West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

INTERNAL MEMORANDUM

28th May 2008

Memo To: West Coast DHB Chair and members

From: Kevin Hague, CEO

SUBJECT: Concerns raised by Judy Forbes

Introduction and Summary

The process surrounding Dr. Forbes' concerns about patient safety at Grey Base Hospital, and their investigation, is inevitably one that has stirred deep and conflicting emotional responses. It is perhaps helpful to remind ourselves that every Board member and every staff member sets out to ensure that West Coasters have the best possible health, including the best possible quality and safety of health services. Where we diverge is in how best to achieve this.

Patient safety also needs to be understood in relative terms, rather than as an absolute. It is almost always possible to construct a hypothetical or actual risk in any situation, so "safety" refers to risks being minimised in a situation, rather than eliminated entirely. Because safety is not absolute, processes to improve safety (and quality generally) need to be understood to be dynamic. A service provider needs always to be working to further minimise risk and thus make services safer. This might involve change within an existing way of providing a service, or a change to a different way of providing the service – in which case the new way may well have new risks, but lower overall risk.

This report provides a response to each of the claims that Dr. Forbes has made concerning services at Grey Base Hospital and is, therefore, narrow in its focus. My conclusion is that none of the matters that Dr. Forbes says create risks to patient safety in fact do so, although several of the matters she raises do suggest areas in which performance can be improved, most notably:

- Implementation of the Central Booking Unit trial could have been significantly improved, and West Coast DHB needs to ensure that when urgent change is indicated, that the standard approach to the management of change (involving full consultation) is compromised only to the minimum extent necessary;
- Compliance with West Coast DHB's policies and procedures around the reporting of incidents is patchy at best. This is a fundamental concern, as the reporting of incidents is a necessary fundamental to their investigation and subsequent process improvement – a critical part of the organisation's quality improvement strategy.

I am also struck by the strong sense that while none of Dr. Forbes' patient safety concerns proved grounded, there seemed to be some underlying real issues around the quality of relationships between the Anaesthetics Department and others. These need addressing and, to this end, I

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intend to work with appropriate professional organisations to commission a prospective piece of work aimed at identifying the best practice policies, procedures and communications mechanisms that Grey Base Hospital will need to address these underlying issues.

Dr. Forbes' claims have received wide exposure in the news media, and subsequently substantial public alarm is likely to have been engendered. I intend that, subject to editing to prevent the inappropriate identification of individuals or other legal constraints, this report is made public.

Overall pattern of concerns

Dr. Forbes first raised the concerns that she said gave rise to patient safety issues at the end of January 2008 in a letter to me.

These concerns were fully investigated in early February and appeared to be resolved through some meetings with the GM Secondary Health Services, with the key resolution meeting on 13th February. Dr. Forbes then took leave from 16th February, returning 22nd March The day after Good Friday. She wrote to the Board on 28th March, indicating that she had exhausted normal management channels and needed the Board to hear her concerns about patient safety. Her letter reprised the issues she had raised earlier and expressed particular concern over the establishment of the Central Booking Office, over the Easter period.

During April Acting Medical Director, Dr. Fiddes investigated Dr. Forbes' 28th March letter. In the meantime Dr. Forbes requested time to present her concerns to the Board at its 2nd May meeting. As there were unusual circumstances (CEO having been away on leave for most of April, the Acting Medical Director having been called away on urgent personal business and not having completed his report) the Board agreed to allow an employee to speak, on some conditions, including the provision of a short written summary of concerns for the Board. Dr. Forbes presented several pages of handwritten notes, which covered the same ground as her previous correspondence, but also added some new examples of her concerns. After the Board meeting Dr. Forbes converted these notes into a further letter (2nd May).

The further matters raised by Dr. Forbes in her 2nd May letter were being investigated with a view to presenting a full report on all of the matters she had raised when, on 12th May the Greymouth Star published a series of claims based on Dr. Forbes' 2nd May letter, of which they had obtained a copy.

As a result the Ministry of Health agreed to the suggestion made by the West Coast DHB that an external party should be appointed to investigate the matters raised, so that the West Coast public could have confidence in the integrity of the actions of the DHB and the safety of its services.

Dr. Forbes' 29th January letter (attached as Appendix 1)

Dr. Forbes characterised her letter as alerting me to "serious threats to patient safety", and indicated that unless the problems she raised were addressed urgently she would copy the letter to the Chair and members of the Board.

The concerns outlined in that letter, and their response is set out below:

"1) RMO shortages which are threatening surgical work that needs undertaking."

This claim was found to be wrong in fact. The Resident Medical Officer (RMO) shortage was a national problem that was particularly acute on the West Coast at the beginning of the year. It did not impact on surgery. The General Manager Secondary Health Services met with the Senior Medical Officers, including Dr. Newton as joint Head of Department, Anaesthetics, in January to discuss this issue. All the surgeons (and Dr. Newton) were prepared to continue with day case and minor overnight cases with no RMOs on the floor.

"2) No medical cover in A&E on several occasions since Christmas."

This claim was found to based on some problems that were experienced, but to misrepresent them, and therefore wrong in fact. Grey Base Hospital had two instances since Christmas where there were problems with Emergency Department (ED) cover:

a) The first was on **[Text Witheld]** when **[Text Witheld**] was listed to start work at 1400 but in fact only arrived on the Coast that afternoon to commence duty on **[Text Witheld]**. **[Text Witheld]** stayed on duty until **[Text Witheld]** arrived at 1700, at which point **[Text Witheld]** was asked if he could commence working. He agreed and worked the remainder of the afternoon shift.

