that key indicators provided to them confirm health care quality standards are being achieved, standards are being systematically pursued, services are being provided in appropriate premises by appropriate staff to an appropriate level of quality in appropriate numbers, and appropriate improvement projects are in place.

This assurance framework is not in place across the Whanganui DHB. Neither the Board nor the Executive Management Team has the structure in place for direct reporting by senior clinicians to them on matters of clinical quality and safety. The executive management team for the DHB does not include the Chief Medical Advisor or the Director of Nursing and Midwifery. Below this level the clinical governance structures present a medically dominated model with the (doctors) staff association assuming some of the functions of a Clinical Board, although a Clinical Governance Committee also exists.

Recommendation 7: that management structures and reporting at governance level be altered to integrate clinical governance.

LEADERSHIP

The reviewers arrived in Wanganui to find a barrage locally of very public criticism of the hospital performance, a dysfunctional Board, and a community unimpressed with and confused about the level of service being provided and the issues surrounding Wanganui Hospital. From interviews with Board members, reviewers concluded that there had been a poor understanding of the clinical volume and outcome relationship that suggests that some services should be further devolved to the community for better access, while for safety, quality, and access reasons other services should be concentrated around clinical and support facilities out of the district. Members felt that the clinical component of the assurance framework being reported to the Board was not authoritative. The Board's role in helping install clinical service collaboration across the region was unclear. Reviewers' were disturbed by the lack of urgency attached to this concept at all levels in the DHB.

While on paper the hospital management structure looks top heavy, reviewers were well aware that reality can be completely different in a small compact organisation.

A serious lack of clinical leadership existed in critical areas (no Heads of Department in General Surgery or O&G). The reporting lines for Heads of Department and Clinical Directors were blurred. There is some confusion and overlap between the HOD and Clinical Director roles. The question is raised as to the need for both in a DHB the size of Whanganui. As well as the separate DHB-wide management structure, the hospital management has clear responsibilities for DHB staff working in primary care and for developing primary secondary integration in general. These DHB-wide responsibilities also affect hospital clinicians. Only the hospital general manager is a member of the DHB-wide executive management team. Meaningful clinician manager partnership and integrated governance is severely inhibited in the absence of clinicians from the DHB-wide executive management team.

The DHB has some fine leaders in management and as Clinical HODs. Absence of the latter in general surgery and O&G is partly due to attempts to persist with an unsustainable service models. Those models are discussed below. The ability to attract young general surgeons is contingent on new recruits being able to pursue the subspecialty areas of the discipline. Clinging to the generalist model is unsustainable in general surgery. Rejecting regionality concepts is unsustainable in both O&G, general surgery (and other specialities).

SERVICE MODELS

Overall the reviewers are complimentary of the DHB achievements against considerable odds, in introducing innovative models of care to replace the unsustainable approach of "all secondary services provided within the district at whatever cost". While yet to bed in, the solutions found for secondary services in urology, radiology and paediatrics meet criteria for clinical quality and sustainability (acknowledging that financial sustainability has yet to be confirmed).

It was clear to the reviewers, however, that there was no overall strategy service by service to select the most appropriate sustainable model of service delivery. The reviewers noted that the Technical Advisory Service process, albeit in its infancy, had introduced an excellent process to engage clinicians in the planning and decision-making of future service delivery across the region. Regional collaboration has previously not had the strategic support of the Board.

There has been a failure to persuade the community that the alternative [regional] models are more likely to provide expert subspecialty secondary services within the district and that high quality access to the complete range of 24/7 specialties is only sustainable within that regional approach. Wanganui residents should expect to travel to a regional secondary base hospital for some treatments, as occurs throughout the rest of New Zealand over a similar or greater distance.

The reviewers offer the following commentary on the DHB adoption of different models:

- a All secondary services provided in-district by DHB departments
- b outsourcing to providers based out of region for in-district service provision
- c regional shared secondary service, some elements in-district
- d referral out of district to secondary service in another DHB
- e combinations

Service sustainability is not just about the provision of medical expertise. However, this discussion centres on this as the main issue.

