CANTERBURY HEALTH LIMITED

A Report
by the
Health and Disability Commissioner
April 1998

This is the report of my investigation into Canterbury Health Limited. The focus for this Report and my statutory role is the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumers' Rights.

This Report consists of the following sections:

n	Title	Description
1.	The Commissioner's Opinion	My Opinion on breaches of the Code by Canterbury Health.
2.	The Commissioner's Comments on Other Agencies	Comments on the role and functions of other agencies who influenced the outcomes at Canterbury Health.
3.	Recommendations	Recommendations and suggestions to Canterbury Health and various other parties.
4.	The Investigation Process	The process I followed in carrying out the investigation.
5.	General Environment	A summary information and facts gathered during the investigation about the general environment in which Canterbury Health provided services. My opinion and comments on these matters are included in section 1 and 2.
6.	Patient Deaths, Complaints and Other Issues	Information in relation to the deaths subject to Coroner's Reports during the course of the investigation, issues raised by consumers and the complaints procedure at Canterbury Health. My opinion and comments on these matters are included in section 1 and 2.
7.	Management and Clinical Issues	A summary of the information and facts gathered during the investigation about management and clinical issues. My opinion and comments on these matters are included in section 1 and 2.
Appendix A	Section 67 Responses	Extracts of responses to adverse comments by parties.
Appendix B	The Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996	Code of Health and Disability Services Consumers' Rights

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SECTION 2 - COMMISSIONER'S COMMENTS ON OTHER AGENCIES

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FOREWORD

In my opinion certain actions of Canterbury Health Limited were in breach of the Code of Health and Disability Services Consumers' Rights. The first section of this report gives the reasons I have formed the opinion that Canterbury Health was in breach of Right 1(2), Right 4(1), Right 4(2), Right 4(5) and Right 10 of the Code. In order to understand fully the environment and complex issues involved in the events at Christchurch Hospital, it is important to read this entire document.

The focus of my investigation was on health consumers in Canterbury and on the right to receive services which met the obligations imposed by the Code. The events that occurred at Canterbury Health from the beginning of 1993 to the end of 1996 were exceedingly complex. The various parties involved in the fierce debate in Christchurch all had good intentions and made many claims and counterclaims regarding safety, communication and quality of service. However this did not engender confidence in the Hospital for the public at large who had little say or understanding of the issues. I expect there will always be different interpretations of the events by the parties involved. This Report, which includes the background information and facts, as well as my opinion and comments, should serve to clarify for the parties and the public the significant matters which were in dispute.

In July 1993, the Health and Disability Services Act became law. It was seen as a means to improve efficiency, reduce costs and establish lines of accountability in the health and disability sector in line with a commercial model. From 1993 to 1996 there was a strong focus in the sector on competition and a lack of disclosure. The environment changed in late 1996, with the emphasis shifting to co-operation and transparent processes. This change occurred within Canterbury Health as well as in the sector generally.

In the interest of consumers, the delivery of quality health and disability services to the public of New Zealand must include a number of key objectives:

- A prime focus at all times on the consumer
- Co-operation between various agencies and providers
- Openness and clarity in communication
- Effective decision-making
- Specified standards
- A reduction in duplication of legislation to reduce wastage of health funds
- Effective and efficient services
- Documented policies and procedures
- Clearly defined responsibilities so that the public know whom to hold to account.

The increased focus on co-operation must not be at the expense of cost effective services, clearly defined accountability and appropriate information to the public. For example, if consumers are to be able to judge the effectiveness and quality of Crown Health Enterprises, the historic emphasis on financial performance compared with financial budgets is not enough. Financial information is meaningless without relevant data on the services produced for those dollars and relative comparison to other Crown Health Enterprises and to standards. With access to full information consumers will be able to hold accountable our public healthcare providers as well as the funding and policy agencies.

During 1997 Canterbury Health made significant changes to improve its quality of service. While the past and the lessons learnt from it should not be forgotten, the tensions which have characterised relationships within Christchurch Hospital must now be put aside. It is time for all to work co-operatively in the interests of providing good service to the people of Canterbury. The same message applies throughout New Zealand.

RIGHT 4(1)

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

Canterbury Health has a responsibility under Right 4(1) of the Code to provide services with reasonable care and skill and failed to do so in the period under investigation in relation to:

(a) its Emergency Department;

(b) the use of the Medical Day Unit;

(c) the management of outliers; and

(d) not implementing recommendations from senior clinical staff.

Emergency Department

In my opinion Canterbury Health failed to provide services with reasonable care and skill in the Emergency Department of Christchurch Hospital and was therefore in breach of Right 4(1).

Canterbury Health did not provide its Emergency Department in 1996 with sufficient resources in terms of space or equipment to enable services to be provided with reasonable care and skill. However, more significant were the shortages of medical and nursing staff to ensure the safety of the patients. The work practices adopted by the Department were made necessary by the shortage of staff, space and equipment. These work practices placed hospital staff in other departments under conditions of "overload", causing patients in other areas to also be put at risk. (This is discussed under Right 4(2).) The standard of care was far below that set by the Australasian College for Emergency Medicine guidelines and less than that required to meet standards generally accepted, resulting in a failure to provide services with reasonable care and skill. Because of inadequate staffing the Emergency Department operated in an unsafe fashion, despite the efforts of the medical, nursing and other staff.

In the absence of relevant standards established by Canterbury Health Limited or Southern Regional Health Authority I decided it was appropriate that Canterbury Health's actions be measured against the prevailing Australasian guidelines for Accident and Emergency Departments set by the Australasian College for Emergency Medicine.

The Christchurch Hospital management were informed about the Australasian College for Emergency Medicine guidelines in May 1996. The College's guidelines were used by a clinician at Christchurch Hospital in a communication to a Service Manager, to calculate that a staff of 27.75 doctors was required in the Emergency Department, compared with 18 doctors employed at that time. At April 1997, there were only 19.65 full time equivalents (FTE) employed in the Emergency Department.

The College's current minimum figure for nursing staff is less precise being around one FTE per 1000 attendances per annum. The College notes that nurse staffing ratios vary widely within Australia, from one full time equivalent (FTE) per 300 attendances per annum to one FTE per 900 attendances per annum.

There were 42.5 FTE nursing staff in the Christchurch Hospital Emergency Department in August 1996 which equates to one FTE per 1,529 attendances per annum. After the 1997 increase of 22 nursing staff, this figure improved to one FTE per 1007 attendances per annum. However, this does not take into account the fact that 13 of the recently employed 22 extra nurses were allocated to the Emergency Observation Area. The Australian figures specifically exclude such allocations. Subtracting these nurses increases the figure to one FTE per 1,262 attendances per annum. All these figures are in excess of the number of patients per nurse of the lowest standard in Australian hospitals and compare with one FTE per 581 attendances per annum at Auckland Healthcare.

The levels of professional experience of staff in the Emergency Department also failed to meet the Australasian College for Emergency Medicine guidelines. While the house surgeons in the Emergency Department were slightly more senior than in other departments, it was not possible to provide services of a reasonable standard while depending on house surgeons who were not properly supervised to provide critical care. The Emergency Department requested additional staff in memoranda and requests were evidenced in minutes of meetings. The acute surgical house surgeons felt so strongly that they could not guarantee the safety of their patients that they wrote to the General Manager Christchurch Hospital Services to protest. However, the safety issues resulting from lack of adequate staffing were not acted on until late 1996 and implemented in 1997. The warnings of experienced medical professionals working in the Emergency Department should have been listened to. They were the surest and earliest signals that all was not well.

In 1997 changes to the facility, level of equipment and numbers of staff in the Emergency Department have improved the standard of care. However, at May 1997 staffing was still below the guidelines of the Australasian College for Emergency Medicine and lower than those at Auckland Healthcare. As such, staffing was insufficient to ensure that services would always be able to meet the standards. I recognise the efforts which took place through 1997. Changes required could not occur quickly and will continue to require review, which Canterbury Health assures me is occurring. Appendix A lists Canterbury Health's response in terms of initiatives since 1997.

I considered whether the actions of Canterbury Health were reasonable in the circumstances, owing to resource constraints. I saw no evidence that Canterbury Health requested the additional resources needed to improve the standards within the Emergency Department. While Canterbury Health requested and received (following notices to Southern Regional Health Authority of intended exit from Emergency Service) increased revenue to pay for emergency services, this income was necessary to meet the existing costs of running the service. In other words, in its application for funding for 1995/97, Canterbury Health received the price it requested for emergency services and this was insufficient to meet its obligations under the Code.

The deaths of Mr Fonoti, Mr Gardiner and Mrs Malcolm illustrate the inadequacy of the standard of care which continued after 1 July 1996 in the Emergency Department. No individual medical or nursing staff can be held personally responsible for these deaths.

Mr Fonoti

In my opinion Canterbury Health's failure to provide an adequate number of senior staff in the Emergency Department and general wards was a breach of Mr Fonoti's right to have services provided with reasonable care and skill.

The number and skill mix of staff in the Emergency Department on the evening of Saturday 25 October 1996 were deficient and available staff were unable to provide adequate medical care for a large number of seriously ill patients. There was only one house surgeon and one registrar on duty. Mr Fonoti was not seen by a doctor more senior than a house surgeon from the time he was admitted at 0240 hours until the registrar saw him on the ward at 0600 hours. By then his condition had deteriorated to a serious level.

While the triage category of 3 was appropriate in the circumstances, in a properly functioning Emergency Department the triage nurse would have had a hand-over from the ambulance officers and read the ambulance notes. If the ambulance officers' notes of Mr Fonoti's score of 15 on the Glasgow Coma Scale (GCS) had been recorded as part of the original assessment, all subsequent examinations and assessments would have been better informed. The number of nurses in the department was insufficient. Consequently the time available for the triage nurse was also insufficient to provide an appropriate level of assessment.

It is not always necessary to admit a patient with uncomplicated head injuries, but, if admitted, such a patient should be placed in an area where experienced nurses can make regular observations. If a policy of observation rather than early Computerised Tomography (CT) scanning is employed, which was the case at Christchurch Hospital, then the observation must be excellent and a CT scan must be available at short notice.

At the time of Mr Fonoti's death, the Medical Day Unit, which was adjacent to the Emergency Department, was being used as a de facto admitting ward. As a result, there were no beds available for a patient such as Mr Fonoti who ideally should have been placed there. In addition, the lack of medical and nursing staff in the Emergency Department resulted in the Department's inability to care for Mr Fonoti. Mr Fonoti's placement in a urology ward was inappropriate.

It is also important to recognise the cultural issues in this case. Mrs Fonoti's reaction to staff in response to her husband's unusual behaviour was not uncommon for a person from a Samoan culture. She felt embarrassed and made excuses for his behaviour. Had staff had the time to ask Mrs Fonoti she may have informed them that her husband's behaviour was very unusual and that she also could not understand him as he did not appear to be speaking either English or Samoan. In this situation an interpreter would not have assisted. While the Coroner recommended that access to the interpreter services be examined, Mrs Fonoti has good English skills and would have been able to communicate effectively with staff had there been sufficient staff available. Mr and Mrs Fonoti's pastor and his wife were with Mr Fonoti for an hour and advised that during this time Mr Fonoti was asleep and no-one at any time attended to him.

The house surgeon on duty in the Emergency Department that night had no-one with whom to consult or discuss problems. She had no time to see Mr Fonoti again and was not alerted to the fact that the ambulance officers' assessment of the Glasgow Coma Scale was 15 as it was not recorded by the triage nurse. She was unaware that during her examination Mr Fonoti was in a "lucid interval" following which he never again regained consciousness.

Mrs Fonoti gave a graphic and tragic picture of the deterioration of her husband's condition. If staffing had been appropriate on 25 October 1996, someone may have had the time to listen to Mrs Fonoti and to observe Mr Fonoti, leading to an earlier diagnosis of his true condition.

Careful and continuous monitoring and observation of Mr Fonoti may have resulted in an earlier response to his drop in GCS rating. My Emergency Department expert noted "*the drop in GCS score is the cardinal sign of trouble, and should always be the cause of skilled re-evaluation, CT scanning and review by a neurosurgeon*".

Mr Gardiner

In my opinion Canterbury Health failed to provide services of reasonable care and skill to Mr Brian Gardiner as a result of the inadequate number of sufficiently experienced qualified staff on duty. The practice of sending seriously ill patients to the wards without being assessed by a doctor in the Emergency Department was dangerous.

Due to the lack of senior medical staff, junior medical staff were inadequately supervised. My Emergency Department expert criticised the responsibility given to the house surgeon on duty that evening in the Emergency Department, and the responsibility given to a trainee intern on Ward 15. "*The judgement of the need for a blood transfusion is a matter of skill and experience, and such judgement should not be left to junior staff, still less to a medical student*". The assessment for the need for a blood transfusion was made by a surgical registrar who had the necessary skill and experience to make this judgement nearly four hours after Mr Gardiner's admission.

Due to inadequate bed numbers in the Emergency Department, patients like Mr Gardiner, who were referred by a general practitioner, were transferred to wards without assessment. Because of the lack of training and appropriate inter-department systems, blood samples were not always collected from the wards in a timely manner. The Coroner referred to the lack of defined protocols as a factor contributing to Mr Gardiner's death.

In addition to the absence of defined protocols, the lack of sufficient medical staff in both the Emergency Department and the surgical ward meant Canterbury Health was unable to provide services with reasonable care and skill. This resulted in Mr Gardiner not being assessed by a senior doctor until 2330 hrs, which was nearly 4 hours after his admission to the Emergency Department.

Mrs Malcolm

The failure to give Mrs Malcolm a higher triage category in June 1996 to indicate that her condition was in need of careful observation illustrates that services were not provided with reasonable care and skill. Further, a more thorough consideration of Mrs Malcolm's medical history and symptoms may have alerted staff to the fact she was suffering from cardiac failure. Such consideration was not possible due to the shortage of staff in the Emergency Department at the time of Mrs Malcolm's admission.

Medical Day Unit

In my opinion, the use of the Medical Day Unit as a de facto acute admitting ward until April 1997 resulted in sub-standard care. Consumers who spent time in the Medical Day Unit were

inadequately supervised. I accept the advice of one of my experts that "*the use of the Medical Day Unit as a de facto admitting ward was a dangerous practice*".

At the end of each day, if there were no beds available in the hospital and there were patients in the Medical Day Unit requiring care, the Duty Manager determined which staff might be available to care for patients in the unit overnight. There were only four beds available in the Medical Day Unit. Additional patients had to remain on trolleys and could sometimes lie on these trolleys for over 24 hours. At times the Medical Day Unit was very overcrowded. There was little room for medical staff to move around the trolleys to attend to patients and there could be an inappropriate mix of cases in the unit at any one time. This situation increased the potential for cross-infection.

The lack of reasonable care and skill caused by the de facto use of the Medical Day Unit as an admitting ward from 1 July 1996 is illustrated by the circumstances surrounding the deaths of Ms Garnett and Mrs Malcolm which occurred in June 1996.

Mrs Malcolm

In Mrs Malcolm's case the registrar relied on the casual nurses in the Medical Day Unit to provide a warning should the condition of Mrs Malcolm cause concern. No senior nurse was supervising the Medical Day Unit. In my opinion the inappropriate levels of staff, both in terms of numbers and qualification, demonstrate that the standard of care in the Medical Day Unit was below the standard to be expected of an Emergency Department.

Ms Garnett

The death of Ms Garnett who was nursed in an inappropriate location with inappropriate resources illustrates the inadequacy of the practices. Facilities in the Medical Day Unit, particularly in the evenings, could not provide the standard of care expected for a patient such as Ms Garnett who would have been more appropriately placed in the Intensive Care Unit.

1997 Changes

On 24 April 1997 the Medical Day Unit was replaced with a 12 bed (increased to 18 beds in June 1997) Emergency Observation Area (EOA) under the direct responsibility of the Emergency Department. The Emergency Observation Area is staffed with specialised experienced nurses. Canterbury Health responded that this measure, combined with the rule that patients are not to leave the Emergency Department without being seen by an Emergency Department doctor, should prevent the types of problems that arose in the winter of 1996. Three senior clinicians prepared a report to Canterbury Health on the success of the new Emergency Observation Area (EOA) arrangement during the winter of 1997. It states that:

"….the five months statistics demonstrates some of the benefits of an acute assessment area. There were 3,046 total admissions under Emergency Department, General Medicine, Respiratory and Cardiology. 986 (32%) were discharged without requiring admission and 69 (2%) were directly transferred to off site facilities."

Outliers

An outlier is a patient who is placed on a ward other than a "home ward" (a ward with specialised knowledge relevant to the patient's condition). From time to time there are outliers in every hospital due to short term constraints. In winter 1996, Canterbury Health ran an acute admitting system where patients were placed in two acute admitting wards which received both medical and surgical patients. When the two acute admitting wards were full, large numbers of outliers were dispersed throughout Christchurch Hospital and clinicians had patients on up to 15 wards.

The Clinical Director of the Emergency Department had no choice but to transfer patients from the Emergency Department as quickly as was possible, to deal with the numbers of patients presenting to her department. When the acute admitting wards were full, and the Medical Day Unit had no more space, acutely ill patients were dispersed throughout the hospital to wards which may not have had the specialist knowledge relevant to their conditions. This particular situation had been foreseen by clinicians. In a "Think Tank" meeting in November 1995, it was noted by a senior clinician that the increase in admissions during the 1995 winter, combined with the problems associated with having insufficient bed numbers and patients scattered across wards, was affecting the quality of care provided.

There were many examples of patients being placed in inappropriate wards during the period under investigation and such placement often compromised patient safety. For example, nurses did not always recognise the significance of changes in their patients' condition, results and reports were sent to the wrong places, doctors could not "find" their patients, ward rounds took longer to complete due to the number of wards being visited and discharge planning was hindered.

Canterbury Health now accepts that the outliers situation in 1996 was undesirable and not conducive to efficient or effective patient care. A home ward system was re-established at Christchurch Hospital in 1997. Patients are therefore transferred to specific wards allocated to medical teams and there are no longer designated "acute admitting wards" that admit all acute patients, no matter what their diagnosis. However, in July 1997 the General Manager Christchurch Hospital Services informed me that the Department of Cardiology "*presently have their patients in 12 different wards*".