The problem was caused by his name being written in the locum book on his arrival date, not his work date. This issue has now been addressed. ED had Medical Officer cover at all times.

b) The second occurred on **[Text Witheld]** when **[Text Witheld]** was expected to recommence work after annual leave. This date was on the roster completed by the previous Nurse Manager. When he did not arrive at work as scheduled, **[Text Witheld]** was contacted (he was in transit and I understand he arrived at ED at 1200). The Duty Manager contacted the weekend RMO who agreed to cover ED and the hospital until **[Text Witheld]** arrived. All on-call Senior medical Officers (SMO) were also contacted and appraised of the situation. Most were on their way to the hospital anyway and stayed until **[Text Witheld]** arrived.

While ED did not have Medical Officer cover for part of the morning shift (0800-1200) there was an RMO covering ED with most on-call consultants on-site, so medical cover was available. This incident has uncovered a related issue with approval of annual leave for this group of doctors, which is currently under review.

"3) General Surgery so disorganised. They see many patients for the 1st time in theatre, not only wasting time but sometimes missing critical information such as history and physical examination."

This claim was not found to be substantiated. The practice of pooling patients for some surgical procedures is accepted common practice across DHBs. This was checked through direct consultation with other DHBs and through seeking the expert opinion of Dr. Ray Naden, consultant to the Ministry of Health. The General Surgery Department is comfortable with the procedures that are used to achieve this. General Surgery is also not the only department here where this practice occurs.

Dr. Vicki Robertson, Medical Director, has spoken with Dr. Terry Mixter, Head of Department, General Surgery, and Dr. Forbes, and has developed West Coast specific guidelines which meet everyone's approval.

If Dr. Forbes has concerns that General Surgeons are making critical mistakes such as those she alludes to then she has at least two responsibilities:

- As a member of DHB staff she has a responsibility to complete an incident form. This is the basic mechanism that West Coast DHB uses organisation-wide to bring issues to the attention of management, to ensure that they are properly investigated and errors are corrected and not repeated;
- As a member of the Medical profession she has responsibilities to raise her concerns about the professional practice of a colleague within the profession.

Neither Dr. Forbes nor anyone else has completed incident forms about incidents of the nature referred to, and Dr. Forbes has not provided any further detail that would allow investigation of this aspect of her claim.

As far as I know, she has not raised these issues within the medical profession.

"4) Rosters for the Operating Theatre are so Shambolic, changing continuously often without clinical input at all.

- ***Worst case scenario* [Text Witheld]*, telephonist ringing wrong Anaesthetist for 10 minutes***
- ***Arrangements made for Anaesthetist Locum without regard for 24 hour cover – some scheduled to leave before the next Anaesthetist arrives."***

The claim was found to be wrong in fact and not substantiated. The rostering system has continued in the same form since February last year, although there has been a change of personnel administering it.

Developments recently before Dr. Forbes' letter included the rostering administrator taking over responsibility for travel arrangements for all visiting specialists and locums as arrangements for this had varied between departments, with increased likelihood of error and inefficiency.

The one department that continued to not comply with the system was Anaesthetics. Repeated reminders about the system have been made to the department, both verbally and in writing from the General Manager.

With reference to Dr. Forbes' comments that the rosters are shambolic with no clinical input, it appears that the most common problem arises from clinicians making changes without following the established process. Rosters are not changed without an instruction from clinicians, usually the relevant Head of Department.

With regard to Dr. Forbes' two bullet point examples, again no incident forms have been filed in relation to either. The first incident Dr. Forbes refers to, with the wrong Anaesthetist being rung, resulted from Dr. Forbes or Dr. Newton making changes to the roster but not advising the person responsible for rostering (and ensuring that the telephonist has the accurate roster).

Grey Base Hospital management is not aware of any occasions where there has not been 24 hour anaesthetic cover.

"5) The Waiting List under extreme pressure with lack of consistent information that it may be beyond repair –* [Text Witheld]*."

[Text Witheld]

In January 2008 routine testing detected that air filtration in Operating Theatre air conditioning systems was not meeting required standards. This necessitated the immediate shut-down of all theatres but one, while replacement filters were sourced and installed (a period of some weeks). This resulted in immediate disruption to scheduled lists, and was a significant additional source of stress for these staff.

It is true that Waiting List staff were also struggling with inconsistent information. This was principally as a result of changes to agreed systems made by Drs. Newton and Forbes, in their new capacity as acting joint Heads of department, and to the exposure of waiting list staff to disagreements between anaesthetists and surgeons about theatre schedules, expressed in inappropriate and informal ways.

The consequences of these Waiting Lists errors (typically information not communicated in a timely way, or poor coordination of the steps in the patient's booking process) were generally inconvenience and frustration.

However, as outlined in Appendix 2, there were situations in *Outpatients'* booking in which patient safety could have been compromised. These were not the subject of Dr. Forbes' complaint, but provided strong motivation for speedy implementation of the Central Booking Unit (CBU) trial, which was also intended to decrease the likelihood of theatre booking errors.

Thus, in summary, with respect to the letter of 29th January 2008, only Dr. Forbes' concern about the Waiting List office raised any issues at all, and none of these could be characterised as 'patient safety' issues. Several meetings were held in early February involving Dr. Forbes, Dr. Robertson (Medical Director) and Chris Le Prou (General Manager Secondary Health Services). **[Text Witheld]**

Dr. Forbes' 28th March Letter (Attached as Appendix 3)

From 16th February, **[Text Witheld]**, through until 22nd March (the Saturday of Easter weekend) she was on leave, with Dr. Newton performing Head of Department duties. Dr. Forbes' return happened to coincide with the establishment of the CBU. A background to the establishment of the CBU is set out in Appendix 2.