SMS Millipaed Ltd contract (model B) is an example of WhDHB purchasing clinical leadership, strengthening collegial networks with a tertiary DHB (Counties Manukau) alongside the building of a sustainable Paediatrician workforce. An example of WhDHB purchasing new imaging capacity, and strengthening collegial links and sustainable radiologist roles is in its Pacific Radiology Ltd contract (model B).

Model B tends to make the DHB independent of its neighbouring DHBs both for capacity and clinician collegial links. Models B and C tend to have opposite effects in promoting regional collaboration. In the case of high acuity 24/7 paediatrics the opportunities for a regional approach to community paediatrics and single regional inpatient facility should not be lost.

A pragmatic combination of models C & D has evolved for urology. In-district urology including non- complex surgery is provided by Capital Coast and Midcentral DHB urologists with more complex secondary surgery patients transferred out of district. Clinical quality in a stable and sustainable model with some patients inconvenienced by out of district treatment is preferable to historical alternatives.

The strategic planning of sustainable service models across the region for three contiguous DHBs requires intense cooperation and coordination at Board level. The comingling of Board membership across the Boards such as the deputy chair metropolitan Auckland model deserves consideration. Artificial DHB geographic boundaries must be erased and service models designed around facilities, population, medical speciality expertise, and clinical quality. Regional departments and regional Clinical Directors should be introduced.

As it stands the adjacent DHBs in the region have a huge amount to offer each other in terms of collegiality for isolated medical specialists, but little to offer each other in terms of capacity sharing. However, future sustainability of secondary services depends on shared capacity and the logic of the future expansion of Palmerston North as a base hospital in the region is inescapable from a clinical quality perspective alone.

CONCLUSIONS

Wanganui Hospital has strengths in possessing stable and experienced nursing and midwifery staff, and a well organised medical staff of which in the senior ranks 80% are vocationally registered specialists. Examples of innovative clinical service developed in recent years (e.g in health of older people the Primary Response Team, the Whanganui Accident and Medical Centre beside ED) attest to the depth of talent and willingness to make changes that resides in the workforce. Where other DHBs still struggle, Wanganui Hospital has a strength in its stable nursing and outstanding midwifery service. Both have carried critical departments that have been areas of concern for long periods relating to SMO shortage, with high levels of professionalism.

Despite allegations to the contrary the reviewers concluded that Wanganui Hospital was a safe clinical environment with a very low level of risk of preventable patient injury that was comparable to other hospitals in New Zealand.

A political sideshow created in the Board and community has led to some loss of public confidence in the locally provided health service which is unjustified. It has diverted attention from the pressing need to design and install sustainable service models affecting not just Whanganui DHB but also geographic neighbours and tertiary hospital partners.

Over the last 3 years several patient incidents at the hospital have occurred, some with preventable components from which the hospital has learnt. Regrettable though these events are they also had many unforeseeable and unpreventable elements and need to be viewed in the entire context of the safe care competently delivered to the majority of patients.

Wanganui Hospital in its current configuration is now out of staff crisis mode and the next steps are to consolidate a sound strategic plan for service delivery designed for long term sustainability.

Terms of Reference

DHB Clinical Review

Purpose of this document

This document outlines the parameters, and the Ministry of Health and Whanganui District Health Board's (WDHB) expectations of the review of clinical services provided by the Provider Division of the WDHB at Wanganui Hospital.

Introduction

The Ministry and WDHB both wish to provide advice to the Minister on the quality of service provided across all services provided by the WDH Provider Division at the Wanganui hospital. The review will be conducted by an independent review team in collaboration with the Wanganui clinical staff. A joint MOH/DHB steering group will guide the progress of the review.

Background

A number of recently publicised events at Wanganui Hospital have raised concerns regarding the quality of the services provided at the Hospital.

In addition to the regular regime of monitoring DHB performance the Ministry has over the last few months been conducting a formal review of the overall performance of the DHB governance, management and service delivery.

Concerns emerging from the review, particularly relating to clinical instability (paediatric and obstetric services) and the financial management prompted the Ministry in December 2006 to move the WDHB to Intensive Monitoring on the Monitoring and Intervention Framework.