In response to this opinion, Canterbury Health noted that in October 1997 the Chief Executive received an account of the preparation for and execution of the delivery of services during winter 1997 showing the problem had been significantly reduced. It reported that the home based ward system (reintroduced in 1997):

> *"... has been a success and flexing General Medical beds between 100 in summer and a [sic] 150 in winter by closing beds in each ward rather than completely closing at least 1.5 wards has meant that for most of the winter the General Medical teams have had their patients concentrated in one or two ward areas. In addition, medical and nursing staff have been able to develop a team approach, which is of mutual benefit as well as contributing to safer patient care. Overflows have been held to a minimum and were much lower than in 1996. General Medical patients admitted into surgical wards numbered 233 in the 5 winter months of 1996 compared with 89 in 1997."*

The report concluded that:

- *"The management of the winter rise in acute admissions in 1997 was much more effective than in previous years in part due to the closer involvement of clinical staff.*

- *More admissions were avoided (EOA), acutely ill medical patients were less often sent to wards during the night (EOA), the Home Base Ward System combined with increased medical beds for the winter meant that overflows were greatly reduced in 1997. The average length of stay was held constant by all the previous factors as well as by increased transfer to off site facilities (Burwood Respiratory Unit and Geriatrics at PMH).*

- *All these changes have made it easier for the medical and nursing teams to care for their patients more efficiently. This has led to improved staff morale and improved quality of care for these acutely ill medical patients."*

Recommendations not Implemented

A number of recommendations were made by senior clinical staff after the 1995 winter which addressed some of the problems Canterbury Health encountered during that period. These included recommendations as a result of the post think tank meetings covering pre-admission, admitting process, inpatients and the discharge process. However, following the announcement of the restructure in August 1995, few of the recommendations were implemented and no information has been provided which explains this inaction. Without the recommended improvements and with the additional pressures in 1996, (which included factors outside Canterbury Health's control such as a flu epidemic, inadequate discharge pathways, and the unavailability of beds at The Princess Margaret Hospital), the services provided by the Emergency Department of Christchurch Hospital in winter 1996 did not meet the required standard of reasonable care and skill. Canterbury Health focused on accessing additional beds from Healthlink South (which would have assisted with the winter load problems) and placed little emphasis on the internal remedies available to manage the winter acute workload.

While undertaking this investigation, I saw many of the papers considered by the Board and the communications between the Board, senior management and Government agencies. This material focused predominantly on issues of efficiency, funding and financial performance. It is not evident from the papers I sighted that the issue of the adequacy of patient care was appropriately considered. While quality indicators, clinical issues and medico legal matters were dealt with by the Board at meetings, reference was rarely made to standards.

Summary

In 1996 the Emergency Department did not function adequately in its role as gatekeeper for the hospital. The inadequate staffing and insufficient observation in the Emergency Department, in combination with the medical/surgical acute admitting wards, the reduction in medical bed numbers, and the wide dispersion of medical patients around various surgical and medical wards, led to a situation where staff and support services were unable to cope.

From 1997 increased resources have been put into the Emergency Department and there has been restructuring of admittance and wards. I recognise the current status and hope this leads to real improvement. I note this was undertaken without additional funding from the Health Funding Authority.

RIGHT 4(5)

RIGHT 4
Right to Services of an Appropriate Standard

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Providers have a responsibility under Right 4(5) of the Code to co-operate with each other so as to ensure quality and continuity of care for consumers. In my opinion co-operation between Canterbury Health and its staff broke down at Christchurch Hospital during 1995 and 1996, affecting the care that consumers received. Poor management, including management of change, was a major factor causing a breach of this Right by Canterbury Health. It led to low morale, distrust and poor communication. As a result, control processes stopped functioning and recommendations, which could have improved the standard of care for consumers, were not implemented.

Background Issues to Management and Communication

The style of management at Canterbury Health from March 1995 and during 1996 created an environment of distrust leading to inappropriate standards of care. The lack of clinical involvement in high level policy planning and decision making was a major cause of the breakdown in clinical/management relations. Insufficient and inappropriate communication between management and staff resulted in failure to implement solutions identified by health professional staff.

As a result of this lack of co-ordination and respect between management and clinicians, patients did not receive appropriate quality care, particularly in the 1996 winter months. In any hospital setting teamwork is required, with the knowledge and skills of managers combining with the knowledge and skills of health professionals. In a public hospital environment, where funds are restricted, teamwork and clinical and management leadership are even more essential. Through teamwork, clinical and financial challenges can be shared, with both managers and clinicians accepting mutual responsibility to overcome the difficulties related to providing appropriate services to the public on limited funds.

Prior to Canterbury Health commencing operations on 1 July 1993, there were three factors which made it likely that the impact of the health reforms would be relatively more significant for Canterbury Health. The Canterbury Area Health Board had not been subject to many of the disciplines that had been forced upon Area Health Boards in other parts of the country. For example, in the Auckland Area Health Board, prior to the health reforms, enormous changes in governance had occurred as a result of the population increasing with no increases in available funds. Another factor leading up to 1 July 1993 was the decision to establish two Crown Health Enterprises within Christchurch city. This caused great concern among clinical staff at Christchurch Hospital and led many clinicians to become sceptical about the health reform process. A further factor was Canterbury Health's inherited "deficiency" from the Area Health Board in a region which on aggregate was over funded on a population basis. This meant the Southern Regional Health Authority had to take funds from other health providers to give additional funds to Canterbury Health. These factors meant the environment in which Canterbury Health commenced operations on 1 July 1993 was a difficult one.

The Chief Executive put in place many initiatives in Canterbury Health's first year of operation. Most involved major restructuring that did not affect clinical or nursing operations. In this first year of operation the Board and management made inroads into increasing the efficiency of Canterbury Health. In order to reduce costs, a very flat structure, which virtually eliminated administrative positions, was created.

For this structure to work efficiently, Canterbury Health needed to have in place good leadership, clear lines of responsibility, established policies and procedures and effective decision-making processes. It also needed good information systems backing up the organisation. These elements were not in place at Canterbury Health but were recognised by management as being required. It is unfortunate that Canterbury Health did not recognise earlier the enormous bottleneck created by insufficient delegation, and in particular, the large span of control held by the General Manager Christchurch Hospital Services, who had 64 clinicians, nurses and managers reporting directly to him.

The evidence gathered during this investigation shows that by 1995, Clinical Directors were frustrated as effective operational management was not possible due to inadequate delegation, including that of financial responsibility. The minutes of the Medical and Surgical Policy Group indicate they were a forum for discussion, but few decisions were reached and no actions were minuted. Substantial decision-making responsibility which impacted on clinical system issues was held by the General Managers, who were unable to process memoranda and other correspondence in a timely manner.

Conversely, management expressed frustration that many clinicians were not prepared to accept the accountability that went with delegation, including refusal to sign job descriptions which defined financial accountabilities. However, clinicians were not clearly informed of Canterbury Health's vision and objectives and did not have adequate financial systems on which to accept such accountabilities. Delegation is fundamental to an organisation so reliant on its clinical staff. This does not necessarily need to be formal but can be demonstrated through communication, management responses and management actions. On day to day issues and new projects (for example cardio-thoracic) established with separate funding, communication was effective between management and clinical staff. In relation to the major fundamental matters affecting the organisation and its services, the communication was not so effective.

These factors provide an indication of the environment in which the major restructure in 1995 took place.

In its response to me, Canterbury Health advised that in 1997 it has placed much emphasis on better communication within the organisation to *"move beyond the confrontation of 1995-1996"* so that it can focus on its prime task of providing better quality care to the people of Canterbury. The range of initiatives included: a weekly newsletter from the Chief Executive, quarterly staff forums, a monthly newsletter, a Clinical Policy and Planning Committee newsletter, clinicians' involvement in funding negotiations, clinician-led initiatives, weekend planning seminars, reports of Incident Review Committee meetings, quality assurance reports to the Board, information packs for clinicians, and Resident Medical Officer Co-ordinator meetings (a junior doctor initiative) to inform management of ideas and opportunities.

Management of Restructure and Efficiency Gains

In late 1994, the Shareholding Ministers placed Canterbury Health in "workout" as its deficit forecast was considered unacceptable. In early 1995, under pressure from the Board, the Chief Executive prepared a business plan he fundamentally disagreed with. In a memorandum to the Board, the Chief Executive warned Directors of the *"not insignificant level of risk associated with the Plan"* and the *"very high level of demand on Management"* and advised the Board *"My Management Team and I are individually and collectively committed to achieving the Plan, but in making this commitment recognise the following factors which will influence our success"*. These factors included the need for a co-operative long-term approach by the Southern Regional Health Authority and reliance on an underlying assumption that acute demand was rising due to availability of services. In respect of clinical efficiencies, he noted *".....The only effective methods of establishing the appropriate levels of clinical resourcing are by "best practice" comparisons and staff consultation. Both of these will require a good co-operative relationship with our clinical staff"* and advised " ... *it is possible that individuals or minority groups will frustrate change by taking legal or political action. Management will take all reasonable steps to avoid such frustration but in the event it occurs this Plan does not allow for such contingency*".

In attempting to implement the business plan, the Chief Executive altered his management approach. Up to that point the Chief Executive had had a good relationship with clinicians and had achieved major restructuring and other initiatives at Canterbury Health (according to Canterbury Health's 1993/94 Annual Report and accompanying Statement of Achievements). The Chief Executive advised the managers reporting to him that the implication of the Plan did not allow the option of continuing to operate in the consensus manner adopted to date. The professional staff quickly recognised this change in approach. A lack of explanation for his change in style resulted in speculation and distrust.

As the Chief Executive did not consider the Christchurch Hospital clinicians would accept the major changes required by the business plan, he kept from clinical staff information he considered likely to inflame them. The Chief Executive's deliberate lack of early consultation and withholding of information, while considered by him to be the best approach in the circumstances, had the opposite effect to that intended. Notwithstanding his reservations, the Chief Executive did make presentations to the staff to explain the overall targets set, including the need to achieve $12 million of cost reductions.

Following the approval of Canterbury Health's business plan, the restructuring proposals were prepared. The only person providing medical input to the team which prepared the proposals for consultation was the General Manager Christchurch Hospital Services. The preparation of this restructuring proposal must have further affected his ability to manage a job that was already very onerous for one person.

The lack of trust between clinicians and management increased dramatically when the restructuring proposal was released for consultation in August 1995, without any input from senior clinicians in Canterbury Health. Medical advisors who met weekly with management were unaware of the proposals for restructuring until they were announced. While the consultation process complied with employment contracts, the lack of communication was perceived as deception, particularly as the proposal significantly changed the formal status of every Clinical Director at Canterbury Health. The management decision to commence consultation on a major organisational and process restructure, without significant prior medical input,

meant Christchurch Hospital clinicians felt that they no longer had any influence on their work environment. The misinformation and miscommunication which resulted prevented the parties from operating in partnership.

Canterbury Health may have been successfully restructured had it been done more slowly, and with greater consultation, improved communication and recognition of clinical status. The proposals for change were released for consultation without any involvement by Medical Advisors. The New Zealand Nursing Organisation's offer to work co-operatively with management on analysing nursing needs was rejected by the Human Resources Manager just two weeks before the Proposal. Senior staff felt marginalised and many refused to participate.

Trust in an organisation takes a long time to build. Canterbury Health had only begun the process of developing this trust and it was destroyed instantaneously when the Proposals for Change were issued for consultation in August 1995. The process of implementing the restructuring at Christchurch Hospital was also jeopardised from the outset by the unrealistic time frames necessitated by the targets of the 1995/98 business plan.

Dr Layton responded to my opinion that *""experts"* [in change management] *have inevitably emphasised the need for restructurings to be initiated quickly. My experience supports this view, which is in complete contrast with the one you implicitly support."*

I accept there are different opinions on whether a restructure should be imposed on staff rapidly or whether more time should be taken to work through the issues with staff until a significant level of buy-in is achieved. A modern view of restructuring involves aligning an organisation so staff have a context within which to evaluate restructuring plans and are able to see opportunities within it. I believe that a successful restructure would have been greatly enhanced at Canterbury Health had Medical Advisors and other influential clinical groups been involved from an early stage. I also believe that taking more time, not only to work through the issues of interpretation and implementation with senior staff, but also to enable all staff to adjust to the cultural shift required, would have assisted the restructuring of the organisation.

I agree that Canterbury Health needed to restructure. The structure proposed in 1995 was designed to improve the organisation's efficiency. Many aspects of its original management structure established on 1 July 1993 were not working. The 1995/96 appointment of Service Managers to take responsibility for department operational management and clinical costs, with Patient Care Managers developing nursing infrastructure and quality professional standards was, and remains today, a sound concept. Many aims of the restructure were excellent but it foundered for a number of reasons, no one of which was in itself critical, but which together contributed to the failure of Canterbury Health management to gain the goodwill of staff necessary to implement the planned changes. A hospital is dependent on the knowledge and influence of its senior clinicians. Yet without warning management proposed that senior medical staff would be relegated to the fourth tier in the organisation and this change was implemented. The organisational chart therefore showed Service Managers in the third tier, reporting to the General Manager. Service Managers were responsible for Clinical Directors. Nursing staff in the positions of Patient Care Managers also held third tier management positions and reported to the General Manager. Clinicians at this stage felt totally disenfranchised and rightly so.

The proposed changes also involved a major restructure of nursing and the introduction of case management. The debate regarding the restructure, both internally and externally, focused on this nursing restructure and case management model. Following the consultation process, the restructuring proposal was altered to ensure that the wards retained a co-ordinating nurse specialist for an 18 month period, and the introduction of case management was altered to be implemented progressively over two years. Management also agreed that case management and care plans would have limitations in some clinical settings.

While the debate continued about the restructuring of nursing and its effect on patient safety, the focus of the clinicians moved to becoming involved in decision making that could have an impact on clinical issues. The Chief Executive consulted the Medical Advisors in December 1995 and sought their advice. They suggested that a Health Professional Advisory Group be established to advise the Chief Executive on *"major decisions that have a potential impact on patient care standards and health care delivery within Canterbury Health"*. The Chief Executive supported the concept. After further consultation with the Medical Advisors, a plan was developed, approved by the Board and taken by the Christchurch Hospitals' Medical Staff Association to the senior clinical staff in a postal ballot. The plan was supported with a two thirds majority. However, in April 1996, there was an almost total change in the Executive of the Christchurch Hospitals' Medical Staff Association and this vote was overturned.

The new Executive described their mandate as being based on majority support of a motion put to the membership through a referendum which suggested:

(a) nurse restructuring compromised clinical safety; and

(b) a planning and policy committee of medical staff needed to be formed to work with the Chief Executive, to give final approval to all decisions in relation to clinical practice. Members of this committee should attend Board meetings.

This new Executive were and remain today very assertive in their approach to management.

In my opinion the nurse restructuring per se did not directly compromise patient safety at Christchurch Hospital. Evidence from minutes of meetings and correspondence during 1995, before restructuring was implemented, demonstrates that the patient safety issues, such as the lack of patient escorts, insufficient resources in the Emergency Department and the large number of outliers, claimed to be caused by the nursing restructure, existed under the previous structure.

However, the restructure indirectly affected patient safety. This was because:

(a) Canterbury Health had not established a strong fundamental base of policy, practice and guidelines on which to effect major staff upheaval in such a short time frame;

(b) Canterbury Health attempted to implement the restructure within an unrealistic time frame;

(c) inadequate management of the restructure resulted in staff/management communication difficulties and loss of morale, motivation and co-operation;

(d) both staff and management spent a disproportionate amount of time dealing with the restructure and its consequences, particularly the difficulties it generated between staff and management, rather than focusing on operational effectiveness;

(e) there were continuing diversions caused by a variety of external reviews and arguments through the media; and

(f) recommendations from various committees to address problems identified after the 1995 winter were deferred or ignored as the parties debated and implemented major restructuring.

In addition, Canterbury Health failed to deal effectively with the problems it had already identified in its admitting, treatment and discharge processes during mid-1995. It delayed taking action until late 1996 when the restructure was complete and the 1996 winter was over.

Failure to Involve Clinical Staff in Decision-Making

When Canterbury Health commenced operations in July 1993, it established managers entitled "Clinical Directors" but did not involve those clinical managers in executive decision making. Clinical Directors were given responsibility but not the financial authority to enable them to implement quality assurance processes or ensure appropriate clinical standards. Canterbury Health alienated staff because it relied on Clinical Directors to manage medical and quality related issues in their departments, yet withheld from them essential information about Shareholders' expectations and the consequential effect of the 1995/98 Business Plan.

The General Manager Christchurch Hospital Services initially held the position of Acting Medical Advisor. In 1994 Medical Advisors were appointed to give advice on clinical matters to the Chief Executive. The former Chairman advised me that "*We had medical advisors in the hospital. And if there was not a proper process going on, then I would say they should have been advising us.*" However, minimal clinical input from Medical Advisors or Clinical Directors occurred at Board level until August 1996. In response to this Opinion the former Chairman advised that the reason for agreeing to the change in August 1996 was not because the Board had lacked clinical input, but because he was aware Christchurch Hospitals' Medical Staff Association had been painting inappropriate pictures of the Board which would be countered by having a number of clinical staff meet the Board at work.

Communication

Canterbury Health failed to communicate to staff its vision, objectives, policies and decisions. Nor did it effectively communicate its plans for organisational change. As a consequence it could not effectively involve staff and get support for strategies to deal with the financial difficulties in which the organisation found itself.

Senior managers also failed to communicate with each other. For example, on 30 September 1996 the Chief Executive notified the Director General of Health that comprehensive incident reporting was in place and advised that there were no safety concerns. Yet seven days earlier, on 23 September 1996, the General Manager Christchurch Hospital Services had received a memorandum from a consultant undertaking a resource project for the Board which highlighted many issues of concern. For example, the memorandum stated: "*Moreover the existing acute admitting process, for medical patients in particular, seems to fragment*

appropriately focused care. The result of this is to create an uncoordinated, over-complex, patient service delivery environment within which some patients inevitably receive what can best be described as inadequate care". If the Chief Executive had been aware of this memorandum he could not have reassured the Director General so unequivocally.

The commencement of consultation on the Proposals for Change restructuring document was communicated badly. While the consultation document complied with the letter of the consultation protocols set out under the collective contracts, senior management handled aspects of the changes insensitively. For example, the letter which introduced the original proposal discussed redeployment options for staff prior to setting out the Proposals. It is not surprising that, as a result, staff failed to focus on the content of the Proposals.

Senior managers also failed to communicate effectively with clinical staff. For example in August 1996 a Medical Advisor was requested to attend a Board meeting without notice and without any briefing or details being given to him. After attending the Board meeting, the Medical Advisor's subsequent letter to the General Manager Christchurch Hospital Services, sums up the poor communication. "*I would like to have a copy of what was sent to the Board to make sure I know exactly what I was supporting..... It was slightly unusual to be speaking about a proposal that I had not seen but I am sure I would support any review which I assume would address the above problems.*" Such uninformed input into management decisions could not help but result in policies and practices which in turn resulted in a lack of co-ordinated care to consumers.

The lack of communication also extended to Service Managers. One example related to an audit regarding the availability of infusion pumps. The Product Manager undertook a complete review of the pumps in Christchurch Hospital which showed that only 60% of the pumps were in use at any time and the balance of 40% were distributed around the wards and not returned to the pool in accordance with policy. The Product Manager wrote to the General Manager Christchurch Hospital Services regarding this but received no reply. This was not unusual. Numerous documents and memoranda were not acknowledged or acted upon.

Leadership

In all organisations there needs to be strong and effective leadership. In 1997, Christchurch Hospital's management was restructured for the third time. The needs of the organisation have not been so fundamentally different between 1993 and 1997 that it should have been necessary to restructure three times, causing upheaval and stress to staff and disruption to services.

While there is unquestionably a need for involvement and participation by staff in any restructure, there is also a need for leadership from senior management. This entails developing and sharing with employees the vision and purpose of the organisation. Leadership also requires inspiration, strength of conviction, open communication, clear direction and decisive action. The Board and management of Christchurch Hospital did not noticeably demonstrate these attributes to employees.