Certainly this was a difficult week: there were delays in phone and computer support for the new Unit, which did create both internal and external communication difficulties for a few days. **[Text Witheld]**

28th March was the Friday of the week following Easter. I received by email a copy of a letter that Dr. Forbes had sent to the Board Chair and all Board members. The next day I was due to go away on leave for four weeks. After consultation with Board Chair, Rex Williams, I briefed Hecta Williams, who was to be Acting Chief Executive Officer in my absence, requesting that she arrange with Dr. Tom Fiddes, who was to work as Acting Medical Director (in Vicki Robertson's continued absence on sick leave), to report on the claims of compromised patient safety in Dr. Forbes' 28th March letter.

In my absence Hecta Williams as Acting CEO, met with Dr. Forbes (and Dr. Newton) to ensure that she understood the concerns being expressed. Dr. Fiddes' draft report is attached as Appendix 4.

Dr. Fiddes' draft report specifically looks at whether any issues, including issues of patient safety, are raised by the move of the Waiting List function to a new Central Booking Unit. Dr. Fiddes concludes that while its implementation could have been better, the CBU is a good idea that should improve patient safety. He does not have any concerns about patient safety arising from the issues raised by Dr. Forbes. Following his investigation of these matters, Dr. Fiddes has met with Dr. Forbes to communicate his findings.

For the sake of completeness, it is perhaps worthwhile to review all of the matters raised in Dr. Forbes' letter of 28th March:

1. "the management/mismanagement of Grey Base Hospital has caused the collapse of these systems which guarantee patient safety as well as dignity and respect. I have expressed these concerns in a letter and a meeting with Kevin Hague without resolution."

The claim is very broad. However its key assertion is that patient safety (and dignity and respect) is compromised by the collapse of systems. In fact the matters that Dr. Forbes raised in her letter of 29th January were all thoroughly investigated and found not to raise any concerns at all around patient safety. Dignity and respect were not specifically investigated, but none of the issues she raised in her letter seem to have any connection to either. The risk that was found to patient safety, in Outpatients, was not one raised by Dr. Forbes, and our solution to that problem was to

strengthen and streamline systems. Strengthening and streamlining systems has also been our approach to efficiency problems in theatre scheduling and rostering. I believe it is the case that our systems for ensuring patient safety are now significantly stronger than they have ever been.

For the sake of completeness, I note that I would not say that Dr. Forbes and I had "met" over these issues. She is referring to a brief conversation that took place in passing when she brought me her 29th January letter. At that point she indicated to me that she had a number of concerns and I undertook to look into them.

2. "I met with the General Manager about some issues intending to resign due to untenable working conditions. I was given multiple promises and assurances, most of which have been abrogated."

Dr. Forbes did meet with the General Manager, Secondary Health Services and with Dr. Vicki Robertson, Medical Director, and some agreements were reached, chiefly about rostering. The principal meeting, at which resolutions were reached, took place on 13th February. Dr. Forbes worked 7 days between that meeting and her letter of 28th March. She does not say in what way she considers the agreements have been "abrogated" and from the DHB's point of view, all have been followed to the letter.

3. "Whilst the modus operandi of the hospital has, for some time, been "lurching from crisis to crisis", more recent changes and decisions* [Text Withheld] *have further decimated the ranks of experienced staff – leaving us unable to compensate even with extra vigilance and cooperation."

It is certainly the case that Grey Base Hospital, as the most rural of the rural secondary hospitals in New Zealand has for some time been experiencing the "sharp end" of the systemic threats to rural secondary care. However, the West Coast DHB has been at the forefront of efforts to develop sustainable solutions to these problems, and is widely recognised in this regard.

As longer term solutions (such as greater collaboration with other DHBs to provide specialised services) take time to develop, West Coast DHB has been making those changes that it can to models and systems of care to make them more sustainable in the interim, while patching up other aspects that are becoming more and more difficult to maintain. Both the threats and the proposed solutions to these are well canvassed in the West Coast DHB Secondary Care Plan, which was developed in close consultation with all DHB staff.

Some staff don't like some of these changes and on occasion this may be a factor in their deciding to move elsewhere. However, selecting our largest workforce group to illustrate the point, an analysis of the reasons that nurses left our employment over a recent 12 month period found that this was not a significant factor at all. There is one experienced person who has recently elected to take early retirement rather than redeployment in a change currently being implemented, but mostly any experienced staff who have left in recent years have done so, because they have reached an age or a life stage where they wish to do something or live somewhere else.

The greatest ongoing difficulty with sustainability in secondary health services is in anaesthetic services.

4. Concerns around the shift of Waiting List personnel to the CBU

The issues raised by Dr. Forbes are mostly addressed in Dr. Fiddes' draft report, especially insofar as she suggests that the move compromises patient safety. I would readily acknowledge that the implementation process was not entirely smooth and, in retrospect, could have been better managed. However Dr. Forbes' letter was written just a couple of days after establishment of the new unit, and it is perhaps understandable that there were some initial problems. These have been quickly resolved.

It is important to stress also the trial nature of the CBU – at the end of the trial there should be clear objective evidence as to whether accuracy and efficiency, in particular, have improved or deteriorated. Patient safety, is most closely associated with accuracy and at this point it seems likely that there has been a major improvement in this aspect.

[Text Withheld]

In relation to the conclusions in Dr. Fiddes' draft report, I note that I have not yet formally considered them, (and they may yet change) but will do so swiftly once the report is finalised.

5. "I speak on behalf of many doctors and nurses who daily re-iterate "no confidence" in the hospital management that undermines patient safety"

Dr. Forbes may believe that other clinical staff share the views that she has expressed, but there doesn't appear to be any evidence of this. While other staff certainly express critical views about their colleagues, including management from time to time, nobody else has expressed to me the view that hospital management is undermining patient safety. On the contrary, since Dr. Forbes has expressed her concerns, many staff, clinical and otherwise, have taken the trouble to express confidence that the organisation is on the right track.