Shortly after this, a significant error in the DHBs handling of patient referrals became apparent. An audit of the DHB was conducted by Health Cert, the Ministry's division responsible for the Certification of Hospitals under the NZ Health and Disability (Safety) Act 2004.

The outcome of this audit was outlined in a Health Cert report that identified twenty six corrective actions. As a result WDHB's certification was amended and five new conditions were added including the requirement to have a corrective action plan by 26 January 2007.

Although the DHB is making acceptable progress implementing these recommendations, other issues (historical and current) have continued to emerge. One of these is the commencement of an HDC review shortly.

Objectives

The Ministry and DHB are concerned to:

- ensure the clinical safety and quality of the services provided

- restore public confidence in the services
- preserve the professional reputation of the competent clinical staff practising at Wanganui Hospital
- identify opportunities for quality improvement.

Scope

The scope of the review is the full range of emergency, medical and surgical clinical services, including the clinical support services provided by the WDHB Provider Division at Wanganui Hospital.

Exhaustive review of clinical services provided within WDHB by neighbouring DHB's is out of scope

Approach

Using primarily interview, survey, document reviews and observation techniques the reviewers will explore the:

- appropriateness of service coverage
- leadership and management of clinical practice (Clinical Governance), at both the DHB and at service levels
- “credentialing” (including appointments procedures) and clinical supervision regimes of clinical practitioners
- service audit and peer review processes in each service
- development and utilisation of clinical protocols and guidelines for high volume and/or high risk clinical events
- clinical risk management including clinical indicators and measures of performance
- critical incident reporting and management
- complaints management
- continuous quality improvement system
- continuing clinical education
- peer support / mentoring opportunities
- clinical interfaces integration, including with tertiary, other secondary and primary services
- staffing levels and skill mix where relevant

Assessment of quality improvement and staff development initiatives will be by reference to any standards and guidelines that apply to District Health Boards and health practitioners in New Zealand, including but not limited to guidelines or statements promulgated by the Ministry of Health, responsible authorities under the Health Practitioners Competence Assurance Act, and by relevant professional colleges.

The reviewers will have access to all relevant WDHB staff and facilities.

The reviewers will request interviews or written statements from any person they deem to have a perspective relevant to the substance of the review. This may include current, ex and contracted staff, (clinical and management), referrers and referral centres, consumer representatives and clients.

The reviewers will also examine the findings and recommendations (and DHBs response) from all external inquiries/audits conducted over the past three years.

Deliverables

- (1) The reviewers will identify and report on:
 - any identified safety issues or unacceptable clinical practice
 - clinical governance deficits
 - inadequacies in the reporting and management of critical incidents
 - barriers to, and opportunities for, professional development and continuous quality improvement
 - the strengths of the clinical systems and outcomes.
- (2) The reviewers will make recommendations on the short, medium and long term options for correcting any issues identified.

Process and Reporting

The reviewers will be accountable to the DDG DHB F&P for the conduct of the review.

A joint steering group will provide oversight of the process and will receive draft reports and provide comments.

Except in matters of patient safety, when immediate reporting would be expected, the review team will provide a weekly verbal report on progress to the DDG DHB F&P and the Chief Executive for WDHB.

An interim report is expected immediately following the conclusion of the review activities.

The reviewers will receive comment on the final draft from the steering group and may include this in the final report.

A comprehensive written report is to be completed within one month of the conclusion of the review.

The Steering Group will be comprised of MOH DDG DHBF&P, Group Manager Funding DHB F&P and Principal Medical Advisor, WDHB Chief Executive and two others (one of whom must be a Wanganui senior clinician).

Media statements or any public comment on any aspect of this review are to be made only by the MOH DDG or the WDHB CE.

Timing

It is expected that the review will substantially be conducted within a six-eight week period excluding the preparation of the final report.

Editorial control of the report is the responsibility of the reviewers.