The Chairman's comments at the staff meeting of 5 December 1995 had a profound effect on the Chief Executive's ability to manage and lead the organisation. At this important meeting of the Board and management with staff, the Chairman did not reassure and support those present to accept and adjust to the restructure. His comment that the creation of a Clinical

Nurse Facilitator position was an unnecessary compromise, has become legend among professional staff as "a sop to the doctors" and his other comment about closing operating theatres was interpreted as "cancer patients can wait". Both comments fuelled anger against Canterbury Health. This one meeting undid any goodwill built up by others, including the Minister of Health, over weeks of consultation and damaged management's efforts to reassure staff that the proposed restructure had a clinical as well as a financial focus. The Chairman later issued a written apology stating *"I accept that statements I made disturbed and offended many of those present"*, but this could not undo the damage to staff/management relations.

Leadership is a quality distinct from management knowledge, experience, formal position and authority. Leadership is shown in the way an organisation acts, communicates, makes decisions and takes action. In my opinion there was a lack of decisiveness and leadership at Canterbury Health. Minutes of meetings in 1995 show a lack of focus and effective decision making.

To effect change successfully in an organisation requires powerful, respected and influential leadership. At Canterbury Health the restructure programme and its implementation was approved by the Board and was management driven. In a hospital, medical staff hold a critical ability to influence the management of patient care and the allocation of resources, yet Canterbury Health chose not to involve them in either developing the restructuring proposal or, to a large degree, in implementing the restructure. The absence of a senior clinician among the staff selected to develop the Proposals for Change was a major error of judgement.

The Board should have recognised in 1995 that the Chief Executive could not lead the organisation through the change process unless he was totally committed to the business plan. The Chief Executive could not have provided the necessary leadership for the restructure without fundamentally believing in his management team's ability to achieve a successful transition in the proposed time-frames or his ability to get senior staff 'buy-in'. While Mr Frame told the Board he was committed to achieving the plan, he also knew he had no option other than to resign. He therefore changed his management style in an attempt to meet the Board requirements. Apart from the initial concern regarding his employment, he believed it was his duty to produce and implement the business plan that the Board wanted. The responsibility for consultation and advice on implementation of the project was delegated to the General Manager Special Projects and her team. The responsibility for implementing the restructure and case management over the next two years lay with the General Manager of each division.

Since the Chief Executive had realised the likely strength of opposition to the Proposals, he should have been alerted to the critical need for effective champions of the Proposals. Some of the early meetings held to discuss the Proposals for change with staff were not attended by the Chief Executive or the General Manager Christchurch Hospital Services because they were away on leave at the time.

Leadership has also not been demonstrated by some senior medical staff, despite their professional status. Some Clinical Directors accepted the challenge of managing within limited budgets and co-operated with managers to achieve realistic solutions. As a result, other senior medical staff stopped trusting these Clinical Directors. There remains a lack of trust between some of the clinical staff which is in part driven by the perception that some clinicians are managers, having been captured by management. Clinicians, like all people, have diverse

operating styles and clinicians are required by the Code to co-operate with each other. The new Executive of Christchurch Hospitals' Medical Staff Association, which took office in April 1996, adopted an assertive and adversarial style because the gentler approach of working with and attempting to persuade management was not seen to have worked.

Many initiatives recommended by senior clinicians who were working with management would have improved standards of care in the Hospital. These initiatives included those from Taskforces and special reviews of the Emergency Department after the 1995 winter. Management let these clinicians down by not implementing the recommendations they made in late 1995 in a timely way. Other clinicians who were critical of management and their peers, stressing that nursing restructuring would imperil patient safety, were unaware these recommendations existed. With trust, teamwork and good professional leadership, clinicians would in all likelihood have shared information about initiatives to ensure safety in the Hospital and given the Board guidance about safety issues. This comment is not made to excuse the Canterbury Health Board, but rather to emphasise that the public would be better served through teamwork and the resolution of personality and style differences within all occupational groups and organisational levels at Canterbury Health.

Following the restructure in late 1995, Service Managers and Patient Care Managers were responsible for developing co-ordinated operational policies across Christchurch Hospital. In general they were inexperienced line managers and were not given sufficient training, support or direction to function as self-managing teams. As a result, the organisation continued to lack policies and procedures for effective incident reporting, complaints management and quality standards.

In 1997 Canterbury Health's style of management changed and now includes communication strategies, more active participation by clinical and nursing staff and re-promotion of Clinical Directors to the third tier in the organisation.

Management Overload

Both before and after the 1995 restructure, Canterbury Health did not recognise the administrative support required to operate effectively. As the drive for efficiencies continued, memoranda were not responded to, incident reporting slowed and complaints recording diminished, due to either staff attrition without replacement or shortage of time. As the distrust between the Christchurch Hospitals' Medical Staff Association and management increased, public debate intensified and the winter overload of patients arrived. Most of the Service Managers' time was spent reacting to immediate operational crises rather than pro-actively developing and improving systems and processes across the Hospital.

Accountability

Following the 1995 restructure Service Managers were expected to achieve change and to do so they needed authority. Senior management at Canterbury Health did not always support these managers to whom they had delegated the responsibility for change. In subtle ways they undermined their status within the organisation. For instance, they were left to find their own way into their roles and even to find their own support resources. Some had offices distant from the departments they managed. When faced with conflict between Service Managers and Clinical Directors, little was done to reinforce the established lines of reporting and accountability. For example, the General Manager Christchurch Hospital Services continued

to keep a large number of both formal and informal reporting lines open to himself, thus reducing his own efficiency, blurring lines of authority and exacerbating the power struggle between Clinical Directors and Service Managers. If the new structure was to work effectively, it was important to reinforce authority and accountability. I recognise that it is appropriate for managers to maintain informal links as long as those links do not undermine the line management structure, which they did in this case.

Overall responsibility for services delivered at Christchurch Hospital was divided between the General Manager Christchurch Hospital Services and the General Manager, Support Services, yet the processes by which financial responsibility in particular was allocated between these two general managers were not clear. There was little co-ordinated policy development between the two, which was particularly apparent in respect of managing demand for laboratory tests, radiology and pharmaceuticals. The Support Services division was accountable for the budgets for providing the services but had no control over the clinicians who ordered them. In the absence of good information systems, no policies were developed between the two divisions to attempt to manage this issue.

Many Clinical and Medical Directors expressed sympathy for the difficulties faced by Service Managers. In areas where workloads were lighter, relationships had time to develop. Where the personalities and attitudes of the individuals lent themselves to the development of good working relationships, good partnerships developed between clinical heads and Service Managers.

Some clinicians defied management by actions such as refusing to sign contracts of employment and non-attendance at departmental and divisional meetings. No actions were taken on these matters. Where any staff grouping ignores policy and lines of authority and the matter is not dealt with, management effectiveness is compromised.

Speed of Change

The 1995/98 business plan developed by Canterbury Health showed programmes to develop efficient and high quality services. However, the time-frames for implementing the change programme in order to meet the targets of the business plan were unrealistic.

In the traditional and stable environment of Christchurch Hospital, the sudden introduction of radical proposals for major change with a very short time to work through the issues came as a major culture shock. Canterbury Health found itself in a position where it was compelled to "push through" changes in a manner that did not allow staff to work through the issues and buy into the objectives.

The Board should have recognised that rapid implementation was not possible. Six weeks was clearly not long enough for massive reorganisation of senior nursing personnel. This re-organisation included selection, appointments, alteration to accountabilities and/or redundancies of large numbers of senior personnel. Even in an organisation accustomed to constant change this would have been an extremely difficult proposition. To attempt this change in an organisation where patient safety depended on consistent processes and the trust of long-standing relationships was foolhardy. The personnel changes eventually took four months and further demoralised the organisation. While the former Chairman's point of concern was "paralysis by analysis", the time frames for the restructuring were culturally inappropriate.

Management of the Change and Efficiency Gains

The business plan indicated that the role of General Manager, Special Projects was pivotal to achieving the programme of efficiency gains and therefore the financial targets envisaged. Although the Special Projects Team appears to have improved service delivery and implemented elements of case management in selected areas as specific projects, the role was operational rather than an organisation-wide planning and project management role at general manager level. The outcomes achieved by the Special Projects Team were less than those anticipated.

The Special Projects Team had little involvement in implementation of the many planned efficiency gains across the Hospital. I conclude that this occurred in part due to a lack of mandate, as well as to the derailment of some of the initiatives due to staff resistance and the loss of focus that occurred as senior management went into fire-fighting mode to control the situation that had developed with Christchurch Hospitals' Medical Staff Association. The role and responsibilities of the Special Projects Team were also not well understood by other managers and staff. With the Chief Executive's resignation, the Special Projects Team ceased to have any authority or function in Christchurch Hospital.

A large number of practical issues combined to inhibit implementation of the restructuring plans:

(a) the four to five months taken to get all senior nursing staff in place;

(b) the reluctance of Service Managers and Patient Care Managers to use the expertise of the Special Projects Team to its fullest in facilitating change;

(c) the relative inexperience of the newly appointed management staff in leadership roles where significant respect and credibility were required;

(d) the absence of a head nursing role to provide continuity and nursing leadership across the organisation;

(e) the New Zealand Nursing Organisation and Christchurch Hospitals' Medical Staff Association's campaign against the Canterbury Health Board's management;

(f) the time taken by management to deal with the resultant showdown between management and the Medical Staff Association; and

(g) the requirements of outside agencies as the claims of compromised patient safety became increasingly strident.

As a result of the inadequate process of change, staff lost trust in management at Canterbury Health. This led to a climate in which the usual control processes which management rely on to alert them to problems in the organisation (such as incident reports) failed and the usual feedback loops for correction of defects ceased to function effectively. I was encouraged to learn that the increase in focus on quality measures in 1997 has improved such feedback and I note that staff who fail to complete incident reporting forms act in an unprofessional and unethical way.

Case Management

One of the underlying reasons for the 1995 restructuring proposals was to introduce a new "patient centred" service delivery model which was expected to achieve improved and consistent outcomes, reduce duplication of services, decrease waiting time for patients and generally produce more cost effective health care. An essential support for the model was considered to be a re-organised management structure which would deliver flexibility, efficiency and accountability.

Opinion on case management is as divided as the numerous terms that are used to describe it. Leaving aside the philosophical background of the debates, the shift in operational management from a highly functional to a process management approach was new. There was considerable distrust and fear surrounding how such a system would work, and the implications for patients of its introduction. Christchurch Hospitals' Medical Staff Association's statement by the Chairman illustrates that distrust: "*I think they thought that they could have a cook book for nurses, which meant someone would fit into a cook book pattern, and that would give the clear pathway for the care*".

Canterbury Health did not manage the dissemination of information well. The terms were not clearly defined and had to be clarified later. Even the substantive document issued by the General Manager Christchurch Hospital Services in August 1996 failed to resolve the confusion. This document was entitled "Critical Pathways" and recommended the use of that term rather than case management. Certainly the various terms - care planning, clinical pathways, care guidelines, care maps, case management, critical pathways - have been used almost interchangeably, whereas they all refer to somewhat different concepts.

The proposal to implement case management across the entire Hospital was highly contentious. Nowhere else has case management been implemented across a hospital of the type and complexity of Christchurch Hospital. Following the consultation, Canterbury Health recognised explicitly that "*Case Management and Care Plans may have limitations in some clinical settings*". This statement was not effectively communicated nor was the management's decision that case management was always intended to be developed over a two year period. Canterbury Health had examples of care plans working within the Hospital but did not disseminate this information to other staff. Even when it was decided that the introduction of care plans would occur only after consultation, this too was not effectively communicated to staff, who continued to argue against its introduction.

In part this illustrates the difficulty of effective communication in a change situation where staff may not hear because they are not listening.

I recognise that Canterbury Health's desire to introduce case management was laudable in its intentions. In fact, it has now been introduced successfully in several areas of the Hospital.

Morale

As a result of the restructure, disputes between Christchurch Hospitals' Medical Staff Association and management, and other issues such as the failure to include senior clinicians in essential decision-making, led to low morale and a decline in quality of services and professionalism. Nurses observed that the restructure impacted on the morale of the professional workforce generally and probably impacted on nurses' ability to cope with winter pressure and their

approach to nursing care. Loss of motivation affected the performance of Canterbury Health as a provider of health care services.

In the clinical report reviewing winter 1997, it was noted that *".... changes have made it easier for the medical and nursing teams to care for their patients more efficiently. This has led to improved staff morale and improved quality of care for .... acutely ill medical patients"*.

In the 1997 Annual Report, Canterbury Health recognises the effect low morale can have on the organisation and the importance of striving to improve this. The Chairman commented in his report that *"There is no doubt that the CHE has been unwell in the recent past, with tensions between clinicians and management spilling into the public arena.……the health of the CHE has improved significantly over the last six to nine months."*

The Chief Executive also recognises in his report *"the need for real partnership between clinicians and management both on a daily and conceptual basis. This must be based on trust and respect and both these are growing from what can only be described as a very low base in 1996."*

Summary

In conclusion, it is my opinion that in 1995 and 1996 the Canterbury Health Board and management did not offer the leadership that builds trust and commitment, or the common vision and purpose to inspire employees and support them. They also did not implement the structure, together with systems for control and accountability, to ensure that responsibility was understood and exercised at all levels. This led to lack of co-operation and low morale. Canterbury Health was warned by many parties that the breakdown in relationships between management and clinicians could lead to a reduction in standards and this occurred.

Canterbury Health believes there has been a distinct improvement in communication and morale in 1997. I congratulate all involved on their efforts to date. The number of health professionals in senior management positions has increased significantly and on behalf of consumers I encourage a continuation of co-operation by both management and health professionals to build together a successful organisation. Canterbury Health and its health professionals are required by the Code to co-operate with each other to ensure quality services are provided to consumers.

RIGHT 4(2)

RIGHT 4
Right to Services of an Appropriate Standard

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

In my opinion Canterbury Health was in breach of Right 4(2) as it did not comply with legal, professional, ethical and other relevant standards.

Policies and Procedures

The lack of formal, hospital-wide, up to date policies and procedures was a breach of Right 4(2). Individual staff members were relied on for their knowledge of unwritten protocols and clinical expectations. When the restructuring commenced in December 1995 the knowledge of these protocols and clinical expectations by individuals could no longer be relied upon because staff were made redundant or transferred to different parts of the Hospital. As few formal policies or procedures had been documented prior to the extensive staff changes, vital operational information was lost and the restructure had no foundation on which to succeed.

Canterbury Health does not draw a distinction between guidelines, procedures and policies. The words "standard", "policy" and "procedure" are used interchangeably, which is confusing. Those policies which did exist were not in a standard format, did not cross-reference with other documents, did not have dates of issue or dates for review, were not indexed or coded and the person authorising the document was not always identified.

While there is a range of policies and guidelines for nursing practice, these are not generally hospital-wide and appear to require updating and reformatting. Nor is it clear whether these policies, guidelines and standards are research-based, or how widely they are used in everyday practice and staff orientation.

I commend Canterbury Health for its efforts during 1997 to introduce standard policies across the Crown Health Enterprise. This is a large and difficult task in a complex environment but is fundamental for ensuring quality services to the public.

Quality Assurance, Risk Management and Incident Reporting

Prior to 1997 there were insufficient effective quality and risk management systems in place to ensure a co-ordinated approach to quality. This contributed to inappropriate standards of service. Co-ordination of quality requires a centralised overview with close links between incident reports, complaints and risk management. While incident forms were filled out by some, incidents were also reported by way of memoranda to either Service Managers or the General Manager Christchurch Hospital Services. Canterbury Health should have ensured these were centrally managed and reported on. It should have undertaken audits on the indicators and used the output data to identify and rectify problems.

The benefit of a quality assurance review and a co-ordinated approach to quality is reflected in the summary of matters discussed at the first three meetings of the Quality Assurance Committee held in February and March 1997, which included:

(a) a review of incident reports for July 1996 to January 1997 which identified several key issues that needed to be addressed to prevent incident recurrence. The following were some actions and resources found to be required in the immediate future:

- skilled transit staff
- systems for timely and appropriate clinical interventions (particularly out of hours)
- Emergency Department resources review
- clarification of bed management for an appropriate/timely admission process
- review of documentation processes;

(b) a review of the process for incident reporting;

(c) confirmation that Morbidity and Mortality Reviews needed to be reviewed and well managed; and

(d) development of a Quality Planning Group to enable a proactive approach to quality improvement.

These three meetings highlighted many issues raised in this report and indicate the value to the organisation of a focused quality programme.

Overall Quality Management

Prior to 1997 there was no emphasis on quality improvement and no leadership from senior management to develop a quality culture at Christchurch Hospital. While Canterbury Health established a high level quality plan in 1995, it did not follow through with an implementation plan. There was no explicit or implicit, planned and systematic hospital-wide quality assurance programme at Christchurch Hospital and little co-ordination between Performance Monitoring, Internal Audit, Risk Management, Infection Control, Patient Affairs/Complaints, Occupational Safety and Health and Disaster Response Planning.

Quality was the formal responsibility of the Divisional General Managers but this responsibility was devolved to a variable extent to the Hospital's third tier managers. In the absence of divisional plans for Christchurch Hospital, quality initiatives were interpreted and initiated on an ad hoc service by service basis resulting in ineffective or non-existent intra and inter-divisional communication, co-ordination and integration of quality activities.

There were inconsistent perceptions by management and health professionals of the roles of the various committees with a quality monitoring role e.g. the Mortality and Morbidity Peer Reviews vis-a-vis the Mortality Review Committee. The "Snapshot" report compiled by the General Manager, Special Projects in January 1997 identified that two of these committees, the IV and CPR Committees, considered themselves to be advisory only. Some committees had concerns about whether their advice was being heeded by management.

Essential monitoring processes, like incident reporting and complaints management, did not operate as the learning process that is the basis of continuous quality improvement.

Quality Indicators

Organisation-wide operational monitoring of measures required by external monitoring agencies like the Crown Company Monitoring Advisory Unit are at best a blunt tool for monitoring service quality. These indicators were not sufficient for a committed quality improvement programme and a robust system of internal monitoring. Risk management at Canterbury Health was financially focused. Effective performance should have been established by comparisons of relevant indicators against internal and external benchmarks and effective performance is not possible without standards or documented policies and procedures.

At the Board level there was an undue emphasis on the autopsy rate as a quality indicator. In New Zealand the reliance on autopsies as a clinical indicator has reduced dramatically in the last 10 years. Canterbury Health's rate was more than twice that of other tertiary Crown Health Enterprises. While I recognise that autopsy reports have a place in any quality review system, the high reliance placed on this indicator was inappropriate.

The initiatives taken at the commencement of 1997 to put in place a Quality Co-ordinator and Committee, as well as a Risk Manager and Committee, indicate a new commitment to co-ordinated quality assurance and improvement programmes across Canterbury Health with appropriate feedback and review mechanisms. The initiatives still need fine tuning to ensure an interface between quality, audit, complaints and incidents as well as with statutory obligations such as occupational health and safety, accident compensation and property.

Quality throughout Restructuring Programme

Some nursing and medical staff indicated they were concerned about the potential for patient safety problems at the time the Proposals for Change were circulated by Canterbury Health in August 1995. However, there was insufficient formal monitoring of indicators which could have alerted managers and the Board to problems or provide reassurance that systems were working during, and subsequent to, the change programme.