In summary, with respect to Dr. Forbes' letter of 28th March it is again the case that none of the concerns she has raised about patient safety seem to be justified. The central thrust of the concerns in this letter is concern that the CBU erodes patient safety. As the CBU is being trialled against some clear criteria, opportunity exists to directly test this contention. Given the wider public concern created as a result of Dr. Forbes' public comments, it may well be appropriate to seek some external involvement in the evaluation team.

Dr. Forbes' Appearance at the Board Meeting (2nd May 2008)

Dr. Forbes followed up her letter to the Board with a request to speak to the Board at its meeting of 2nd May. Because of the exceptional circumstances involved, particularly the transitions of responsibility between CEO and Acting CEO because of leave, and the interruption to Dr. Fiddes investigation because of his personal commitment to be away from the Coast for a time, Board Chair Rex Williams agreed to allow Dr. Forbes to present to the Board. He stressed to her that it was highly unusual for the Board to meet with a staff member, as its only employment relationship is with the CEO, stressed that she would have a short time to speak, told her that she must not raise any criticism of any particular staff member (either explicitly or implicitly) and asked that she provide a brief written note beforehand covering off her main points.

Dr. Forbes agreed to these conditions and met with the Board on 2nd May in its in committee section, having first provided several pages of hand-written notes. The Chair again expressed the ground rules.

Dr. Forbes spoke for several minutes, mostly in general terms, about her concerns, largely covering the same ground traversed in her letters, and referring to a couple of cases (without identifying detail) that she said illustrated the validity of her concerns. She then indicated that she thought it would be best for Board members to ask her questions. Members asked two questions, about the extent to which Dr. Forbes' colleagues endorsed her views, and what exactly she meant by her claim that the Patients' Code of Rights was routinely breached at Grey Base Hospital every day.

Dr. Forbes responded to the first question by commenting unfavourably on the suitability or qualification of many of her colleagues to express a view about the matters she had raised, but closed by indicating that the physicians and nursing staff supported her stance. I note, but did not point out to the Board at the time, that as far as I am aware this is not the case (in general at least), and indeed Dr. Forbes' concerns about patient safety are not supported by the surgical staff.

Dr. Forbes responded to the second question by giving three examples (again without identifying details) of patients for whom the booking process had not worked correctly: wrong date, delayed letter, procedure already done etc.

There being no further questions, Dr. Forbes left the meeting and the Board resolved to ask me to prepare a full report on the matters raised by Dr. Forbes, incorporating a report on the investigation undertaken by Dr. Fiddes. After the Board meeting I sent an email to Dr. Forbes expressing the Board's thanks for her speaking with them and communicating the Board's decision.

Dr. Forbes' Letter of 2nd May 2008 (Attached as Appendix 5)

On the evening of 2nd May, Dr. Forbes (who was clearly dissatisfied with her encounter with the Board) sent an unpleasantly worded email to Rex Williams and another letter to all Board members. This letter repeats much that had already been addressed in her earlier correspondence, and covers off the additional material that she had presented verbally to the Board.

Analysis of the letter follows:

"I have just returned from a most unsatisfactory meeting with you. I do not accept that "unusual circumstances' are responsible for the problems which I attempted to bring to your attention."

The only mention of "unusual circumstances" was by the Chair, as he carefully laid out why the Board would hear directly from a staff member at all.

"As I have been through all management channels to correct these problems without any resolution, I am forced to leave my position."

The only "management channel" Dr. Forbes has, in fact, used was the letter she delivered to me in January, and subsequent meeting with Dr. Robertson and Mr. Le Prou. As already stated, the most basic such channel is to comply with the DHB's policy regarding incident management. Dr. Forbes had not completed incident reports in relation to any of the issues she has been raising. She later began doing so, indicating that her lawyer had advised her to.

Dr. Forbes' employment intentions and obligations are being excluded from the scope of this report.

"However, in the interim, I want you to be informed that Grey Base Hospital cannot guarantee patient safety as most systems have been broken down."

This is a repeat of her rhetorical claim from March. In fact, rather than breaking down, patient safety systems are now being strengthened and enforced.

"The rosters are constantly changing with serious repercussions."

Dr. Forbes doesn't mention what the serious repercussions are, and no incidents have been reported concerning serious repercussions of roster changes. However, scrutiny of rosters, which are effectively set by the Heads of Department, including Dr. Forbes, reveals that the roster that is changing most is the anaesthetics roster, while others are pretty stable, enabling us to deliver greater notice and certainty to patients.

"The theatre is difficult to plan from one day to the next and general surgery is in free fall. Patients are often seen by the surgeon for the first time in the anaesthetic room just prior to surgery. This is unacceptable."

General surgery is not in free fall, but in fact is remarkably stable. For many years there have been issues on which the Anaesthetics and General Surgery departments at Grey Base Hospital have had different views, and these issues have not all been well resolved.

One of the current points of difference is the practice of pooling patients for some procedures, and Dr. Forbes' point here was covered in the investigation of her January claims. The practice of our General Surgery Department is in place in many DHBs and is considered to be standard and acceptable. If Dr. Forbes objects to it, then she needs to pursue her objection through the appropriate professional channels.

"The biggest debacle in terms of patient safety was a nearly overnight change from a waiting list department based in the operating theatre with medical supervision and constant communication, to a central booking office managed by information technology (IT) located at hospital reception without clinical supervision."