APPENDIX II: PERSONS INTERVIEWED

PERSONS INTERVIEWED

Terry Johnson	Chief Medical Advisor Clinical Director Psychiatry
Memo Musa	Chief Executive Officer
Jeff Hammond	Clinical Director Nursing & Midwifery
Sue Capenerhurst	General Manager Public Hospital & Health Services
Peter Beirne	General Manager Corporate Services
Tracey Schiebli	General Manager Health Planning Improvement & Funding
Tom Thompson	Physician, HOD
Peter Schenk	Anaesthetist, Clinical Director
Declan Rogers	PDCP Co-ordinator
Joanne Vigenser	Nursing Directorate – Nurse Educator
Janene Laurens	Clinical Nurse Leader Paediatrics & Neonates
Jacqueline Pennefather	Registered Nurse Paediatrics & Neonates
Maria Jardin	Clinical Nurse Leader - Medical
Kathy Easton	Staff Nurse - Medical
Lucy Petit	Midwife - Maternity
Debbie Beatson	Midwife - Maternity
Robin McDougall	Midwife - Maternity
David Wilde	O & G Consultant
Heather Dixon	Duty Nurse Manager
John Rivers	Geriatrician & Clinical Director Medicine & Paediatrics
Helen Lloyd	Dentist, HOD
Vicky Watkins	Clinical Nurse Manager – Combined Surgical Ward
Medhat Osman	Radiologist, HOD
Trish Newton	Clinical Quality and Risk Advisor
Andrew Baxter	Risk, Quality & Commercial Services Manager
Lenna Young	Head of Midwifery/Manager
Patrick O'Connor	Board Member
Guy Taylor	Rheumatologist, Clinical Audit Portfolio
P.J. Faumui	ENT Surgeon, Whanganui Hospital Board Member
Kate Joblin	Chair – Whanganui District Health Board
Ormond Stock	Deputy Chair – Whanganui District Health Board
John Van Dalen	Orthopaedic Surgeon, HOD
Clive Solomon	Whanganui Hospital Board Member – ex-employee – General Surgeon
James Kennedy	Risk Management – Accreditation
Ferlin Hontanosas	Pathologist, HOD
Louise Torr	Service Manager Community & Rural Services (Acting)
Gerard Bonnet	General Surgeon
John McMenamin	GP Wickstead House - Clinical Director, Wanganui Regional PHO
Jim Corbett	GP Raetihi
Mike Miller	Anaesthetist, HOD
Dianne Carson	Clinical Co-ordinator - Theatre
Heather Richardson	Acting Clinical Nurse Manager - Theatre
Louise Oskam	Service Manager Acute & Inpatient Services
Pam Loader	Staff Nurse Surgical (combined Ward)

Shona Kirby	Staff Nurse Surgical (combined Ward)
Jan Denman	Clinical Nurse Manager - Outpatients
Anne Davies	Mental Health – Service Manager – Acting GM
Athol Steward	Medical Director Emergency Department
Mark Stegmann	O & G Consultant - ex-employee
David Montgomery	Paediatrician - Contracted
Peter Wood-Bodley	Service Manager Surgical Support Services
Kevin Baker	Nurse Manager - Community
Diana Mallalieu	Clinical Nurse Specialist - Wound Care
Helen Adams	Clinical Nurse Specialist – Diabetes
Carol Briant	District Nurse
Ann Foley	Clinical Nurse Specialist - Continence
Jan De Kock	Ophthalmologist, HOD
David Van der Walt	Wanganui Accident and Medical Centre
Martin Swosowski	ED Officer
Ken Crafer	Hospital Action Group
Laurel	Manager – Aged Concern
Maria O’Leary	Consumer
Chester Burrows	National MP
Trina Mille	Assistant Manager Health Advocacy & Disability Services
Paul Trownson	Consumer
Bill Douglas	GP Wanganui