Instead of formal monitoring, the focus was on obtaining evidence of actual harm and incidents of compromised care which management then attempted to counter. This was a reactive rather than a pro-active approach to the monitoring of quality and standards.

The span of responsibility of Patient Care Managers and the disestablishment of a quality assurance role caused a loss of organisational overview of nursing quality. These matters were both raised by the New Zealand Nurses Organisation in 1996. Patient Care Managers were on a steep learning curve in 1996 and were only able to offer a limited amount of nurse leadership support.

Incident Reporting

An organisation of the size and complexity of Christchurch Hospital could reasonably be expected to have a clear and consistent policy and an effective system for monitoring incidents, particularly in view of the restructure and concerns being expressed about safety.

The environment in Christchurch Hospital in 1996 was not conducive to routine medical incident reporting. The Medical Advisors and the management should have been aware that the

system was not working from the small number of incident forms received from medical staff in 1995/96. The failure of medical staff to adopt the incident reporting system is not surprising. It takes more than a memorandum to implement such a system. In addition, a hospital-wide incident reporting system can only be developed when there is trust within the organisation.

As trust between clinical staff and management rebuilds at Christchurch Hospital, improved systems for incident reporting are developing. For example, in response to this opinion Canterbury Health advised that in the 1996 12 month period, only 4 incident reports were received from medical staff compared with 65 incident reports in the first 10 months of 1997.

The possibility of charges of manslaughter and other legal risks is commonly raised as inhibiting clinical incident reporting. However, the main inhibitory influence at Canterbury Health appeared to be fear of "blame" of individuals, particularly among junior medical and nursing staff. Canterbury Health needs to continue to encourage incident reporting in a supportive and non-threatening environment and take disciplinary action for failure to complete incident reports or non-compliance with other quality initiatives.

Reporting of an actual or potential incident is by no means the only method of determining whether an environment is safe. Responsible professional opinion on a situation (e.g. the overcrowding in the Medical Day Unit) is valuable and should be treated in the same way as a report of a specific incident. If an effective incident reporting system had been in place at Christchurch Hospital in 1995 and 1996, the proof required by the Board would have been available. Health professionals need continuing education as to what constitutes an incident and incident forms needed to be filled in consistently by all staff, not just nurses. A central quality improvement unit should have been initiating and co-ordinating reports in a methodical way, analysing the information and providing feedback to the management and clinical staff where such analysis indicated process changes were required. In this way management's attention would have been drawn in a responsible, objective and non-threatening way to the existence of many risky situations, without the need to show that specific harm had already been done.

International research indicates that almost 40% of errors in a hospital environment are caused by individuals. Not only were few incidents reported at Christchurch Hospital, but the environment and the lack of systems, policies and resources led to a situation where every incident was blamed on "systems error" and very few individual errors were recorded. Statistically this is extremely unlikely. Improvement in quality monitoring will reveal when both system changes and staff development are needed. Individual professional performance must be monitored and individuals must be accountable in the interests of professionalism and safety. The audit and monitoring process at Christchurch Hospital has not routinely included such review for all health professionals.

Guidelines for incident reporting were re-written and circulated in January 1997 to all parts of Christchurch Hospital and Canterbury Health advise they are now included in the Policy and Procedure manuals.

Infection Control

The absence of a policy on the reuse of single use items at Christchurch Hospital was inappropriate and did not meet professional standards. The Infection Control Committee developed draft policies on the issue in 1996 when it wished to examine safety aspects and sought assistance

with costings. This costing information was not produced and the matter did not progress to the development of a Hospital policy. It is reassuring to note that Canterbury Health has prohibited the reuse of single use items until such time as a policy is developed, and a Committee has been re-established for that purpose.

Summary

In my opinion in 1996 Canterbury Health breached its obligation under Right 4(2) to establish effective measurement tools to ensure that systems and staff were delivering appropriate services to the public of Canterbury and to establish mechanisms for feedback and change where standards were not being met.

During 1997 Canterbury Health demonstrated a commitment to quality assurance through the establishment of numerous quality initiatives and committees. In December 1997 it established and ratified a health quality policy for its Policies and Procedures Manual which states *"The purpose of this policy is to clearly state Canterbury Health's commitment to focus on the patient and the greater community in our continuous improvement in health care"*.

Support Services

Structure

The organisational chart indicated that the breadth of control of the General Manager, Diagnostic and Support Services, included Radiology, Laboratories, Nuclear Medicine and all other allied health and support services, some of which he managed directly for periods of time from 1994 to 1996. The size and span of control would have been difficult to manage and during that period was likely to have been a factor affecting his ability to keep up with correspondence or consider and decide on the many issues put to him.

Radiology

The service provided by the Department of Radiology was below the acceptable standard for a major teaching hospital, and the standard of supervision and care of sick patients within Radiology was in breach of Right 4(2).

The following deficiencies were identified.

(a) The Department was unable to meet demand in a timely manner and there were unacceptable delays in issuing reports;

(b) There was a significant shortage of radiologists over a lengthy period and insufficient sub-specialisation by radiologists for a tertiary referral centre. Management were slow to acknowledge and respond to this shortage and there was a slow decision-making process for new appointments;

(c) There were insufficient written policies and protocols and this impacted on the prioritisation of patients, consistency of conduct of procedures and reporting on them, and ensuring that adequate qualified personnel were covering all shifts;

(d) The transfer of severely ill patients to the Department of Radiology and the hand-over and monitoring in the Department was not of an adequate standard. I note that since May 1997 there has been a nurse present until 8.30pm during week days;

(e) Results have not always been promptly provided to an appropriate person. This is particularly important as quality care depends on information from Radiology being included in decision-making at an early stage;

(f) The standard and availability of service after hours was not adequate;

(g) Services to the Emergency Department were compromised by the physical distance between the Department and Radiology, by delays in patient transport and waiting times in Radiology;

(h) There was no formal audit process nor a credentialling system for radiologists;

(i) The lack of co-ordination between Radiology and referrer services prevented effective prioritisation and management of demand.

The deficiencies in the Radiology Department were compounded by the uncontrolled demand for services as a result of the lack of fiscal responsibility by referrers and the general practitioner referral contracts with Southern Regional Health Authority.

All but one of the radiologists employed by Canterbury Health were partners or employees of the private practice competing with Canterbury Health for external contracts and radiologists. This created a conflict of interest which escalated because of Canterbury Health's failure to manage the employment relationship with its radiologists. Canterbury Health and the radiologist partners of the private practice needed to put in place policies to manage the conflict inherent in this situation.

The services provided to Mrs Watson illustrate the importance of timely reporting of x-rays. Mrs Watson's condition had deteriorated significantly by the time her x-ray findings were eventually communicated to the house surgeon. This affected the chances of successful surgery and consequently Mrs Watson's decision not to undergo surgery which may have saved her life.

Prioritisation and management of internal and external demand, which are important aspects of providing efficient, effective radiology services, were not addressed effectively by Canterbury Health. The absence of management systems to co-ordinate policy development and implementation between the Hospital Services Division and the Support Services Division resulted in unacceptable pressures on staff and resources and led to a decline in standards of service.

Canterbury Health contracted to provide services to outpatient clients of the Accident Compensation Corporation. This resulted in delays to Canterbury Health's inpatients who were often seen in the evening, when staffing levels were at a minimum, because outpatients were booked during the day.

The deficiencies identified above amounted to a breach of Canterbury Health's obligation to provide radiology services of an appropriate standard.

Canterbury Health, in response to this Report, advised that:

- in August 1997 it was granted three years accreditation by the Royal Australasian College of Radiologists (to achieve this accreditation Canterbury Health was required to ensure a minimum standard of facilities is available for the proper training of registrars in Diagnostic Radiology);
- two additional staff have been hired specifically to organise the prioritisation of Radiology patients;
- from 1 February 1998 there will be 15 full-time equivalents in the Department.

Laboratory Services

Based on incidents reported during the investigation, consumer feedback and accreditation status, there is no evidence to indicate that Canterbury Health has breached Right 4 in relation to its Laboratory Services.

However, Christchurch Hospital lags behind other major hospitals in getting laboratory results on line to the wards. During 1996 written confirmation of results was slow and uncertain due to continual transfer of patients from ward to ward.

Secretarial and Administrative Support

The shortage of secretarial and administrative services resulted in delays in accessing records and discharge details for patients. For example, general practitioner reports, discharge summaries and general correspondence were not produced in a timely manner, which affected the quality of services for consumers. "*Unless notes were hand-written, some surgeons would still be waiting for their notes after they had met the patients they had operated on in Outpatients twice. Letters and notes were waiting up to four weeks to be typed*". Further, reports between departments were not always timely.

Managing Demand in Support Services

Christchurch Hospital worked in a situation where demand increasingly outstripped resources. In my opinion there were insufficient attempts to manage this tension. This has particularly caused strain for support services as they have attempted to maintain standards and meet the demands of the Hospital.

The information presented during interviews was consistent with the overall position and thrust of the 1995/98 business plan for Canterbury Health and for support services, indicating that operational budgets were failing to keep up with increasing internal and external demand.

Little evidence was presented to demonstrate that, prior to 1997, Canterbury Health management and clinicians took proactive steps to manage demand for services. Managing increasing workloads is a joint problem for both management and clinicians and should be co-ordinated and prioritised over the entire organisation.

Supervision and Training

General

The supervision and training of junior medical and nursing staff at Canterbury Health has not been appropriate. The staffing levels and the skill mix at Christchurch Hospital were inadequate to

ensure proper supervision and training. A structured and formalised training programme was not established to ensure all clinical and nursing staff remained appropriately trained. This affected the standard of care provided to consumers.

Most hospitals organise an induction programme for new doctors. Usually new interns/house surgeons (i.e. the doctors who are joining the organisation immediately after qualifying in medicine) have two or three days during which they are paid to be instructed in the basics of the new job and familiarised with the organisation. Such an induction was only recently introduced and it is still rare at Canterbury Health for more senior doctors to have any further instruction, even though they may come from another hospital, or even another country. All staff should receive induction and be familiarised with the organisation.

At the end of 1997 Canterbury Health introduced an orientation programme for incoming house surgeons and registrars and a two day orientation programme now exists for permanent and casual nurses.

Surgery

The standards of the Royal Australasian College of Surgeons are the relevant standards for the application of Right 4(2). The lack of sufficient consultant surgeons to provide appropriate consultative work in the Emergency Department and other areas has been acknowledged by management and two new part-time positions were established in 1997.

The orientation for surgical registrars was inadequate at Christchurch Hospital. There are a number of factors to consider in a new environment other than technical expertise. Registrars need to operate with their seniors, to gain local knowledge on how a hospital works in its entirety. Supervision is not adequate if a registrar does not know how to enlist assistance when required.

Canterbury Health does not have a credentialling system for surgical staff. This does not meet the College's standard. The issue of credentialling is of national relevance and is not particular to Christchurch. The current Chief Executive has approached the Clinical Director of Surgery in Christchurch Hospital to look at the establishment of a credentialling committee, which would be responsible for credentialling surgeons and withdrawing this status where appropriate. The establishment of a credentialling system is necessary to meet the obligations of Right 4(2).

Emergency Department

Until 1997 there was a poor pass rate by registrars of the Primary Examination of the Australasian College for Emergency Medicine at Christchurch Hospital. Registrars require adequate supervision and training. There were too few senior consultants and medical staff at Christchurch Hospital to allow adequate time for study or training and supervision. Throughout Australasia there is a shortage of Fellows of the Australasian College for Emergency Medicine (FACEMs). While Canterbury Health's staffing and reputation is low it has a reduced chance of attracting FACEMs, which in turn increases Christchurch Hospital's understaffing problems. Since 1997 staff numbers and pass rates have increased and this will assist Canterbury Health's chances of attracting future staff.

Nurses

Christchurch Hospital has historically employed people who have previously worked in Christchurch and there is generally a high number of nurses who have worked at Christchurch Hospital for some time. However, there have been inadequate processes to assess the competence of nursing staff, limited performance management and limited access to education for core nursing staff working in some specialist care areas. The management of acute patients, the large numbers of patient outliers and lack of speciality education added to the stress and pressure during the winter of 1996. While nurses worked hard to manage in difficult circumstances, there were instances when care did not meet appropriate standards and staff were not always supervised adequately. Certainly there was no formal process for the supervision of less experienced staff. After-hours, Duty Managers were also unable to supervise staff due to their high workload managing beds, accessing casual staff for the next shift and dealing with emergencies with limited clinical support.

Disaster Planning

Staff identified that while there were some instructions about what should happen in particular units in the event of a disaster, the overall Hospital plan was out of date. While the Emergency Department has demonstrated its ability to cope with multiple emergencies on a few occasions (for example, the Rolleston Train Crash and the Christchurch Girls High science experiment), I am concerned about what would happen if the Hospital was inundated with patients. While there have been disaster response practices within the Emergency Department, general ward staff education and practice in disaster response procedures needed updating. The lack of an approved hospital wide disaster plan was in breach of Right 4(2).

Canterbury Health advised me in its response to this opinion that in October and November 1997 new internal and external disaster plans were ratified and included in Policy and Procedure manuals. In December 1997, these new plans received encouraging feedback from St Johns Ambulance which wrote to the Southern Regional Health Authority commending Canterbury Health's work.

Nursing

Nursing is a central component in the provision of health services and co-ordination of patient care. Prior to the changes proposed in 1995, the nursing service lacked a clear vision and framework for professional leadership. The service:

(a) lacked cohesiveness and a shared vision, even within the Professional Nursing Unit;

(b) lacked a professional link to the operational management of the hospital;

(c) established standards and expectations which were not always enforced;

(d) lacked consistent monitoring systems, although some quality assurance activities were established;

(e) lacked support systems such as professional supervision processes and occupational health systems;

(f) had the beginning of a "clinical career pathway" which was not linked to specific competencies or education programmes; and

(g) failed to develop contemporary research-based practice.

For consumers to receive a reasonable standard of care there must be:

(a) adequate numbers of nursing staff and other resources to meet demand;

(b) nursing staff with sufficient knowledge and skills to cope with the clinical needs of consumers and their families;

(c) policies, guidelines, standards, supervision and education supporting staff to provide consistent and effective care and attention;

(d) clinical support systems and resources to assist nursing staff to assess and monitor a consumer's response to treatment and progress;

(e) monitoring systems to identify when things are not going according to plan and a process for dealing with problems that do occur;

(f) systems that provide support and reassurance for nursing staff; and

(g) patient-focused care and a focus on continuous quality improvement.

This assessment of the nursing service is based on expectations listed in the New Zealand Council on Healthcare Standards and is a minimum foundation criterion on which to establish professional leadership. The standard was breached by Canterbury Health during the period under investigation in the following ways.

Casual Nurses

The use of casual nurses by Christchurch Hospital has been high in comparison with other Crown Health Enterprises. This caused skill mix problems and difficulties providing supervision which contributed significantly to the way in which nurses coped with winter pressures. In particular, the reliance on casual nurses to work on the acute admitting wards and in the Medical Day Unit in 1996 was inappropriate. These nurses did not always feel capable of caring for patients with diverse care needs, there were too few permanent ward nurses to provide balance and the casual nurses were not always aware of how to get help. There was minimal education of these casual nurses about the expectations and clinical protocols for care of acute patients.

Nurse Staffing and Skill Mix

In some services the number of nursing staff has been inadequate to cope with demand. For example, there were inadequate resources and a lack of clear systems to support staff escort of patients within the Hospital.

While generally the care provided by nurses through the 1996 winter was to the best of the nurses' ability, there is evidence to show that staffing numbers, skill mix and patient volumes affected nurses' ability to meet patient needs. The high utilisation of casual nurses during 1996 compounded skill mix difficulties and the ability to develop the expertise of the casual nurses. Staff did not always have adequate experience to cope with outliers. This situation

compromised the quality and safety of patient care. While many potential system problems and staffing problems had been presented to management prior to the restructuring at Christchurch Hospital, little was done to address them and this compounded the problems during the winter of 1996. The ability to differentiate the skill of the workforce is essential to achieve a satisfactory skill mix, and existing systems did not facilitate this.

Patient-Focused Care

While nurses displayed a commitment to patient care at Canterbury Health, there was a lack of understanding of the meaning of continuity of care and how processes such as care planning and discharge planning can enhance patient outcomes. There was not much progress in the review of patient processes, documentation and outcomes management during 1996 and early 1997. While case management of certain patient groups may achieve continuity, an improved standard of care could have been achieved through a re-focus on co-ordinated care delivery without necessarily re-structuring the clinical teams. Attempts to be patient-focused varied across the organisation and examples from consumers of Christchurch Hospital services demonstrate a lack of co-ordination, lack of care, poor discharge planning, lack of patient focus as well as inadequate nursing staff.

Nursing Education and Supervision

The lack of effective operational systems, professional development, explicit standards and expectations, performance management systems and development processes resulted in some nursing staff not receiving the coaching and guidance they needed. There was limited commitment by management to nursing staff development and essential skills certification. Performance reviews for nursing staff are being reactivated with the development of a new performance appraisal form. There is still no formal graduate programme. A number of professional development initiatives were implemented in 1997.

Professional Leadership

While there have been some positive results from the efforts of the new leaders, especially since the beginning of 1997, the nursing service did not receive strong professional leadership over the period 1995 to 1996. This was due to a lack of professional development opportunities, lack of consistent standards and lack of a 'patient focus'. The new Patient Care Managers did not receive professional coaching or guidance but appeared to have used their ideas and experience to achieve gains in setting standards, organising preceptorship programmes, developing the appraisal form and beginning to make changes to practice. Despite these efforts, Christchurch Hospital's nursing service was still struggling to re-develop professional leadership in May 1997.

Canterbury Health advised me in January 1998 that:

- A director of Nursing has been appointed who is supported by a senior team with line responsibility.
- The clinical nurse facilitators have been renamed clinical charge nurses and have been made permanent.
- It now relies less and less on casual staff. An analysis of nursing staff used per ward per day shows that in December 1997 an average of 7.1% of nursing staff used were casual.

- Casual staff must attend a paid two day orientation programme which includes CPR training. In 1997 CPR training days were held to update pool and casual staff who had not had CPR training since commencing at Christchurch Hospital.

- A formal escort policy has been developed and circulated to all relevant staff.

- Over the last 12 months nursing staff have worked extremely hard to improve patient care through the numerous initiatives which have been introduced and which have required nursing input.

Equipment

There was a lack of equipment in the Emergency Department and the Medical Day Unit which led to inappropriate standards of care. In addition, acute admitting wards were opened with inadequate equipment. During 1996 and 1997 there has been an improvement in much of the basic patient care equipment available, but in February 1997 there remained a lack of some essential monitoring equipment for a hospital of this size and acuity. Canterbury Health advised this was addressed by mid 1997.

The Hospital also lacked a product standardisation policy, for example, in respect of defibrillators, which resulted in staff not being fully trained and being unfamiliar with certain equipment.

The replacement of equipment was also inappropriately managed. Some basic equipment should be replaced before it reaches the end of its useful life. For example, defibrillators should be replaced in accordance with the maker's recommendations so that effective treatment is not delayed because defibrillators fail to deliver a sufficient electric shock. Canterbury Health advised that the 5 oldest Lifepaks were replaced in December 1997.