This matter is covered in the investigation of Dr. Forbes' March letter and Dr. Fiddes' subsequent report. I believe that evaluation of the pilot is likely to demonstrate that accuracy, and therefore patient safety has increased as a result of moving the Waiting Lists function to the CBU. In fact the "constant communication" referred to by Dr. Forbes resulted in the correct systems and processes sometimes not being used and distraction of staff, making errors more likely. There are some inaccuracies in this part of the letter concerning the CBU: it is not being managed by IT, it is not "at hospital reception" and it has good systems for providing clinical input when this is necessary (bearing in mind that the Waiting Lists function is essentially non-clinical).

[Text Withheld]

"Now one month later, patients are on the theatre list for the wrong procedure with the wrong anaesthetic. The patients receive appointment letters the day after their appointment. Patients are prepped for the wrong procedure."

Dr. Forbes has been invited to provide specific cases with identifying detail in relation to these claims and has been reminded of her responsibility concerning incident forms, but had done neither until mid-may, when she began to file incident forms. This makes these general claims virtually impossible to trace or investigate. These are precisely the types of problems that were occurring prior to the establishment of the CBU, and I am not aware of any incidents of these types occurring with bookings made since the CBU was established (though conscious that the past week has seen a sudden rash of incident forms, and some of these may relate to events subsequent to the CBU trial beginning).

Appendix 6 provides a summary of the claims made in Dr. Forbes' 2nd May letter, and indicates those for which incident reports have been made (and therefore investigations undertaken).

"A knee replacement has a letter for dental clearance."

No incident report has been made concerning this, and Dr. Forbes has not provided any identifying detail, despite requests. However, I understand that this incident did take place, and relates to a booking made by the old Waiting Lists office.

"A patient appeared on the list for a two hour procedure who had his procedure done six weeks ago in another hospital under contract with the West Coast DHB."

No incident report has been made concerning this, and Dr. Forbes has not provided any identifying detail, despite requests. The circumstances described do not enable us to readily identify the incident, verify it or investigate.

[Text Withheld]

"Two other management decisions made without any consultation with concerned departments or clinicians were:

1: No notes would be obtained from other West Coast DHB hospitals for clinic or operating theatre procedures. A few days later an elderly man turned up for a long awaited orthopaedic surgery. He had a recent admission to Christchurch Hospital directly from Reefton Hospital for cardiac intervention. As no notes were available this procedure was delayed for 2 hours in order to get the relevant medical details from Christchurch Hospital. This procedure could easily have been cancelled."

Although the need to obtain notes from the primary care centres at Reefton and Buller Health has been questioned, no decision to not obtain them has been made. Reefton and Buller health are not hospitals except insofar as they provide continuing care for older people in need of hospital-level care. Maintaining notes in multiple locations increases risk that errors will occur through duplication and gaps. The general principle that sits behind West Coast DHB's information systems strategy is to move to a single, electronic patient health record that is accessed as required by all staff involved in a patient's care. This will mean that the patient "notes" are identical in all locations where care is delivered. As West Coast DHB moves towards this goal, a sensible waypoint would be the consolidation of all paper records.

In relation to the example given, no incident report has been made concerning this, and Dr. Forbes has not provided any identifying detail, despite requests. The circumstances described do not enable us to readily identify the incident, verify it or investigate. Nonetheless, the bald account given by Dr. Forbes is enough to make clear that a single record would have avoided the problem. In any event a search of the iSOFT Patient Administration System would have disclosed the referral to Christchurch. The case does highlight a problem, which is that Reefton and Westport are sometimes still treated by others (in this case Christchurch Hospital) as secondary hospitals. It is necessary to ensure that all referrals for secondary or tertiary services off the Coast are made through and reported back to Grey Base Hospital.

"2: All elective caesarean sections would now go through the central booking office. Caesarean sections are only "elective" in that they can be booked within the week of the patient's delivery date. Previously when the surgeon decided the patient needed a c-section, he walked ten meters to the theatre based waiting list office and it was arranged and fixed in concrete. **[Text Witheld]**

Grey Base Hospital has 'acute/arranged' lists, which are now used for elective Caesarean sections. Previously the Obstetrics and Gynaecology theatre list was used, which meant that the list could not be booked until a week prior to accommodate Caesareans. Otherwise elective patients would have to be cancelled to make room. Clearly neither the high risk of cancellations nor having surgery planned only one week out is a satisfactory situation. By booking these procedures on the 'acute/arranged" list through the CBU, Grey Base Hospital is maximising the efficiency of lists.

The new procedure was developed with clinical input and I have asked Dr. Fiddes to provide separate comment to me on whether he considers any aspect of the new practice to be anything other than clinically appropriate.

In relation to the example given by Dr. Forbes, no incident report has been made concerning this, and Dr. Forbes has not provided any identifying detail, despite requests. The circumstances described do not enable us to readily identify the incident, verify it or investigate.

"With these distractions I find it very difficult to concentrate on my own job. Most of my time is spent fighting fires. In addition to working with an endless stream of locums surgeons and anaesthetists with unknown skill and experience, I am often the only New Zealand qualified doctor involved in the patients care and thus responsible for the outcome. I am frequently providing the continuity of care as surgeons chop and change often with little or no handover."

This account significantly exaggerates the situation. While Grey Base Hospital does make significant use of locums the fact is that West Coast DHB is now drawing these locums from a small pool of 'regulars', with consequently improved continuity and deeper understanding on their part of the environment in which they are working.

The only discipline in which West Coast DHB sometimes uses locums who do not have New Zealand vocational registration is Orthopaedics, where Pradu Dayaram has on rare occasions approved a locum without Vocational Registration for acute cover.