APPENDIX III: DOCUMENTS RECEIVED

1. Joint Review of Whanganui District Health Board (WDHB) Draft Version 2 – 26th March 2007.
2. Health Cert. Inspection Report resulting from a reportable event Whanganui District Health Board Wanganui Hospital 27th November 2006 – 5th December 2006.
3. Report of the Health and Disability Commissioner Wanganui Hospital – Emergency Department – Inadequate Communication between doctors in relation to patients referred to hospital by general practitioner – 28th February 2007.
4. Whanganui District Health Board Annual Report – 2005 – 2006.
5. Hewlett-Packard – Patient Administration Process reviewed – Draft for discussion – 22nd February 2007.
6. Concordia organisational assessment – Workplace Audit May-June 2006
7. External Review of WDHD Ophthalmology Department
8. Memo – Terms of Reference External Review of Ophthalmology Issued by WDHB
9. WDHB Review McLellan and James External Review Report November 19, 20 2002 – Associate Professor Jack Havill
10. Report on Review of the Department of General Surgery at Wanganui Hospital – Reviewers S. Vallance and N. Marlborough
11. Risk and Audit Committee Agenda Wednesday 11/4/2007 2pm – 1.30pm Workshop for Board Members Only
12. Risk and Audit Committee Agenda Wednesday 6/12/2006.
13. Risk and Audit Committee Agenda Wednesday 4/10/2006
14. Risk and Audit Committee Agenda Wednesday 5/7/2006
15. WDHB Extensive Review Report – McLellan & James November 19th and 20th 2002 – A/Prof. Jack Havill
16. Agreement for Supply of Paediatric Senior Medical Officers WDHB – SMS Millipead Ltd – 28/1/2007
17. Radiology Service Accreditation Assessment Report Initial Assessment 14-17th March - I.A.N.Z.
18. Senior Medical Staff Credentialing Status document Current accreditations
19. Agreement for the provisions of Radiology Services (Pacific Radiology Limited) and Whanganui District Health Board
20. Credentialing Status of SMO's – T Johnson
21. Health Select Committee questions due by 30/April 2007 Information requests and questions from meeting held on 28 March 2007
22. Parliamentary Health Select Committee - Inquiry into the Provision of Paediatric Services by the Whanganui District Health Board - Submitter: Kenneth Lance Crafar, 6 West Way, Durie Hill, Wanganui
23. Review of Whanganui District Health Board's Complaints Policy and Procedures April 2005 – draft 20 April 2005
24. Credentialing – paper regarding credentialing status of SMO's
25. Whanganui Regional Primary Health Organisation Annual Business Plan 2006/2007
26. Medical Council of New Zealand Draft Disruptive Doctor Guideline Consultation paper – March 2007 Medical Council of New Zealand
27. Mary Bryan: "Outgoing general surgeon Clive Solomon wants a scalpel taken to unsafe Wanganui Hospital." Wanganui Chronicle 25.11.2006].

APPENDIX IV: QUESTIONS FOR CLINICAL SERVICE HEADS

Questions for Clinical Service Heads

1. **Quality systems (CQI):**
 - Annual performance reviews
 - Per review
 - Nursing skill mix, skills mix
 - Clinical indicators of patient outcomes – LOS, readmission, complications
 - Surgical audit
 - Quality audit – reportable events, complaints, policies, guidelines, patient satisfaction
2. **Competence of staff / checking systems:**
 - Orientation of staff
 - Accreditation of SMOs and Medical officers (up to date, 5 years) – assigned clinical privileges
 - RMO supervision
 - Other clinical supervisory roles
 - CME
 - CNE – PDRP levelling
 - Fire/CPR
3. **Clinical Meetings:**
 - Interdisciplinary (nursing and Allied Health included – clinical cases, education, M&M Primary secondary clinical meetings.
4. **Medical Staff:**
 - Medical – Unit specific journal club, M&M, cases
 - Grand rounds
 - Imaging, pathology, other disciplines
5. **Various**
 - Teaching by Unit members – unit / hospital
 - Safe hours – medical, nursing, allied
 - Designated HOD
 - Clinician managerial partnership
 - Voice heard
 - Strategic and delegated authority
 - Research opportunities
6. **Facilities:**
 - Availability – ACU, OR
 - Pathology
 - Pharmacy
 - Library
 - Level of service provision
 - Access to clerical typing
 - attendances