The lack of an appropriate system for the storage, retrieval and return of infusion pumps is a breach of the Code. The system must be properly documented and staff trained in its effective use. Centralisation will ensure pumps can be readily accessed, are clean and properly maintained.

Canterbury Health informs me it is committed, within the constraints of its capital expenditure budget, to progressively upgrade equipment.

Transit Care

It is accepted in clinical practice that patients who are unwell and distressed are at risk in the unfamiliar environment of a hospital and require particular care and attention. It is also well recognised by health professionals that patients admitted for assessment and treatment require regular monitoring and attention.

There are clinical reasons for providing optimum care to the patient while in transit. It is essential that the patient receives care during transport that is as good as that being received in the particular department that they are leaving. This care is necessary for three reasons:

(a) the equivalent level of monitoring must continue;

(b) the patient may be in potential jeopardy (for example where an endotracheal tube is in position, or the patient is recovering from anaesthesia); and

(c) the patient may require an anaesthetic for a procedure.

Even if a patient appears to be stable, it is still necessary for that patient to have immediate access to equipment and expertise should it be required.

Examples were provided of cases in which the transit of patients from wards to other departments, the intra-hospital transport and management of patients with trauma and other acute conditions, and the transfer of patients from wards to ambulances, have been below that which is acceptable for a major hospital.

Canterbury Health should also have an efficient well-trained retrieval service. In the absence of a dedicated service, Canterbury Health had some standing orders and clinical guidelines but these were not consistently followed and this situation was exacerbated by the shortages of staff.

Christchurch Hospital had no dedicated nursing escort service and failure to provide nursing or medical escorts amounts to a breach of relevant standards. Canterbury Health advised that an escort policy was introduced in December 1997.

Duty Management

Duty Managers play a key safety role and Christchurch Hospital was not appropriately staffed with experienced Duty Managers during the winter of 1996. Most major acute hospitals have a duty management system and the role works most effectively where it is perceived as an extension of the general manager function, with a focus on patient admission and placement, response to emergencies, accessing of supplies and equipment, staff deployment, and bereaved family support. The role is usually included in management decision-making and has authority to act on a wide range of issues in the absence of the general managers.

At Christchurch Hospital in August 1995, the daytime Duty Manager was replaced with a Bed Manager and the daytime Duty Manager's other duties were rotated among the Patient Care Managers. This resulted in a reduced standard of service for a variety of reasons, including:

(a) Patient Care Managers often had insufficient knowledge of areas outside their own cluster;

(b) Patient Care Managers undertook their own duties in addition to those of the Duty Manager, which included the requirement to attend cardiac arrest emergencies;

(c) Patient Care Managers were not necessarily up to date on the various clinical specialities and therefore were unable to provide clinical support and guidance where needed;

(d) while the Bed Manager received a hand-over each morning from the night-time Duty Manager, the afternoon Duty Manager had difficulties when commencing duty with a hand-over from both the Bed Manager and a Patient Care Manager;

(e) the afternoon Duty Manager often found the skill mix of staff was inappropriate but it was too late to change this.

The role of Duty Manager at Christchurch Hospital was under-resourced and not given sufficient authority. Therefore Duty Managers were unable to provide adequate support for the front-line nursing staff. Duty Managers met with management to explain the pressure they were under but no action was taken. They did not receive the management support and coaching

essential for the effective management of an acute hospital. The fact that Duty Managers were given insufficient training, authority and support resulted in an inability to fulfil their role and was a breach of Right 4(2).

In early 1997 Canterbury Health ceased to employ a Bed Manager and stopped using Patient Care Managers for Duty Management. A full-time Duty Manager was reinstated during the day.

Paediatrics

Concern was expressed that the Paediatrics Department at Canterbury Health also had inadequate resources in terms of space, equipment and staff. I have not formed an opinion on whether there was a breach of the Code in this Department.

RIGHT 1(2)

RIGHT 1
Right to be Treated with Respect

2) Every consumer has the right to have his or her privacy respected.

In my opinion Canterbury Health breached Right 1(2) in respect of several areas in Christchurch Hospital where the personal privacy of consumers has not been respected. The areas which came to my notice and were in my opinion a breach of Right 1(2) are as follows:

Gastrointestinal Investigative Unit

During 1996 there was no area to give consumers their diagnosis in private following examinations. Further, sometimes personal information was given to a consumer in the recovery room where a number of other consumers might be present. As a result consumers were told the results of certain procedures in the corridors in an attempt to provide some form of privacy.

Dental Department

The clinic was open plan and three dental chairs shared the same area, resulting in no privacy for consumers during consultations. In addition, new patients were required to provide personal information at the front desk, which was located in the waiting area.

Emergency Department

In 1996 clinicians and nurses in the Emergency Department were concerned about the number of patients who waited for treatment and were treated in corridors where there was no privacy. Photographs of such patient crowding were shown to the General Manager Christchurch Hospital Services. Canterbury Health has advised that there is now a procedure room for patients who require additional privacy in the Emergency Department.

Uronephrology Department

Elective patients were frequently prepared for surgery in a "day-room" due to a lack of beds in the ward. There was no privacy in this room, but patients were assessed there and completed the consent process, which may involve the disclosure of procedures, in the presence of others.

Examples were given of an elderly patient who waited throughout the day and into the evening becoming "*upset and exhausted*", and of another who underwent bowel preparation in the day room and had to run 40 metres to a toilet.

Reasonable Actions

The former Chairman advised that Canterbury Health took reasonable actions in the circumstances to give effect to Right 1(2). The circumstances indicated resource constraints and complying with the Code would have necessitated capital expenditure to remodel buildings. The Directors were obliged, under letters of comfort, to take a conservative approach to capital expenditure.

To claim this defence, Canterbury Health would have to show it took steps to bring the necessary capital expenditure to the Shareholders' attention. I was given no information to suggest that Canterbury Health raised with Shareholders the expenditure necessary to address the privacy issues and the onus to show that reasonable actions were taken is on the provider.

RIGHT 10

RIGHT 10
Right to Complain

1) *Every consumer has the right to complain about a provider in any form appropriate to the consumer.*
2) *Every consumer may make a complaint to -*
   a) *The individual or individuals who provided the services complained of; and*
   b) *Any person authorised to receive complaints about that provider; and*
   c) *Any other appropriate person, including -*
      i. *An independent advocate provided under the Health and Disability Commissioner Act 1994; and*
      ii. *The Health and Disability Commissioner.*
3) *Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.*
4) *Every provider must inform a consumer about progress on the consumer's complaint at intervals of not more than 1 month.*
5) *Every provider must comply with all the other relevant rights in this Code when dealing with complaints.*
6) *Every provider, unless an employee of a provider, must have a complaints procedure that ensures that -*
   a) *The complaint is acknowledged in writing within 5 working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period; and*
   b) *The consumer is informed of any relevant internal and external complaints procedures, including the availability of -*
      i. *Independent advocates provided under the Health and Disability Commissioner Act 1994; and*
      ii. *The Health and Disability Commissioner; and*
   c) *The consumer's complaint and the actions of the provider regarding that complaint are documented; and*
   d) *The consumer receives all information held by the provider that is or may be relevant to the complaint.*
7) *Within 10 working days of giving written acknowledgement of a complaint, the provider must, -*
   a) *Decide whether the provider -*
      i. *Accepts that the complaint is justified; or*
      ii. *Does not accept that the complaint is justified; or*
   b) *If it decides that more time is needed to investigate the complaint, -*
      i. *Determine how much additional time is needed; and*
      ii. *If that additional time is more than 20 working days, inform the consumer of that determination and of the reasons for it.*
8) *As soon as practicable after a provider decides whether or not it accepts that a complaint is justified, the provider must inform the consumer of -*
      i. *The reasons for the decision; and*
      ii. *Any actions the provider proposes to take; and*
      iii. *Any appeal procedure the provider has in place.*

In my opinion Canterbury Health did not meet its obligation to provide an accessible, efficient and effective complaints procedure in accordance with Right 10.

In particular, Canterbury Health failed to:

(a) actively inform consumers about whom to complain to and how to complain;

(b) acknowledge or respond to complaints within reasonable time-frames, including those set by Right 10(7);

(c) inform consumers about the progress of their complaints at least monthly;

(d) advise consumers of the availability of independent advocates and the Health and Disability Commissioner as required by Right 10(6)(b);

(e) train staff about their obligations under the Code;

(f) ensure consumers could complain in a manner that allowed them dignity and confidence about their future utilisation of the services of Canterbury Health in accordance with Right 10(5);

(g) ensure all matters raised by complainants were answered; and

(h) advise complainants of the reasons for decisions and proposed actions.

The documented cases in relation to Mrs Brown, Mrs Watson's family, Mrs Humphrey's family, consumer "A" and consumer "B" as set out in Section 6 of this Report, show breaches of Right 10.

The overall policy for handling complaints was not put into place until January 1997, which in itself was a breach. Even after the policy was implemented, not all employees were aware of the policy or the Commissioner. This was clear at the commencement of this investigation when it became apparent that some Canterbury Health employees did not know of the Commissioner or her role. While the new Canterbury Health policy was supposedly in place on 1 January 1997 and assurances to this effect were given by the Chief Executive, it was obviously not working in practice. During the course of the investigation I reviewed three complaints made to Canterbury Health in 1997 which had not received a response.

In summary, to be effective a complaints process must be useful to the person complaining. The Code demands this. If a consumer says "I am not happy and want to tell you about it" this is a complaint and the consumer has the right to be heard and to receive a response. While Canterbury Health put in place a new complaints policy in 1997 it was still not effective in ensuring all complaints were processed in accordance with its obligations under the Code.

CLAUSE 1 - CONSUMERS HAVE RIGHTS AND PROVIDERS HAVE DUTIES

1 Consumers have Rights and Providers have Duties:

1) Every consumer has the rights in this Code.
2) Every provider is subject to the duties in this Code.
3) Every provider must take action to -
a) Inform consumers of their rights; and
b) Enable consumers to exercise their rights

All Crown Health Enterprises including Canterbury Health were visited by me prior to the implementation of the Code and informed of their impending legal obligations. Despite this, few of the consumers interviewed during the investigation had been informed of their rights under the Code.

At the time the investigation commenced, none of the Canterbury Health complainants subsequently interviewed had complained to me or knew, at that time, of their right to do so.

Canterbury Health, in failing to inform consumers of their rights, breached Clause 1(3) of the Code.

CLAUSE 3 - PROVIDER COMPLIANCE

3 Provider Compliance:

1) A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.

2) The onus is on the provider to prove that it took reasonable actions.

3) For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

Resource Constraints

In accordance with Clause 3 of the Code, in forming my opinion I considered whether Canterbury Health had taken all reasonable actions in the circumstances to meet its obligations under the Code. This included a consideration of whether Canterbury Health had taken all reasonable actions to meet the Code in light of its resource constraints. I found little documented evidence that Canterbury Health had taken reasonable actions in the circumstances. Canterbury Health did not advise the Crown Company Monitoring Advisory Unit that the efficiency drive and the time-frames of the workout programme might threaten standards of patient care, nor did it advise Southern Regional Health Authority that revenue was inadequate to meet its obligations. A mitigating factor was Southern Regional Health Authority's refusal to fund additional Accident Treatment and Rehabilitation beds at Healthlink South, which contributed to the crisis in the winter of 1996.

On the contrary, Canterbury Health did not recognise that it was providing inappropriate services and was paid the price it requested in 1996/97 from Southern Regional Health Authority for Emergency Department services.

In response to my opinion Canterbury Health Ltd submitted that, in the circumstances, it did take all reasonable steps to prevent a breach by managing the limited resources it had, and obtaining more resources. Canterbury Health advised that it received $5 million less than requested and $15 million more than the Southern Regional Health Authority had initially offered. They also advised that due to the nature of bulk funding in the 1995/97 contract, any price requested for emergency services was a notional figure only.

However, the Code places the onus on a provider to prove that it took reasonable actions and no documentation demonstrated that Canterbury Health advised the Southern Regional Health Authority that it would be unable to provide services of an appropriate standard on the basis of the funding received.

Funding

In 1997 the Chief Executive of Canterbury Health has been forthright in his correspondence with Southern Regional Health Authority and Crown Company Monitoring Advisory Unit about funding shortcomings and the impact of insufficient revenue on Canterbury Health and the services it provides to health consumers.

Canterbury Health has committed substantial expenditure in 1997 to address many of the deficiencies identified in this opinion. For example, in the Emergency Department Canterbury Health informed me that it has spent $800,000 on equipment and that an equivalent of $1.3 million per annum will be invested in staff. Canterbury Health has no option but to spend these sums if safe care is to be delivered.

Canterbury Health advised me it is concerned this expenditure has been undertaken without funding from the Health Funding Authority and, in particular, that the Emergency Department is under-funded by $2.68 million. Canterbury Health advised it has provided these facts to the following key organisations and health officials: the Southern Region of the Health Funding Authority, the Ministry of Health, Crown Company Monitoring Advisory Unit, the Chair of the Health Funding Authority, the Health Minister and the Parliamentary Select Committee on Health.

GENERAL OBSERVATIONS

This investigation was a very complex task involving a large number of parties who influenced the outcomes at Christchurch Hospital. My investigation at Christchurch Hospital was into the actions of Canterbury Health Limited and I have reported my opinion on those actions accordingly.

However, this Report would not be complete without some comment on the actions of various other parties who were not investigated under the Act but whose actions had varying degrees of influence on the events that occurred.

MINISTRY OF HEALTH

Responsibility

The Ministry of Health is responsible for:

advising the Minister of Health and the Government on policy for health and disability support services and on health implications of policies in other sectors;

acting as the Minister's agent for administering public funding to the sector, negotiating Funding Agreements with Regional Health Authorities (now a Health Funding Authority) and managing their performance;

protecting, promoting and improving public health, and reporting annually on the state of public health; and

monitoring the overall performance of the sector.

In my view there have been failures by the Ministry in meeting certain aspects of its responsibilities which are reported below. Some failures concern the sector generally, but there were also failures specific to events at Canterbury Health.

Overall Sector Monitoring

Firstly, no policies were developed to guide Regional Health Authorities in the purchase of emergency services for the public of New Zealand. Secondly, no standards were or have been developed on which to monitor the quality of emergency services or to enable a comparison between regions. The absence of national policies and standards for the delivery of emergency and other health services makes it difficult for both providers and the public to evaluate the performance of both Regional Health Authorities and Crown Health Enterprises.

Given that one of the main reasons for the separation of purchasing and delivery was to improve transparency and accountability in the purchase and provision of health services (Statement of Shareholders' Expectations), much work remains to be done to establish national purchasing policies and service standards. These are necessary to hold Regional Health Authorities (now the Health Funding Authority) and Crown Health Enterprises accountable for delivering services in a uniform and acceptable manner across the country. Under its responsibilities, the Ministry should have ensured broad policies and standards were in place.

The Ministry has reported comparisons but these are based on actual performance and produced up to 15 months after the end of the financial year. In assessing the appropriateness of Canterbury Health's

services, I reviewed national intervention rates which show the volume of services purchased relative to the population served. Lower intervention rates tend to result in increased acuity of presenting cases, increase the cost of treatment per case (the case weighting) and push the non-deferrable portion of work higher. The analysis of the public intervention rates of the Southern Regional Health Authority for the 1994/95 year showed purchases of surgical services from Canterbury Health were 20% below national rates and medical services were 18% below. Canterbury also had the lowest intervention rates in the Southern Region by a wide margin. The Ministry expressed concern regarding the use of target intervention rates as an indicator and advised me that booking systems are an alternative and probably more appropriate long term solution to ensure consistent service nationally.

In July 1996, a waiting list fund was introduced to clear waiting list backlogs as at May 1996 and to act as a catalyst for the implementation of booking systems by June 1998. Until 1997, only a small amount of waiting list funds were accessed by Canterbury Health which may have increased the volumes of emergency services required at Christchurch Hospital. While responsibility for making applications to the Fund resided with Canterbury Health who worked through the Southern Regional Health Authority, improved monitoring by the Ministry of access to these funds across the country may have drawn to the Ministry's attention questions regarding the provision of services in the Canterbury region.

Canterbury Health Monitoring was the Direct Responsibility of the Southern Regional Health Authority

The Ministry compounded difficulties at Canterbury Health by directly reviewing operations, thus encroaching on the responsibility of the Southern Regional Health Authority. It was Southern Regional Health Authority's role to monitor Canterbury Health and by becoming involved and undertaking the review the Ministry intervened in this direct monitoring responsibility, blurring the lines of accountability. It is critical that lines of authority are clear and this early direct intervention by the Ministry reduced the accountability of the Southern Regional Health Authority to perform its proper monitoring function. It also compromised the Ministry's suitability to monitor the overall process of purchase and provision of services at Canterbury Health as it had itself become part of that process. While the current legislative framework permits multiplicity of review, it is not effective in practice for multiple parties to be responsible for monitoring an organisation.

The Ministry requested the Southern Regional Health Authority to follow up safety issues with Canterbury Health after its first review in February 1996. I saw no correspondence to show the Ministry ensured the Southern Regional Health Authority did this. The Ministry again expected that the Southern Regional Health Authority would monitor the quality of service provision at Christchurch Hospital following the second review in September 1996 and again I saw no correspondence to show this monitoring occurred. Finally, the Ministry failed to provide the Southern Regional Health Authority with a copy of the Patients are Dying Report which it received in January 1997. These failures indicate the Ministry not only directly intervened in the Southern Regional Health Authority's lines of authority but did not undertake appropriately its own function of managing the performance of the Southern Regional Health Authority.

The Ministry's Reviews of Canterbury Health

The Ministry's reviews were focused narrowly and concentrated mainly on nurse restructuring, workloads and staff mix, with minimal reference back to standards or any comparative data which could have shown whether Canterbury Health was meeting its obligation to provide services of an appropriate standard.

The second review was undertaken as a result of the report "Systems Failure threatening Patient Safety at Christchurch Hospital" prepared by Christchurch Hospitals' Medical Staff Association and delivered to the Minister of Health on 12 September 1996.

This report was mainly about nursing issues but included a few paragraphs which pointed to a much wider issue for Canterbury Health. For example:

"....

(c) On many occasions the Medical Day Unit has been pressed into service as an acute admitting ward. It is not equipped for this purpose. Patients were cared for on trolleys placed within a foot to 18" of one another. Such patients have included those with serious infections, such as meningococcal meningitis and life threatening pneumonia, side by side with patients with unstable cardiac conditions. The potential for cross infection is obvious. The inability to appropriately resuscitate an acutely collapsed cardiac patient in such a cluttered setting is also obvious.

...

(e) A further indicator of quality is the ability of staff to be aware of the location of all patients who are their responsibility at any point in time. The artificial and preventable bed shortage experienced in recent months has resulted in doctors visiting up to 15 separate wards per day in order to see all the patients under their care. This has posed an additional burden on medical staff time (simply moving from ward to ward) at a time when the patient load is at its highest and when all available time should be devoted to effective clinical management at the bedside ... The combination of inaccurate listing plus wide geographic dispersal of acutely admitted patients in multiple wards, carries obvious risk. In July 1996 specialist physicians of up to 30 years experience stated in a letter to the General Manager agreed to by 22 physicians (<u>all</u> those responsible for acute medical admissions at Christchurch Hospital) that recent months have seen the lowest safety standards for acutely admitted patients in living memory.