As for permanent staff, all of the DHB's physicians, three of our general Surgeons, our Orthopaedic surgeon and one of our O&G specialists have full New Zealand Vocational Registration. The one General Surgeon and one O&G who do not have full registration both have Provisional Vocational Registration and have completed their stints in other hospitals on their way to full registration.

Grey Base Hospital does make extensive use of locums in anaesthetics. These are mainly from the Durban anaesthetics practice with whom West Coast DHB has now been contracting for many years, and most are returning to the Coast for repeat placements with us. To claim that these doctors have unknown skills and experience is bizarre. Mainly they have worked here previously and, in any case, their applications to work here contain full details of skills and experience and are signed off by the Head of Department, Anaesthetics, who will typically supervise their practice while here.

The suggestion that Dr. Forbes is solely responsible for the outcome of patients' care either mis-states or misunderstands both her legal and her professional responsibility.

"It has been my privilege and pleasure to care for the people of the West Coast for the past 15 years-many of whom are my friends and neighbours. The community spirit and the physical beauty of the Coast should be a drawcard for attracting and retaining medical personnel. However the current working environment is untenable. The hospital does not meet the Health and Disabilities Service Consumers Rights, a copy of which I have enclosed."

Dr. Forbes has not indicated in what ways she believes that the Code is being breached, and the DHB would be interested to learn. In the past three years the DHB has been found by the Health and Disability Commissioner to be in breach of the Code on one occasion, when it was found that the DHB had, through delays, not facilitated the speedy resolution of a patient's complaint. It is possible that there were other breaches in previous years.

Conclusions

All of the concerns that have been raised by Dr. Forbes in her three letters of January 29th, March 28th and May 2nd, have been investigated to the extent that it is practicable to do so given the information that she has provided.

In all cases the claims she has made of compromised patient safety have proved to be groundless.

Dr. Forbes has focused particular attention on the trial of a Central Booking Unit, and this has received the greatest scrutiny in the investigation. The CBU was established because of significant concerns about accuracy and efficiency, and has been founded on principles that should improve both of these, and provide for better quality – and safer – services for patients.

While the implementation of the CBU was not ideal, the evidence to date is that it is working extremely well. Next month's evaluation process will enable us to know for sure, and future decisions will be based on that evidence.

In the meantime, the letter Dr. Forbes sent the Board on 2nd May has unfortunately been provided to the news media and she has given a number of interviews with news media about it and about the issues she is concerned with. Both the letter and her subsequent comments have received extensive coverage.

A consequence of this is that many members of the West Coast public are likely to now be concerned about the safety and quality of local health services. Another consequence is that many staff feel – correctly that the quality of the work they do or service they provide has been unfairly maligned.

The DHB needs to be able to move to absolutely reassure people that the services that it provides are safe, and to clearly and publicly vindicate Hospital staff in the wake of these criticisms. To this ed the DHB approached the Ministry of Health on Tuesday 6th May with a suggestion for an external review of the way in which Dr. Forbes' concerns had been handled by the DHB. The Ministry agreed to this suggestion on 12th May and Dr. David Galler was assigned, with the DHB's consent to undertake this work. The Terms of reference are appended as Appendix 7.

Appendix 1: Dr. Forbes Letter of 29th January

Not included in this version as content is referred to in text

Appendix 2: Establishment of the Central Booking Unit

Ongoing data entry and quality issues forced a rethink about how the outpatient and inpatient booking process works.

Despite several attempts to refocus systems to improve quality, issues continue. Key problems included:

- The generally poor quality of data entry in the DHB
- Not complying with Ministry of Health guidelines in relation to prioritisation of referrals
- Issues with the Ministry caused by data quality
- Difficulties in providing leave cover with two separate units of two people
- Communication issues between the staff responsible for rostering, waiting lists, theatre and clinicians resulting in an inefficient use of available clinics and theatre sessions and failure to develop a theatre schedule and coordinated roster for surgery and outpatient appointments to be booked sufficiently in advance.
- The current timeframe for booking clinics and theatre of two-three weeks ahead needs to be increased
- The impending physical split of Outpatients (OPD) from the Emergency Department
- OPD staff being distracted by also being responsible for some public contact functions;
- Waiting list staff being distracted by clinical staff (with sometimes conflicting instructions);
- Manual systems in both places being used instead of the DHB's electronic systems for some things, with some confusion between systems;

Previously, the outpatients booking was undertaken by two staff located at outpatient/emergency department reception at Grey Base, with data entry also undertaken by staff at Westport, Hokitika and Reefton as part of their duties. Inpatient booking was undertaken by two staff located in the theatre reception area. The reporting line for both inpatient and outpatient staff was to the Clinical Nurse Manager Theatre & OPD. Peripheral location staff reported to the respective managers of those locations.

The proposal was to centralise all booking functions at Grey Base, creating a Centralised Booking Unit to undertake outpatient and inpatient booking functions. The proposed staff numbers are 4, effectively the existing FTE at Grey Base Hospital.

The key changes to existing processes that occurred with the formation of the new unit were:

- The functions were centralised into one unit
- Each team member looks after one aspect of the process for all specialties
- Team members will rotate monthly, learning the entire process
- Other administration staff in the hospital will train in one aspect of the process
- Better control of processes through audits and quality management
- No dealing with the public face to face
- Move to a semi-paperless system by scanning documents into Healthviews and using the electronic records rather than the current manual, paper based system
- Better placed to ensure compliance with MoH guidelines

There is also some work that is planned to properly map the booking processes using the patient journey principles in order to streamline and improve them.

All of these will contribute to a marked improvement in data quality.