...

(f) A further quality indicator is the efficiency of correspondence between staff and management. This has failed on multiple occasions."

These matters were not addressed adequately by the Ministry in its review or its recommendations issued on 11 October 96. The review and recommendations concentrated on nursing and incident reporting.

At the same time as the second review was undertaken by the Ministry, a Resource Review Report commissioned by Canterbury Health in August 1996 provided information that unsafe practices had developed. *"... This series of delays out of normal working hours might very well be described as inadequate clinical service delivery, and could very well contribute to the exacerbation of admitting difficulties at the Department of Emergency, further deterioration of patients' conditions over time leading to the requirement for increased clinical care support, and might even be described as unsafe*". The Ministry were informed of the commissioning of this report in Canterbury Health's response of 1 October 1996 to the second review.

Other Indicators

The Ministry of Health received other indicators that the situation was not satisfactory in Canterbury.

2.5.1 Lack of a Contract

The failure of the Southern Regional Health Authority and Canterbury Health to sign a formal contract for the purchase of health services over a two year period indicates that the commercial principles

underpinning the health contracting processes were not working effectively and ought to have led to a review of the issues and their potential impact on service delivery.

2.5.2 Lack of Rehabilitation Beds

On 23 April 1996, Southern Regional Health Authority sent the Director General of Health a signed copy of its letter to Canterbury Health which advised that no further funds were available for the proposed solutions "*to meet the winter crisis for older people*". This letter was received between the Ministry's two reviews and was a signal of the pressures on Canterbury Health. The Director General neither acknowledged nor queried this letter. The Ministry does not appear to have considered the impact of this lack of beds in terms of the review it had recently completed. Nor did it address the issue in its next review in September when Canterbury Health also advised the Ministry of the problems this created.

Summary

In my view the Ministry of Health did not adequately meet its responsibilities. It did not establish effective policies for purchasing, particularly purchasing emergency services, nor did it set standards for effective performance monitoring. The Ministry of Health's monitoring of the Southern Regional Health Authority was inadequate and its early intervention in the issues at Canterbury Health was inappropriate as the reviews should have remained the responsibility of the Southern Regional Health Authority. By undertaking these reviews the Ministry confused the lines of accountability. The Ministry's reviews of Canterbury Health, particularly the second review, were not undertaken in sufficient depth. While I understand that the Ministry got caught up in the dysfunctional aspects of the Hospital's operations, it should also have physically inspected the Hospital. Finally, the Ministry should have requested and held the Southern Regional Health Authority accountable for effective audits of Canterbury Health and ensured the Southern Regional Health Authority negotiated and signed contracts with Canterbury Health.

SOUTHERN REGIONAL HEALTH AUTHORITY

Responsibilities

The objectives of Regional Health Authorities are to:

(a) promote personal health;

(b) promote the care of and support for those in need of personal health services or disability support services;

(c) promote the independence of people with disabilities;

(d) improve, promote and protect public health to the extent enabled by their funding agreements; and

(e) meet the Crown's objectives to the extent enabled by their funding agreements.

The functions of Regional Health Authorities are to:

(a) monitor the need for public health, personal health and disability services for the people described in their funding agreements;

(b) purchase such services for those people;

(c) monitor the performance of providers with whom the Regional Health Authority enters into Purchase Agreements; and

(d) perform any other functions they are given under any enactments or as authorised by the Minister.

From 1 January 1998 the four Regional Health Authorities merged to form a single funding agency, the Health Funding Authority, with regional offices.

Purchase of Services

A major part of Canterbury Health's business plan was to obtain efficient prices from the Southern Regional Health Authority and to withdraw from services if the prices required were not attainable. Despite long and difficult negotiations, the Southern Regional Health Authority did not sign a formal contract with Canterbury Health for the two year period from 1995 to 1997. A Heads of Agreement was signed for the period 1995/97 in January 1996, which was seven months into the financial year.

My review of correspondence and other documentation provided by both parties shows that the Southern Regional Health Authority, as principal purchaser of services from Canterbury Health, did not have a productive relationship with Canterbury Health. Its stance fell well short of good commercial contracting practice. The Southern Regional Health Authority could not be relied on to respond to requests for information in a timely and positive manner. Nor did it necessarily honour its agreements, as evidenced by its failure to pay in a timely way the sum of $6.5 million in revenue for the 1994/95 year which was agreed under the Heads of Agreement in 1996 and finally paid out in November 1996. The effects of this non-payment on Canterbury Health's cashflow do not seem to have been understood by Southern Regional Health Authority. In my view the inability to communicate with and rely on its major purchaser had a detrimental effect on Canterbury Health as it attempted to manage increasing demand while at the same time implement a major programme of change to improve its efficiency.

Under the current health policy model in New Zealand, Canterbury Health is expected to earn an appropriate return on shareholders' investment. The model also requires the purchaser to pay sustainable medium term prices. From the outset of the reforms in 1993 it was assumed that better management of patients by providers, competition between providers, and the pressure to create internal efficiencies, would enable Crown Health Enterprises to break even within two to five years of the introduction of health reforms.

Southern Regional Health Authority advised in its response that *"Also of note is that RHA funding was not increased to reflect cost increases (inflation). Government expected the CHEs to increase efficiency to offset cost increases. The conflict between the CHE seeking compensation for cost increases, and the absence of an inflation adjustment to RHA funding was a fundamental cause of tension between the parties"*.

The successful implementation of any health policy is dependent on all parts of the system working in the manner intended. It can only be reasonable to expect a certain level of performance from Canterbury Health if the Southern Regional Health Authority, as principal purchaser, purchases services in a manner that enables the Crown Health Enterprise to meet its targets if it operates efficiently. While Canterbury Health found itself under severe pressure from its Shareholders to break even, the Southern Regional Health Authority neither purchased the volumes nor paid the sustainable medium term prices necessary for Canterbury Health to achieve its objectives.

The nature of the relationship between Southern Regional Health Authority and Canterbury Health was not conducive to improvements in service delivery or the maintenance of service standards by Canterbury Health. Given the lack of suitable alternative providers in many areas of health service when health

reforms were introduced, in my view a co-operative rather than an adversarial process was then and remains today the proper method of negotiation to improve health outcomes for the public of New Zealand.

Insufficient Funding

The Southern Regional Health Authority did not pay sufficient revenue, either in terms of the price paid or the volume purchased, to enable Canterbury Health to provide appropriate services in the short or medium term. Southern Regional Health Authority advise its *"purchasing role required an active attempt by SRH to negotiate competitive prices and services"* and *"...it was a requirement of CHEs to negotiate the 'best deal' they could with the purchaser"*. Southern Regional Health Authority took an aggressive approach to negotiations and did not appear to take into consideration the effect of this approach on the standards of care provided to the public if Canterbury Health was not able to negotiate appropriate funding for the required volumes.

I recognise that in the first few years of the health reforms reliable comparative data to establish the right prices and volumes of purchasing was difficult to obtain. Studies now available make it very clear that Canterbury Health was not paid appropriate prices and the studies support the case for more realistic revenues in the future. While Southern Regional Health Authority paid Canterbury Health 97% of its total requested price for services in 1995/96 and 100% of its requested price for Emergency Services, to achieve this price Canterbury Health gave notice that it would withdraw from the provision of emergency services unless the request was met. The negotiated outcome was an increase in payment from $5.8 to $6.8 million.

Although the Southern Regional Health Authority paid the requested price, it should have undertaken comparisons, both in terms of the costs of other tertiary Crown Health Enterprises and the prices paid by other Regional Health Authorities to tertiary Crown Health Enterprises. However Southern Regional Health Authority only undertook benchmark pricing regionally and looked at international data. The Commissioner was advised that it paid the mid point of such prices. The Southern Regional Health Authority declined my request to provide information on these price benchmarking studies. In my view it should have considered that the average of prices paid to Crown Health Enterprises in the South Island was not necessarily an appropriate benchmark for the price that should be paid to a major tertiary hospital providing regional emergency services. I have no information on which to consider whether volumes were also taken into consideration in this benchmarking.

In response to these comments, the Southern Regional Health Authority advised "*The prices used by SRH during negotiations leading up to the agreement were based on prices submitted by all six Crown Health Enterprises in the southern region during early 1995. These were supported by prices obtained from overseas, the private sector, and other New Zealand costing and pricing information.*

The Commissioner has given far too much weight to the view of the National Benchmarking Agency, which is, in fact, a commercially based organisation, commissioned by CHEs to support their pricing negotiations with RHAs.

Also of note is that the ability of SRH to compare its prices to the prices paid by other RHAs was limited by the Commerce Act and by different ways of purchasing hospital services.

Establishing prices for the enormous range of services provided by hospitals commenced in 1994, and was still developing in 1995."

Certainly as further information on prices and volumes became available in the 1996/97 year, Southern Regional Health Authority should have commenced more extensive benchmarking to assess both the efficiency and output of Canterbury Health compared to other similar Crown Health Enterprises. No

evidence of such benchmarking was produced by the Southern Regional Health Authority. In late 1996 Canterbury Health itself obtained this comparative data.

The letter sent by Canterbury Health's Chief Executive to the Minister of Health in February 1997 reinforces my view that, as a consequence of significant under-purchasing by Southern Regional Health Authority, an environment had developed where standards were impossible to maintain once Canterbury Health delivered the volumes demanded of it as a provider of last resort. The letter states "*Canterbury Health's difficult financial position over the last three and a half years has resulted in a shortfall in resources to meet, what are in my view, minimum levels of capital equipment and skilled staff requirements in some areas. The Emergency Department at Christchurch Hospital is a case in point where I believe the shortage of resources, relative to the workload, approached the point last year of becoming dangerous*".

I agree with Canterbury Health's concern. This level of under-funding has its most significant effect on emergency services, which are the core of Canterbury Health's business. It created a ripple effect throughout the organisation.

There is clear evidence that the Southern Regional Health Authority did not contract sufficient volumes from Canterbury Health relative to the population served, either when measured by national intervention rates or by comparison with intervention rates for the remainder of the South Island. In my view there is also clear evidence that Southern Regional Health Authority did not pay Canterbury Health appropriate prices for those health services.

Southern Regional Health Authority commented *"If Canterbury Health was concerned about intervention rates, then it had the opportunity in 1996 and 1997 to access the separate funds* [waiting list funds] *made available by the Minister of Health for additional elective surgery to be undertaken by CHEs. This required CHEs to make formal application to their regional health authority for access to these funds. In the early stage of the scheme, SRH documentation will show that staff strongly encouraged and then assisted the CHE to take advantage of this additional funding option.*

Over the period under review, Canterbury Health also had the highest acute volume growth rate of any southern regional CHE. As noted, the RHA in its purchasing had first to compensate for this care, but also had to adjust downwards its purchasing of non-acute (arranged surgical) care to allow it to live within overall budget settings."

I note that the particularly important period for accessing the waiting list funds was during May to September of 1996 when matters at Canterbury Health were at their most critical.

Canterbury Health was required under the Statement of Shareholders' Expectations to continue to treat patients irrespective of the fact that the funder was contracting insufficient volumes to cover those patients whose procedures could not be deferred. The volume pressure increased the acuity of the cases admitted and increased Canterbury Health's costs. In the 1997/98 Heads of Agreement the Southern Regional Health Authority acknowledges that it is not able to fund the volumes which it should be purchasing to enable Canterbury Health to treat non-deferrable cases.

In Southern Regional Health Authority's response it advised that *"In 1997/98 a more detailed EDS* [Emergency Department Services] *specification was used for negotiating by SRH. To their credit, CHL had already embarked on upgrading their EDS. Lack of available additional funding meant SRH was not able to increase its price for EDS in the 1997/98 year."*

"The Health Funding Authority intends to pay nationally consistent prices to all providers commencing from July 1998. Work is currently underway, in conjunction with most Crown Health Enterprises, to establish efficient prices for all hospital services."

During 1997 a more co-operative process appeared to develop between Canterbury Health and the Health Funding Authority, Southern Region. This co-operation enables the sharing of information to determine realistic prices and volumes. In my view this will also encourage efficiencies and enable an improved focus on a seamless transition of care between providers.

Audits

The purpose of any audit by the Southern Regional Health Authority into quality standards should have been not only to ensure Canterbury Health had policies for delivering services of an appropriate quality, but also that those policies were implemented and operating properly to maintain standards. In my view the Southern Regional Health Authority processes for monitoring and auditing Canterbury Health were not adequate and did not meet its requirement to monitor the performance of providers.

The Southern Regional Health Authority service specifications, under the "Duty of Care" section, requires its Crown Health Enterprises to "*provide and uphold at all times appropriate standards of care; emergency care; continuing and transfer of care*".

Monitoring the safety and quality of services is part of a Regional Health Authority's statutory responsibility. To meet this obligation the Southern Regional Health Authority required Canterbury Health in the Heads of Agreement to "*provide a narrative report including your assessment of your performance in the previous quarter in meeting the requirements of the Agreement.* [as well as] *Any issues you would like to discuss with us, your responses to any previous identified issues ...*" In this way the Southern Regional Health Authority effectively relied on Canterbury Health's monitoring of its own activities to identify problems and did not provide separate independent oversight.

In effect those audits undertaken were self assessments. While I can appreciate that in the initial years of implementation of the health reforms the Southern Regional Health Authority's focus was necessarily on the development of tools to monitor processes and standards of care, Southern Regional Authority did not take steps at Canterbury Health to ensure the tools it relied on were put in place nor did it review the outcomes from the use of these tools.

In February 1998, the Health Funding Authority, Southern Region responded:

"SRH believes it is not inappropriate to rely on a provider's own monitoring of clinical service delivery. In signing the contract, the provider accepts the obligation to raise with the purchaser any areas in which their performance is not meeting purchase agreement requirements. When supplemented by routine monitoring, complaints resolution, priority based audits, and outcome monitoring, the purchaser is appropriately carrying out its obligations. ... It is misleading to state that the purchaser's goal in these activities was an assessment of clinical service delivery. Rather the goal is assessment of compliance with the provisions in the contract, which describes the volumes and quality systems required to be in place. The provider has the primary obligation for identifying and addressing problems with clinical service delivery, including specific patient management reviews. Again, this also reflects the Commissioner's lack of clarity about the respective roles of organisations, such as the purchaser."

During 1996, when there were mounting concerns regarding patient safety at Canterbury Health, it was inappropriate in my view for the Southern Regional Health Authority to consider its obligations effectively discharged by simply writing letters to the Chief Executive seeking reassurance about patient safety. The extent of its failure to meet its obligations is demonstrated by the fact that it never followed up and obtained a copy of the "Patients are Dying" Report, the existence of which was widely and publicly reported. It is unacceptable that despite the public concern which developed around the Christchurch Hospital situation, including a major media debate, the prospect of a ministerial inquiry and questions being asked in Parliament, the organisation responsible to the public for the adequacy of services did not urgently obtain a copy of the report which had provoked the

controversy. To my knowledge, as at April 1997, the relevant people at the Southern Regional Health Authority had still not obtained a copy of the report.

Integration of Care

Further to its obligation to purchase sufficient services for the public, the Southern Regional Health Authority should have fostered co-operation with its providers and among providers. In the January 1996 Heads of Agreement, the Southern Regional Health Authority recognised the additional cost Canterbury Health faced because blocked discharge pathways resulted in beds being occupied longer than necessary and Southern Regional Health Authority agreed to work with Canterbury Health to find solutions. By April 1996, the Southern Regional Health Authority acknowledged there were insufficient Accident Treatment and Rehabilitation beds for the winter crisis and that there were no additional resources available to purchase additional beds. In June 1996, with the winter crisis at its peak, the Southern Regional Health Authority advised Canterbury Health that it would have to manage the problem itself by prioritising admissions and discharges. Southern Regional Health Authority should not have left the problem with Canterbury Health.

On the basis of the Ministry of Health's population based guidelines the Southern Regional Health Authority significantly under-purchased Accident Treatment and Rehabilitation beds in the 1994/95 and 1995/96 year. The purchasing decisions in this area resulted in the inability of Canterbury Health to discharge patients from emergency care and contributed to the crisis during the winter of 1996. The Southern Regional Health Authority's failure to take short-term measures to unblock Christchurch Hospital beds, its slow response to Crown Health Enterprise proposals and the reliance it placed on providers to develop initiatives to solve the problem, suggests it did not have the ability to meet its obligations.

The Southern Regional Health Authority had an obligation to share the risk with the providers and, while I applaud the initiatives taken with providers to set up an integrated pilot of programmed care by the end of 1997, it must still purchase short term solutions while developing these longer term plans.

Health Funding Authority

The establishment of a single national purchasing agency, the Health Funding Authority, provides an opportunity for the parties to put behind them the experience in Christchurch since 1993 and foster a new environment in which all parties fully accept their responsibilities and recognise that co-operation and collaboration is required. This is particularly significant in the health and disability sector where different providers must work together to ensure continuity of care to consumers.

The Health Funding Authority will be of critical importance in this process. In my view it should accelerate its efforts to develop and purchase integrated care packages involving all health providers from primary to tertiary. With better consumer focus, clear service specifications and adequate monitoring, I expect to see more efficient provision and improved service.

Consumers have a right to expect as much importance placed on monitoring providers to ensure quality services as there is on negotiating the volumes and prices in contracts. Both are statutory functions.

Summary

On the information presented by way of correspondence, contracts, audits and monitoring by the Southern Regional Health Authority, it is my view that the public of Christchurch were not well served by the Southern Regional Health Authority in terms of either purchasing services from Canterbury Health on their behalf effectively or in monitoring that those services delivered were of an appropriate standard.

THE CROWN COMPANY MONITORING ADVISORY UNIT

Responsibilities

The Crown Company Monitoring Advisory Unit (CCMAU) is responsible for monitoring and advising Shareholding Ministers on State Owned Companies including Crown Health Enterprises. Specifically, in the health sector, the Crown Company Monitoring Advisory Unit is responsible for:

(a) advising the Government on ownership objectives and targets for Crown Health Enterprises, the Crown's investment in Crown Health Enterprises, and the impact on Crown Health Enterprises of proposed health policy options;

(b) monitoring and advising the Minister for Crown Health Enterprises on Crown Health Enterprise performance against objectives and targets; and

(c) managing, on behalf of the Minister, appointments of directors and the process of assessing the performance of Crown Health Enterprise Boards.

The Business Plan

In my view CCMAU was instrumental in precipitating a chain of events which contributed to Canterbury Health breaching the Code. CCMAU monitored Canterbury Health on behalf of the shareholding Ministers of Finance and Crown Health Enterprises. In December 1994, CCMAU placed Canterbury Health in "workout" and required a business plan to be prepared which would ensure Canterbury Health achieved financial viability. In requiring that business plan CCMAU gave insufficient regard to the impact it might have on the quality of services the public would receive. CCMAU placed Canterbury Health under severe pressure to improve its financial performance according to a plan that CCMAU acknowledged was a high risk, but did not consider or monitor the effect its implementation had on the Hospital's delivery of service.