Issues precipitating urgent action

In February a new staff member, discovered over 400 patients had been logged onto the outpatient booking system without any further care being recorded. Effectively they appeared to have been lost to the system. This was investigated urgently and the number for which no explanation could be found was reduced to 150. Explanations for the missing journeys include:

- Loading the same patient twice. Once when a fax arrived and once when the hardcopy of the fax arrived.
- Priority was assigned by the medical staff but this was not loaded.
- The patient was seen in a clinic but the detail of this was entered to another initial loading entry of the same patient.
- The initial request was loaded against the wrong specialty
- Requests for appointments were declined and the initial loading information was not withdrawn.

In the original surgical waiting list office there were a number of matters giving rise to concerns as to efficiency. For example, a number of dictated tapes were found. At least some of these had not been actioned. There appeared to be no log of patient calls.

Rather than just frustration and inconvenience, some of these errors appeared to have the capacity to actually risk patient safety.

Also cause for concern was the implication this might have for elective services reporting (and income).

Management reached the conclusion that the CBU needed to be implemented without delay, in the interest of patient safety and consequences of inefficiency. As the decision to implement had effectively been made it would have been disingenuous to engage in a consultation exercise at this point.

Certainly some staff have indicated unhappiness with the process and speed of implementation. In retrospect I do believe it should have been possible to do more to explain to staff the reasons for the changes and for the urgency of our actions.

Implementation was not made easier by sick leave of some key staff, and delays in organising communications and IT for the new CBU. In his report, Dr. Fiddes indicates that the hostility of some staff to the new unit that had been established with minimal consultation could have posed a risk to patient safety, but this risk was averted by the hard work of the CBU staff.

Pilot programme

While the DHB believes that significant improvements to patient safety, service quality and efficiency will result from the CBU, West Coast DHB cannot be sure of this, and so have identified the new unit as a pilot.

This pilot commenced as of 25 March 2008 and will be in place for a period of three months, ending on 27 June 2008. While the pilot is running, the CBU is based in the former IT training room adjacent to the main reception area.

After two months of the pilot, a review of the CBU will be commenced (with both formative and summative components) to assess the success or otherwise of the CBU. The review process will include discussions with the team involved in the project both as individuals and as a team so that the DHB can obtain as much constructive feedback as possible. There will also be a need to obtain feedback from other key stakeholders involved in the pilot. This process will assess the soft data available for the project.

The criteria used to asses whether the project has been successful in terms of hard data will include:

- Has data quality improved (as evidenced by daily audits)?
- Are communication lines between key staff groups more robust?
- Are the number of errors in data extracts sent to the Ministry of Health reducing?
- Are all outpatient clinics and theatre sessions being fully utilised?
- Has the timeframe for booking clinics and theatre been increased?

The review will be conducted by Mr Terry Mixter (Head of Surgery), Peter Watson (Acting Clinical Nurse Manager Theatre), Sophie Jaine (Elective Services Co-ordinator) and Chris Le Prou, General Manager, Secondary Health Services. The review report will make recommendations for the ongoing structure for the waiting list functions.

If the report makes recommendations that may have permanent impacts on positions and staffing then there will need to be a Management of Change process undertaken. If a Management of Change process does occur then there will need to be a consultation period of at least 2-4 weeks before any changes can occur and unions would also need to be informed as required.

Appendix 3: Judy Forbes' Letter to Board 28th March 2008

Not included here as content has all been referred to in text

Appendix 4: Dr. Fiddes' Report on Dr. Forbes' 28th March concerns

Draft Review of "Expressions of Concern about Patient Safety" in letter from Dr. Forbes to the West Coast DHB, 28th March 2008

Report prepared for West Coast DHB CEO
Dr. Tom Fiddes, Acting Medical Director
28 April 2008

Introduction
I have completed my review of Dr. Forbes' complaint (28th March 2008) to the Board Chair. In the course of this I have interviewed Bernie Olsen, Chris Le Prou, Edie Nimmo, Elaine Topp, Gayle Davidson, Judy Forbes, Lonnie McAllister, Rochelle Wilson Bruce, Sofie Jaine, Susie Newton , Peter Watson, Alice William. and have received some patient detail from Elaine Topp and Bernie Olsen.

The Complaint
Dr. Forbes' complaint principally concerned changes made to the systems for surgical waiting lists and booking, which she asserts have created risks to patient safety. She also alluded to concerns she had raised earlier.

Surgical waiting lists
Problems with surgical waiting lists were long-standing and continued despite the General Manager's attempts to provide help for the two staff responsible for the service. This continuing problem in turn generated Dr. Forbes further concern and led to her letter to the Board Chair (28th March 2008).

In addition in February a new staff member, discovered over 400 to 500 patients had been logged onto the outpatient booking system that did not have any further patient journey information. Effectively they appeared to have been lost to the system and had not received any care. This was investigated and the number for which no explanation could be found was reduced to 150. Explanations for the missing journeys include:

- Loading the same patient twice. Once when a fax arrived and once when the hardcopy of the fax arrived.
- Priority was assigned by the medical staff but this was not loaded.
- The patient was seen in a clinic but the detail of this was entered to another initial loading entry of the same patient.
- The initial request was loaded against the wrong specialty
- Requests for appointments were declined and the initial loading information was not withdrawn.

Management were concerned for the patient safety issues raised, and concerned about the Ministry of Health reporting implications and the financial consequences of patients receiving treatment but not appearing in the data forwarded to the Ministry.

Management also had concerns about the utilisation of outpatient clinics.
Coincident with the above events unfolding, management had had an increasing frustration at not being able to evolve a system that booked patients for surgery two months in advance.

In the original surgical waiting list office there were indications of some disorganisation that led to concern about proper adherence to the DHB's policies and procedures.

A decision was made by management to combine the two booking systems and locate them on the ground floor. In my view this was a good management decision. It provided a quieter atmosphere for the data entry, it provided an opportunity for staff rostering efficiencies and provided a setting where new attitudes around the data entry could be developed.