In its response to this Report, CCMAU wrote *"the advice CCMAU provides to shareholding Ministers is confined to high level advice on the overall organisational and financial performance of CHEs. To the limited extent we obtain certain information from a CHE which is of a clinical nature it is of a general nature and used in relation to our reports on overall, and not specifically, clinical, performance."*

The Risks

CCMAU and Treasury informed the shareholding Ministers of Finance and Crown Health Enterprises that the financial risks in the business plan were high and the targets almost impossible. In fact the risks were such that they advised Ministers that the efficiency gains should not be included in the Crown's budgets. Treasury and CCMAU stated in a memorandum to the Ministers on 6 May 1995:

> *"The efficiency gains, representing 10% of current operating cost, are aggressive. There is a risk that all the gains identified will not be achieved in the proposed timelines. Officials feel that it may be appropriate for Crown budgeting purposes to set less stringent, more realistic targets for the CHE. Conveying such a message to the Board and management is not recommended as it will likely undermine their resolve to achieve the targets set".*

In my view, in deciding not to convey this information the Crown misled the Board and in doing so put consumers at risk. With knowledge of the identified risks, the Board and Chief Executive may have been more alert to indications of patient safety concerns.

The drive for efficiency within an unrealistic time-frame, with minimal patient focus and without appropriate purchaser support, contributed to the under-resourcing of Canterbury Health and a breakdown in the relationships between clinicians and management.

I acknowledge that the tension between services and funding is explicitly recognised by the Health and Disability Services Act 1993 which refers to the provision of health and disability services that are *"reasonably achievable within the amount of funding provided"*.

In my view the aggressive business plan which CCMAU urged on the Canterbury Health Board for cost saving reasons and CCMAU's drive to develop tension in the system did not take adequate account of human or structural factors that required a reasonable time-frame, good information and adequate resources to work through the process of change. Due to inadequate systems and revenue to support appropriate investment in staff, processes and equipment, there was no flexibility in the system. While management concentrated on the restructure and the tension it was intended to create, system changes identified in 1995 were not implemented which contributed to the safety issues which occurred in the 1996 winter.

The onus on Canterbury Health to improve its efficiency was not matched by a similar onus on the Southern Regional Health Authority to pay sustainable prices and to purchase adequate volumes. CCMAU identified demand as part of the problem and both Canterbury Health and the Southern Regional Health Authority should have been required to address the issues.

In response to this comment, CCMAU stated *"The tension you refer to is inherent in any public health system and this was recognised by Parliament which made this tension transparent by expressly incorporating it in the H&DS* (sic) *Act. Section 4(a) of that Act requires the best health etc...that is reasonably achievable within the amount of funding provided." (see also the long title to that Act and section 8(3))."* Furthermore, Treasury responded that they disagreed with the implication that it was Treasury's intention to develop tension in the system. *"The government had directed wide ranging reforms in the health sector in order to create a more effective and efficient public health service. Consequently it was important to ensure established practices and processes throughout the system were fully scrutinised, in an attempt to curb rapidly rising costs and to get a greater volume of services from the available funding."*

Equity Injections

It is also apparent from analysis of the potential risks identified in the business plan by CCMAU and Treasury, as well as independently by the Chief Executive, that many of the assumptions in the Plan were unrealistic. The "workout" intervention by CCMAU did not enable Canterbury Health to operate in the intended commercial manner, particularly in the absence of adequate revenue. A commercial company may well have called in a receiver but the Canterbury Health Directors were supported in their efforts to achieve financial viability by a letter of comfort from shareholders. Such a letter is by its nature a form of guarantee to remove liability from certain risks of directorship. The letter dated 10 October 1995 from the Ministers of Finance and Crown Health Enterprises recognised that revenue was a factor in the delay to achieving financial viability and committed the shareholders to equity injections if necessary.

> *"... your recently submitted Business Plan proposes that the company will achieve operating viability in 1996/97. However this is based on an assumption relating to the level of revenue contracted by the Southern RHA. Unfortunately this level of revenue has not yet been secured by Canterbury Health Limited (CHL), resulting in a delay to the achievement of operating viability.*
>
> *The Crown is committed to working with CHL and to achieve an ongoing sustainable financial basis. The Crown acknowledges shareholder support, by way of further adjustment (such as*

through equity injections) to CHL's capital structure, may be necessary so that CHL has a sustainable financial basis upon which to implement its business plan; and the Crown will provide such support where necessary."

It is unfortunate that the Crown provided and continues to provide equity injections to cover the deficits of Crown Health Enterprises rather than address the underlying problem of quantity and revenue. In doing so it does not report the true cost of the nation's public health service, nor does it allow its health policy to operate in the manner intended. The absence of accurate payment for services reduces the incentive for Crown Health Enterprises to operate efficiently. Also the public cannot clearly identify and compare the efficiencies and the relative performance of Crown Health Enterprises in a transparent way as intended by the current health policy framework.

I was informed by CCMAU that the Government is aware of this issue and officials are working to rectify the matter. *"In 1997 CCMAU assumed a leadership role, in bringing all of the relevant agencies together (CCMAU, HFA, the Ministry of Health, Department of Prime Minister and Cabinet and Treasury) to provide coordinated policy advice to Ministers which will result in a re-alignment of appropriations through a "deficit switch". Ministers then agreed to this appropriation subject to an agreement on a robust and sustainable pricing methodology.*

As a result, the portion of Vote: CHE currently used to fund deficits resulting from underpurchasing, will be transferred from Vote: CHE to Vote: Health and will be used by the HFA to purchase services from CHEs at prices that should sustain the financial viability of CHEs. This will assist significantly in providing the transparency originally envisaged in the health reforms, as the true cost of health services will be paid by the HFA. Any CHE deficit will only result from inefficiencies within the company itself."

I was advised by Treasury that while it may be unfortunate that the Crown provided and continues to provide equity injections, the Crown must either provide equity or let the CHE change ownership, and that the provision of equity has been the preferred option if a CHE has the potential to become solvent.

Failure of the "Workout"

The reality is that the ultimate cost to the shareholders of the failure of Canterbury Health to successfully implement its business plan has probably exceeded the cost that would have been incurred if the Plan had been implemented successfully over a more realistic time-frame. The fact is that the adoption of an aggressive strategy failed at Canterbury Health. The impact of this aggressive business plan on the decline in standards of service to the Christchurch community was significant.

There are two requirements for improving Canterbury Health's financial performance. One is to improve its efficiency, the other is to ensure it is adequately remunerated for the services it provides. It is important to get the balance of these two correct. CCMAU advises that it has *"assumed a leadership role, on behalf of Ministers, in facilitating, and where necessary brokering, mutually acceptable contracts between the HFA and CHEs".*

Interface with the Ministry of Health

Although CCMAU provided regular briefings to the Minister of Health and other officials from central agencies, in my view CCMAU should have been more active in ensuring the Ministry of Health was aware of the issues and risks in the Plan as a result of purchasing decisions by the Southern Regional Health Authority. CCMAU identified these major risks in its memorandum to shareholding Ministers. Not only did it not monitor the impact, it did not advise the Ministry of Health which could have monitored the Southern Regional Health Authority.

Accountabilities

Both Treasury and Crown Company Monitoring Advisory Unit expressed concern that I did not understand the fundamental plank of the current health model, being the separation of the purchaser and provider roles. The shareholding focus is on the Crown's investment in Crown Health Enterprises and the provision of service. The provision of service is the responsibility of Crown Health Enterprises overseen on behalf of the shareholding Ministers by officials from Treasury and Crown Company Monitoring Advisory Unit. There is a separate accountability to ensure appropriate health services are available to the people of New Zealand and that the purchase of these services represents value for money. This purchasing function is the responsibility of the Health Funding Authority overseen by the Minister and Ministry of Health.

This explanation of the differences in function is set out to ensure that there can be no misunderstanding of the roles. The accountability structure is entirely appropriate. However, the question of inter-dependence is not recognised in these descriptions. Canterbury Health is a monopoly provider relying on a single funder. In such a situation they must co-operate. Such co-operation would occur in any commercial environment where two parties are mutually dependent. The principles of a commercial model are relevant where shareholders and directors would not supply substandard service and risk the collapse of a business through lack of customers, nor would a purchaser knowingly allow a major supplier to operate at a deficit for long periods of time because it would result in the supplier going into receivership.

Another aspect of this inter-dependence is the reliance of the Health Funding Authority on Crown Health Enterprises to provide feedback on the services required in a particular community so as to ensure that relevant services are being purchased. Consumers of health and disability services are likely to give their feedback to a Crown Health Enterprise and this will assist the Health Funding Authority in future purchasing decisions.

THE CHRISTCHURCH SCHOOL OF MEDICINE

The Christchurch School of Medicine is a Clinical School within the Faculty of Medicine of the University of Otago and was established in 1972. The school is responsible for the clinical training of 60-70 students annually in years 4-6 of the Otago MB ChB programme. The School has a wide range of postgraduate programmes for medical and non-medical graduates and currently has about 200 research programmes/projects, many of which are well established and internationally recognised. The School's relationship with Canterbury Health is governed by a Memorandum of Agreement and formal liaison is through a Joint Relations Committee and other decision-making groups. Informal liaison occurs mainly between the Dean and the Chief Executive of Canterbury Health.

The establishment of Canterbury Health under new legislation in 1993 changed the nature of the relationship between the University and Christchurch Hospital. At an early stage the Board of Canterbury Health made it clear to the Dean of the School and the University that the commercially sensitive nature of its activities precluded the Dean's formal involvement, or that of the University, in Canterbury Health decision-making at a Board or senior management level. As a consequence the School and University were excluded from participating in decision-making regarding the development of delivery of clinical services, although many of the School's joint clinical staff became involved in some decision-making in their capacity as Clinical Directors.

In April 1997 the Dean was invited to attend monthly Board meetings for approximately half-an-hour to discuss any matters of concern to the School. The Chief Executive and the Dean also meet monthly to discuss current issues. The Dean has also been invited to join Canterbury Health's Clinical Policy & Planning Committee.

By comparison, the Chair of the Board of Auckland Healthcare, the Chief Executive and the Dean of the University of Auckland School of Medicine have worked closely together since 1993 to establish a strategic alliance. The strength of the alliance is recognised by both parties who actively co-operate on all matters.

I have not investigated the relationship between the University of Otago and the three Medical Schools or the relationship between the Christchurch School of Medicine and Christchurch Hospital. However, the University of Otago and the Christchurch School of Medicine are involved in the delivery of service at Canterbury Health through the training of clinical staff and became involved in the disagreements between Canterbury Health and its clinical staff.

The differences in perspective of the University and School of Medicine, and Canterbury Health, were evident in Christchurch and included:

(a) The Christchurch School of Medicine believed that the Board and senior management of Canterbury Health failed to appreciate the value of the Medical School in terms of the strength it could bring the Crown Health Enterprise by way of quality staff and quality service; and

(b) The Board was unhappy about what it saw as the University of Otago's bias towards the interests of the Dunedin Hospital where the University of Otago is centred.

In 1994 the Australian Medical Council undertook a review of the Otago MB ChB programme. An accreditation review is of major importance to the Medical Faculty as it establishes the credibility of the undergraduate medical programme internationally and access of New Zealand graduates to Australia. Accreditation can be given for a period of up to 10 years and Otago hoped to get full accreditation as was subsequently given to Auckland. The outcome of the Council's review was a five year accreditation and the Council expressed several major concerns, particularly regarding the relationship between the University of Otago and its local Crown Health Enterprises.

I agree with the Australian Medical Council Accreditation Team's analysis that excellence in health care can only be achieved where teaching, research, service and management are all valued and nurtured. All the Medical Schools of the University of Otago will be revisited by the Australian Medical Council Accreditation Committee in 1999. Unless the deficiencies that were identified in the 1994 Accreditation Report have been remedied, the University of Otago risks, once again, only being accredited for a short period and having conditions attached to its accreditation. The matter has been raised with Canterbury Health at meetings of the Joint Relations Committee and ways of addressing the University's concerns are being discussed.

It is disappointing that no international or other benchmarks or comparisons with other tertiary teaching hospitals were put forward by the University or School as evidence which would have assisted clinicians and management in discussing and debating the issues surrounding patient safety and staffing levels in 1996/97.

CHRISTCHURCH HOSPITALS' MEDICAL STAFF ASSOCIATION

Background

During the investigation the Executive of Christchurch Hospitals' Medical Staff Association (CHMSA) advised the Commissioner that they wanted Christchurch Hospitals' Medical Staff Association's conduct at Christchurch Hospital to come under scrutiny. They wished the Commissioner to comment on their involvement to show they were not "mischief-making". However, this investigation was not into the actions of Christchurch Hospitals' Medical Staff Association and I have included this chapter because it is necessary to comment on the effects of Christchurch

Hospitals' Medical Staff Association's actions on the rights of health and disability service consumers.

Objectives of Christchurch Hospitals' Medical Staff Association

Christchurch Hospitals' Medical Staff Association's constitution states as its objects:

"to present the views and co-ordinate the activities of the Medical and Dental Staff of the Christchurch Hospitals from the following points of view:

a) Professional

b) medico-political

c) social and

d) other".

Its full membership comprises all members of the Christchurch Hospitals' medical and dental staff above the grade of registrar, medically and dentally qualified staff of the Christchurch Clinical School of Medicine or equivalent academic status, and all members of the Honorary Consulting Staff. In 1996 CHMSA calculated that the number of senior doctors eligible to vote was 274. It also has associate members who are persons with close clinical or scientific contact with patients. Associate members do not have voting rights. Medical staff of the grade of registrar or below or scientific staff may attend meetings or parts of meetings at the invitation of the Chairman, but have no voting power. The control of the Association is in the hands of its members and it is financed by the members of the Association. The Executive of CHMSA is elected annually.

On 26 April 1996, after what the former Chairman of CHMSA described as "*one of the most keenly contested elections for the Executive in recent memory*", a new Executive was elected which changed the focus of CHMSA from "*more routine*" functions. The new Executive described its mandate as the two motions put to the CHMSA membership in March 1996, which related to supporting the surgeons in their expert opinion that the nursing restructuring compromised patient safety, and that an Executive Committee Planning and Policy be formed by CHMSA with direct access to the Board to work with the Chief Executive of Canterbury Health in all decisions related to clinical practice and to give final approval to such decisions.

"Patients are Dying" Report

On 24 December 1996 CHMSA presented the "Patients are Dying" report to Canterbury Health. The report elaborated on its earlier report entitled "Systems Failures Threatening Public Safety at Christchurch Hospital" presented to the Ministry of Health on 12 September 1997. After reviewing the report, Canterbury Health wrote to the Ministry of Health and requested an independent inquiry into events at Christchurch Hospital.

The "Patients are Dying" report was the culmination of efforts by CHMSA to have concerns about safety brought to the attention of, and rectified by, management at Canterbury Health. Over time these efforts had become increasingly confrontational. By the time the report was presented, the relationship between CHMSA and management was openly hostile and characterised by a mutual lack of trust. Although the final catalyst for an external, independent investigation, the report itself did not have the scope or detail necessary to offer Canterbury Health solutions to the Hospital's critical issues. However, it did contain new material on specific incidents and internal memoranda which the Chief Executive and Board were able to investigate. Given the significance of this new data and the

seriousness of the issues raised for consumers, it would have been useful for Canterbury Health to have received an advance indication of these matters prior to Christmas Eve.

Nursing Restructuring and Systems Issues

CHMSA advised Canterbury Health that systems issues, in particular the nursing restructure, were at fault at Christchurch Hospital. My investigation has revealed that nursing restructure in itself was not the fundamental issue.

In my view, CHMSA was unable to adequately bring systems failures to management's attention because it was unaware of the fundamental causes. In order to prove its concerns had foundation, CHMSA set about documenting individual cases. The cases reported were primarily documented by retrospectively seeking information from throughout the organisation, relying on the memories of individuals rather than formal incident reports.

Risk to Individual Health Professionals

One reason for the lack of specific, detailed information being provided to Canterbury Health was CHMSA's concern about the possibility of legal action against individual clinicians. I can understand this concern, but in the circumstances the resulting lack of information hampered the Board's and management's ability to identify and analyse the underlying issues and therefore to rectify them. In particular, if all medical staff at Canterbury Health had completed incident reports in line with Canterbury Health policy then the issues of safety may have been more easily documented.

Clinicians' Obligations to Provide Quality Services

Management is not solely responsible for systems as clinicians play an integral part in hospital processes. As a key link in the chain of service delivery, all health professionals are responsible for the provision of quality services which meet the obligations of the Code of Rights. Health professionals cannot point to management as being solely responsible for systems failures unless all reasonable steps have been taken to identify and bring the perceived failures to the attention of those ultimately responsible to rectify them. Apart from the demands of the new consumer legislation in the form of the Health and Disability Commissioner Act and the Code, professionalism itself demands such an approach, despite the potential risk of professional liability for individuals.

A Co-operative Approach

The provision of safe, quality services is dependent on clinicians and management working together in co-operation. Health care cannot be provided without health professionals. It needs to be understood that management also plays a vital part in the delivery of effective health care. If lessons are to be learnt from events at Christchurch, they include the lesson that opposition between clinicians and management ultimately operates to the detriment of consumers. It is all too easy for the consumer to be lost sight of as parties adopt entrenched, opposing positions, irrespective of the rationale for adopting those positions. Canterbury Health is taking proactive steps to address the issues at Christchurch Hospital. The task is a difficult one and needs commitment and co-operation from all parties.

While recognising the events which led to CHMSA's increased activism in the past, CHSMA must acknowledge that its constitution is different to the objectives of Canterbury Health. CHMSA has a valuable contribution to make and can assist its members deliver quality services within the Christchurch Hospitals. However, to achieve the maximum benefit for consumers, members are required to operate within the standard management processes applicable to all organisations which

include employment contracts, acknowledging and confirming responsibilities and compliance with approved organisational policies.

Summary

In conclusion, it is my view that the CHMSA Executive were not mischief-making but entered into a siege campaign with management as a result of increased frustration with an organisation which would not listen to its health professionals. However, it is also my view that the Christchurch Hospitals' Medical Staff Association Executive were not always co-operative with the management of Canterbury Health Limited and, in promoting a general resistance to Canterbury Health, did not encourage implementation of Canterbury Health policy, such as incident reporting, which would have been beneficial to all. With more co-operation the interests of consumers would have been better served.

CANTERBURY HEALTH LIMITED

While some of the following recommendations may be in place, or have been put in place by Canterbury Health during or subsequent to the period under investigation, they are included here for completeness and to ensure they are followed up.

I recommend that Canterbury Health:

Emergency Department of Christchurch Hospital

- Develops standards in its Emergency Department and implements these in conjunction with the Health Funding Authority.
- Reviews continually its staffing (both numbers and seniority), equipment and physical space. Observation area staff should be calculated as additional to staffing in the Emergency Department itself and all reviews of staffing for the Emergency Department should ensure there is an adequate 24 hour service and an assessment of clerical, orderly and security staff.
- Provides Radiology and Pathology systems which report results rapidly and in a form which ensures they are immediately accessible to the Emergency Department staff.
- Ensures the Emergency Department computer system allows patient tracking at all times. Methods of rapid transmission of discharge data to general practitioners should be available to staff.
- Makes available appropriate imaging to the Emergency Department in an adequate timeframe.
- Has sufficient up-to-date monitoring equipment in all the resuscitation cubicles, and all the cubicles used for patients with cardiac and respiratory problems. There should be central monitoring for all these areas, including for those patients placed in the Emergency Observation Area.
- Has available blood alcohol level monitoring equipment.
- Considers whether the routine treatment of minor orthopaedic problems, such as fractures of the wrist, should be part of the normal work of the Emergency Department.
- Carefully records clinical indicators for measuring the performance of the Emergency Department and continually monitors staffing and other resources to ensure these indicators are maintained at, or near, the recommended levels.
- Has a "Trauma Team" available to respond at all times.
- Adopts and continuously monitors trauma indicators and publishes reports on these indicators regularly to allow comparisons with the other major centres in Australasia.
- Collects access and admission data and publishes this at regular intervals to allow comparisons with other major centres.