Its implementation was flawed. The physical relocation was carried out with the minimum of consultation, the existing staff were not brought on board and this led to staff distress and extensive stress leave being taken. To add insult to injury the original theatre based surgical booking office was redesignated as an IT training area.

The absence of the two data entry operators has meant other staff with limited clinical backgrounds have had to continue the service. They in turn have had to ask clinical staff for information. Many of the clinical staff disapproved of the way in which the initiative was implemented and this led to an awkward dynamic. A number of protocols have needed development to keep the system running.

This implementation (as opposed to the initiative itself) had the potential to compromise patient safety (had clinical staff not been prepared to support the CBU) but this has been avoided by the work of management and staff working in the Central Booking Office, who have had to work excessive hours to provide a safe service. Their work ethic is to be commended. Clinical staff have also had to be more vigilant as their confidence in the system was eroded.

There have been further data entry problems discovered in the inpatient data base and these have come to light as the new unit has evolved.

It emphasised for me the care needed around managing change. A good initiative can be compromised by poor change management.

Dr. Forbes' other concerns

Dr. Forbes' complaint speaks of "collapse of systems that guarantee patient safety" In addition to her concerns about surgical waiting lists this refers to other issues raised in January 2008:

- RMO shortages threatening surgical services
- No medical cover in A&E on several occasions since Christmas
- Disorganised General Surgery
- Shambolic operating theatre rosters

Following a meeting (12th February) of Dr. Forbes with the Medical Director, Dr. Vicki Robertson, and GM Secondary Health Services, Chris Le Prou, agreement was reached on the organisation of the anaesthetic and surgical rosters.

The assertions of disorganised general surgery related to the management of breast cancer, and pooling of surgical waiting lists together with processes around booking patients for surgery. These were resolved and agreement was reached on how to move forward on these issues.

Some concern was expressed around same day endoscopic services. This is a good initiative and the concerns reflect in part the need for attitude shifts and lack of attention to some preoperative detail. With goodwill this should not be a continuing issue.

In my opinion these other concerns have been addressed to a point where patient safety is not compromised. West Coast DHB operate in times of national shortages that impact on some of the above concerns.

Conclusions / recommendations

- The new booking unit (currently partially developed) does not compromise patient safety.
- The decision to combine the two booking systems into a single unit located separately was a good one.
- It will be important to manage the interface between the frontline clinical staff and the data entry team. Consideration needs to be given to the background of the person who manages this unit. Clinical staff will have reservations about someone with an IT background occupying this role. Management may well have reservations about a clinical oversight. Getting this particular appointment right could defuse some of the antagonism which is hindering the development of the unit.
- The final development of the unit involves the integration of the outpatient booking waiting list into the unit. This will require careful management to avoid a repetition of staff distress.
- Review the current planned area for the new unit and ensure it is big enough for the number of staff employed in it. Ensure the planned photocopier site passes OSH requirements
- Give consideration to a more surgical use of the original surgical booking office.
- Consideration should be given to mending the divisions this change has created. Some further far reaching restructuring is in the advanced planning stage, and could be derailed if this discontent is not managed. There has been a considerable head of steam developed over the handling of the waiting lists and if this is not defused it will break out in other areas.
- The training of the various data entry staff in the previous locations was deficient and this needs to improve in the future. Poor data entry can and did go undetected for many months. At best this is an inconvenience to all concerned but at worst it will compromise patient safety.
- It is important to track down the remainder of the missing patient journeys to ensure patient safety has not been compromised.
- It would be prudent to implement audits which would detect poor data entry. They should have been in place at the time of the iSOFT implementation. I imagine these could be semi automated
- Outputs that will allow a formal evaluation of the pilot unit need to be developed and disseminated.
- Staff involved in operating the Central Booking Office need to be formally thanked for the work they have put into this area.

Dr. Tom Fiddes
Acting Medical Director
WEST COAST DHB

Appendix 5: Dr. Forbes Letter to the Board of 2nd May 2008

Not included here as content has all been referred to in text

Appendix 6: Incidents Reported Against Dr. Forbes Claims in 2nd May Letter

Incident	Form Completed	Current Status	Outcome
Patients seen by the surgeon for the first time in the anaesthetic room just prior to surgery	Yes	Closed	Discussed with Surgeon concerned – happy with his current practice
Overnight change from a waiting list department based in the operating theatre with medical supervision and constant communication, to a central booking office managed by information technology (IT) located at hospital reception without clinical supervision	No	N/a	N/a
Patients are on the theatre list for the wrong procedure with the wrong anaesthetic	No	N/a	N/a
The patients receive appointment letters the day after their appointment	No	N/a	N/a
Patients are prepped for the wrong procedure	No	N/a	N/a
No notes obtained from other West Coast DHB hospitals for clinic or operating theatre procedures	No	N/a	N/a
All elective caesarean sections now go through the central booking office	No	N/a	N/a
Theatre rosters constantly changing	No	N/a	N/a
An elderly woman was apparently 'lost in the system" after admission for an incarcerated hernia. She was sent home for a day or two awaiting equipment from Christchurch. One month later she presented to the booking office as she still had no appointment.	Yes	Closed	Patient was discharged from Ward without having operation due to equipment shortage, but no appointment was made for her on subsequent list
A patient appeared on the list for a two-hour procedure who had his procedure done six weeks	No	N/a	N/a

ago in another hospital under contract with the West Coast DHB.			
A patient was given the wrong medical advice by IT staff to stop medications without clinical consultation	No	N/a	N/a

Appendix 7: Terms of Reference for Dr. Galler's Report

Not included here as included in Dr. Galler's report.