- Provides appropriate conditions for teaching in the Emergency Department, including providing senior staff with the appropriate experience and with the time in which to prepare, teach, supervise, monitor and evaluate the performance of trainees.

- Provides senior medical and nursing staff with the opportunity to pursue their own continuing medical education.

- Ensures clear triage guidelines are in place which incorporate psychiatric conditions into the triage scales.

- Incorporates ambulance assessments when considering the triage category and includes these assessments in admission notes.

- Has a concise practical manual to assist in the management of common mental health conditions relevant to the Emergency Department and ensures that expert psychiatric specialists are available when required.

- Develops mechanisms for admission and discharge together with General Practitioners, Healthlink South and the Health Funding Authority to ensure appropriate use of facilities and management of demand in an environment where risk is shared in order to obtain the best possible consumer outcomes.

- Tests the new internal and external disaster plans, regularly carries out regional alerts and continuously updates disaster plans.

Quality

- Involves clinical staff in all health care decision-making and in planning and contractual negotiations with funders.

- Places overall responsibility for quality issues and continuous improvement in the Hospital under the leadership of a senior manager.

- Reviews the terms of reference, modus operandi, composition and responsibilities of all committees in Christchurch Hospital to confirm the current relevance and function of each committee, its status and delegated authority, and the means by which its recommendations are to be incorporated into Canterbury Health's policy. As a part of that review Canterbury Health will consult with its professional staff regarding the Clinical Policy and Planning Committee and its place alongside the other committees, Medical Advisors, and Clinical Directors. The final decision on the structures must not compromise the ability of line managers, including Clinical Directors, to manage efficiently and effectively and must recognise that Canterbury Health requires cross-functional health professional input to assist its decision-making. It currently receives this input through a variety of mechanisms including Medical Advisors.

- Ensures all committees, including those with hospital-wide responsibilities, report to a line manager who is ultimately accountable for the committee's objectives, tasks, functions and decisions.

- Establishes clear links and consistency between all Hospital-wide committees and the Quality Assurance Committee and Risk Management Committee.

- Ensures that managers responsible for other processes with a quality function provide regular reports to the Quality Assurance Committee. This might include product

evaluation, occupational health and safety reporting, incident reporting, complaints and trends from analysis of post-CPR events.

- Vests responsibility for reviewing incidents in line management, with the Quality Assurance Committee reviewing outcomes and trends. Potential incidents should be reported along with other incidents and reviewed as part of continuous quality improvement.
- Continues the compilation and implementation of policies and procedures which should be subject to constant update and review.
- Continues to drive improvements in services to maximise their availability to the public.
- Undertakes consumer surveys to check customer satisfaction and provide input to quality initiatives.
- Improves its information systems over time to assist in producing data that will detect inefficiencies and identify sustainable improvements.
- Ensures senior medical staff from the various disciplines review the requirements of their relevant Royal Colleges to provide quality assurance systems that comply with professional obligations.
- Undertakes formal analysis at the end of each winter to assess how the Hospital coped and, where necessary, improve systems and processes in preparation for the next winter.
- Develops policies in respect of single use items and infection control.

Personal Privacy

- Reviews all areas of Christchurch Hospital to ensure consumers' rights to privacy are met in accordance with the Code of Rights. If there are resource issues, the alternatives should be reviewed and procedures put in place to maximise personal privacy.

Staffing, Training and Supervision

- Ensures staff job descriptions specify accountabilities, delegated authority and an express requirement to focus on consumers, quality, professionalism and compliance with Canterbury Health policies.
- Develops orientation programmes for all staff which should be compulsory and, among other things, include an introduction to the organisation, involve ward-based structured orientation for nurses, and include training on provider obligations under the Code of Rights.
- Implements a formal process of staff appraisal which, over time, should link to complaints and quality processes.
- Addresses all staff training needs in a formal and methodical manner. Individual staff training should be reviewed as a part of the appraisal system.

- Reviews the training in management of cardiac arrests to ensure all front-line clinical staff are regularly trained to manage this process consistently.
- Reinstitutes a professional development programme within the nursing service to assist with risk management, differentiation of the workforce, staff education, performance recognition and motivation.
- Resources the education needs of the nursing staff.
- Trains all staff in effective communication skills for internal purposes and to meet consumers' rights to effective communication under Right 5 of the Code of Rights.
- Negotiates with the School of Medicine to ensure that academic employees of the School of Medicine are bound by Canterbury Health's contractual obligations which include compliance with Canterbury Health's policies and procedures.
- Develops a policy to address conflicts of duties including conflicts in relation to public/private practice and research.
- Introduces a formal debriefing process for staff, especially in services where there is a high incidence of stress.
- Appoints new graduate nurses to positions on wards where they can be appropriately supervised. Graduate nurses should not be used on the casual pool.
- Establishes systems to recognise the different levels of skill in the workforce and ensure a satisfactory staff mix.
- Sets at an agreed limit on the number of casual nurses per ward per shift (e.g. 30%) and manages the mix of staff accordingly.
- Collects and analyses information about casual nurse staff usage and costs per ward monthly.
- Reviews the systems for managing patient escort and transfer, puts in place appropriate policies and systems to reduce risk to patients and establishes a Transit Care nursing team similar to those operating in other major acute care hospitals in New Zealand.
- Reviews the role of the Duty Manager to ensure the role has appropriate authority and responsibility in management decision-making.
- Ensures there are adequate numbers of senior medical staff available to assist junior medical staff, particularly "out of hours". The accountability structure for accepting the responsibility for the clinical work of trainee interns should be clarified and built into job descriptions.
- Sets up and monitors Credentialling Committees. Discussions should occur with the various professional Colleges to ensure applicable standards are met. If Credentialling Committees are not established, the reasons should be documented and approved by the Board.

- Establishes a clear internal complaints mechanism to address staff concerns regarding quality of service. Where staff are dissatisfied with the outcome of their complaints through the usual lines of authority, there should be an independent and confidential service available to address staff issues. If these mechanisms fail to resolve staff concerns, then Canterbury Health should ensure that staff are aware of their ability to complain under the Health and Disability Commissioner Act where the matter relates to consumers' rights.

Support Services

- Reviews its Paediatric and Orthopaedic services. Although these were not subject to in-depth investigation, both were raised as areas of concern.
- Considers the establishment of satellite radiology services in the Emergency Department.
- Reviews its Radiology service to ensure it provides appropriate standards of care in a timely way. The review should include the establishment of procedures for managing radiology demand, both internal and external, as well as staff numbers, staff mix, transfer and hand-over of patients to and from the Radiology Department and reporting systems.
- Monitors compliance with meal and cleaning service contracts to ensure patient and environmental needs are met. There should be consumer surveys to obtain feedback.
- Co-ordinates the delivery of meals with nursing services to ensure quality services to patients.
- Employs sufficient secretarial and administrative support staff to ensure health and disability services can be provided which meet appropriate standards.
- Ensures that laboratory results are on line to the wards.
- Introduces a managed strategy to deal with demand. Managing increasing workloads is a joint issue for both management and clinicians, particularly in support services which often face uncontrolled demand.

Equipment

- Undertakes research into clinical staffs' expressed need for more equipment and develops plans for short and medium-term replacement and upgrade of equipment in a systematic way.
- Undertakes a full review of equipment with capital expenditure prioritised on a risk and benefit basis.
- Purchases standardised equipment throughout the Hospital as a reasonable safety measure.
- Centralises the co-ordination and management of infusion pumps so that available pumps can be easily accessed, cleaned, and maintained. There should be access to standardised defibrillators.

Consumer Rights and Complaints Procedures

- Makes available interpreters where necessary and reasonably practicable to ensure effective communication with consumers. Support persons should also be encouraged to assist in effective communication.

- Makes available promotional material and relevant information to ensure consumers are informed of their rights.

- Reviews the current complaints procedure within three months to ensure it is functioning in terms of Canterbury Health's policy.

- Considers the establishment of an independent complaints review committee, which includes a member of the Board and a consumer representative, to randomly monitor a set number of complaints at appropriate time intervals and act as an appeal mechanism for consumers who are dissatisfied with the way their complaint has been addressed by Canterbury Health.

- Recognises that concerns raised by patients on a Christchurch Hospital Customer Response Form are complaints to be actioned in terms of the complaints procedure.

Coroner's Recommendations and Medical Advisor Protocols

- Ensures that all Coroner's reports are reviewed by the Quality Manager.

- Assigns the task of implementing Coroner's recommendations to a senior manager who should report monthly to the Chief Executive on their implementation and status. This should commence with a report on all the recommendations arising from the Coroner's reports referred to in Section 6 of this Report, and the protocols recommended by Medical Advisors in relation to patient deaths.

- Develops a formal handover protocol between a clinical team and its successor to ensure that patient details are brought to the attention of the incoming team.

Patients' Complaints

I recommend that the Chairman of the Board:

- Apologises in writing to the immediate relatives of patients whose deaths are referred to in this Report.

- Invites these families to meet with representatives of Canterbury Health management and the Board of Directors if they wish to do so. At this meeting the family should have explained any outstanding matters with respect to the death of their family member, or their general complaint. Canterbury Health should then demonstrate to the family any relevant physical and other changes which have occurred and the implementation of any recommendations of the Coroner or Medical Advisor protocols.

MINISTRY OF HEALTH

I recommend that the Ministry of Health:

- Reviews the multiplicity of health provider reporting requirements imposed by statute with a view to proposing a reduction in inefficiencies resulting from duplication.

- Activates powers vested under the Hospital Act 1957 or the Health and Disability Services Act 1993 only after advice to the Minister of Health. Such advice should carefully consider the various accountability measures that co-exist and whether such accountability has been utilised by the appropriate monitoring agency.

- Sets defined objectives on the extent of quality monitoring for which the Health Funding Authority is accountable.

- Develops criteria for the approval of Ministerially declared quality assurance activities under the Medical Practitioners Act to ensure consistency in applications and approval of such activities.

- Leads the development of national guidelines for emergency services and hospitals in New Zealand, including national guidelines for the management of mental health care in emergency departments. These guidelines should incorporate indicators and performance criteria on which compliance can be monitored and be developed in conjunction with the Health Funding Authority, providers, health professionals and consumers.

- Defines the terms "emergency", "urgent", "semi-urgent" and "non-urgent" services currently described in the 1996/97 Funding Agreement with the Health Funding Authority so that the Health Funding Authority can set service specifications in contracts to meet the guidelines and so that the public can understand the definition of such terms.

- Establishes collaborative working groups on standards, indicators, and safety and quality measures, with particular emphasis on providing direction to improve integrated monitoring throughout the health care system. These collaborative working groups should review accreditation, credentialling, re-certification and peer review activities in conjunction with the Medical Council, Nursing Council, medical and nursing Colleges and consumer groups.

- Commences a review of current standards and quality processes in every public hospital in New Zealand using an accredited quality agency. The purpose will be to ascertain the comparative levels of quality policies, and quality control, in different hospitals. The aim over time must be to ensure that consistent standards of care are applied and that all hospitals comply with standard risk management techniques.

- Works with the Crown Company Monitoring Advisory Unit to facilitate the relationship between purchasing and provision of services and, where necessary, to appoint in conjunction with Crown Company Monitoring Advisory Unit, independent arbitrators to resolve contractual issues. This will ensure that contracts are concluded effectively and that sound commercial principles are applied in negotiating prices and volumes.

- Reviews and reports on the implementation of the recommendations in this Report with respect to the Health Funding Authority.

HEALTH FUNDING AUTHORITY

I recommend that the Health Funding Authority:

- Establishes national standards of intervention, which may vary depending on local needs, to enable providers and the public to monitor the performance of the Health Funding Authority.

- Reports on the development and application of booking systems to enable comparisons in purchasing throughout the country.

- Reviews the information available to the public about its planning and purchasing processes in order to raise the quality of debate about services to be publicly funded and the extent of such funding.

- Examines the funding arrangements for Emergency Departments in public hospitals.

- Re-assesses its purchasing priorities to ensure the Health Funding Authority purchases the necessary volumes of emergency services.

- Consistently applies its purchasing policy to enable providers to plan effectively for the efficient delivery of health and disability services in the medium term.

- Applies pro-active risk assessment in monitoring all aspects of health and disability services purchased.

- Co-operates and collaborates with providers to ensure seamless delivery of services to consumers and to ensure equitable purchasing across the country.

- Develops mechanisms for admission and discharge together with General Practitioners, Healthlink South and Canterbury Health to ensure appropriate use of facilities and management of demand in an environment where risk is shared in order to obtain the best possible consumer outcomes.

- Establishes in conjunction with the Ministry of Health, Crown Company Monitoring Advisory Unit and tertiary Crown Health Enterprises, a set of relevant quality indicators which are able to be reported on and analysed in a timely fashion.

- Pro-actively works with Canterbury Health to improve their relationship, thereby ensuring it is in a position of knowledge about the Crown Health Enterprise, its processes and its standards.

- Audits the key processes by which Canterbury Health monitors its standards and the results of this monitoring. Auditing should include but not be limited to implementation of a quality strategy, incident reporting, patient complaints, medical peer review and audit, and infection control strategies. With the exception of patient complaints, these processes can only be audited effectively by on site monitoring.

- Develops and purchases integrated care packages that involve all health and disability service providers from primary care to tertiary services. Such packages should provide efficient seamless service delivery which is patient focused, contain clear service specifications for each provider and their mutual obligations, and include shared risk arrangements, probably in a fund-holding contract.

- Reviews and reports on the implementation of the recommendations in this Report with respect to Canterbury Health.

CROWN COMPANY MONITORING ADVISORY UNIT

I recommend that the Crown Company Monitoring Advisory Unit:

- Actively continues to work with relevant agencies to finalise agreement on a robust and sustainable pricing methodology, to address the underlying issues of quantity and revenue and replace equity injections to Crown Health Enterprises.

- Continue to co-operate with the Ministry of Health and Health Funding Authority to ensure efficiency in Crown Health Enterprises is not to the detriment of standards.

- Monitor Crown Health Enterprises' comparative effectiveness in the delivery of health services as well as their efficiency in meeting the financial outputs required in their business plans.

SCHOOL OF MEDICINE

In recognition of the inter-dependence of the University of Otago and Canterbury Health I recommend that the School of Medicine:

- Reviews its Memorandum of Agreement with Canterbury Health and re-confirms a strategic alliance based on mutual respect and co-operation.

- Ensures that the Memorandum of Agreement covers matters of employment, adherence to Canterbury Health policy and protocols, including among other things those relating to the making of public statements by School of Medicine employees who hold positions with Canterbury Health.

- Reviews the employment contracts of its academic staff holding positions with Canterbury Health to ensure such staff are bound by the terms included in the agreed Memorandum of Agreement.

- Jointly appoints with Canterbury Health all future academic staff who will act as consultants at the Canterbury Health.

CHRISTCHURCH HOSPITALS' MEDICAL STAFF ASSOCIATION

I recommend that Christchurch Hospitals' Medical Staff Association:

- Considers its role within Canterbury Health and determines where it can add professional expertise to enhance its members' services to consumers.

- Re-considers its objects with a view to including a new aim of encouraging professional development by its members.

- Undertakes a process of clarifying its membership through formal enrolment.

- Accepts that its professional contribution is one of many inputs Canterbury Health must consider in effectively operating a complex hospital.

- Co-operates with management in a review of the Clinical Policy & Planning Committee. Canterbury Health operates in a dynamic environment and since Christchurch Hospitals' Medical Staff Association's original proposal in 1996 for an Executive Committee on Policy and Planning, Canterbury Health has significantly increased the status and management responsibility of Clinical Directors and has also formed a number of advisory committees which have health professional membership. I encourage Christchurch Hospitals' Medical Staff Association to pro-actively participate in all reviews of the various committees and structures which currently give professional multi-disciplinary advice to Canterbury Health.

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THE COMMISSIONER'S INVESTIGATION

As Commissioner, I decided to commence an investigation on my own initiative under the Health and Disability Commissioner Act 1994 (the "Act") on 5 February 1997 (after receiving reports alleging unsafe practices at Christchurch Hospital, including the Patients are Dying Report on 5 February 1997). My decision to investigate was subject to a judicial review in the Christchurch High Court in early March and was upheld by the High Court on 12 March 1997.

The party under investigation was Canterbury Health Limited ("Canterbury Health"), the Crown Health Enterprise. The investigation considered whether any action of Canterbury Health occurring after 1 July 1996 was in breach of the Code of Health and Disability Services Consumers' Rights. The investigation focused in particular on actions during the winter of 1996 at Christchurch Hospital and the situation investigators found at the Hospital until May 1997. My task was to consider if any action of Canterbury Health was in breach of the Code and I particularly focused on breaches of Right 4, the Right to Services of an Appropriate Standard. Events or circumstances which took place before 1 July 1996, when the Code came into force, were taken into account if they were relevant to possible breaches of the Code after that date. This report includes some discussion about the events of 1997 and includes a list of recommendations.

The business and affairs of Canterbury Health are required by law (section 128 of the Companies Act 1993) to be managed by, or under the direction or supervision of, the Board. The Board can then delegate its power to an employee of the company or any other person. The Board is responsible for monitoring the exercise of the power by the person(s) to whom it delegates. A Board should not delegate unless it believes on reasonable grounds that the delegate will exercise the power in conformity with the duties imposed on directors of a company by the Companies Act and the company's constitution. For the purposes of this report, reference to the term "management" is a reference to Canterbury Health's Board of Directors and to the Chief Executive and Managers to whom management functions were delegated by the Board. From time to time it has been necessary for clarity to comment on individuals who acted in such capacities.

Under section 14 of the Act the Commissioner is empowered to make public statements on any matter affecting the rights of consumers. In undertaking this investigation I observed a number of issues which occurred before 1 July 1996 and actions by parties not subject to the Code. Where those matters affected consumer rights I have commented on them.

THE COMMISSIONER'S ROLE

I was appointed in December 1994 for a term of five years. The Health and Disability Commissioner is responsible for promoting and protecting the rights of health and disability service consumers and for securing the fair, simple, speedy and efficient resolution of complaints relating to infringements of those rights.

Justice Tipping gave the following description of the benefit of the investigation:

> *"The primary public utility in any inquiry must be in examining whether present circumstances at the Christchurch Hospital are such that health consumers have any reasonable grounds for concern. Thus the principal advantage of the Commissioner's investigation will lie in such comfort she may give to health consumers if all is well and such recommendations and other actions which she may make or take if all is not well."* (Nicholls v Health and Disability Commissioner [1997] NZAR 351.

TERMS OF REFERENCE

In the period leading up to the commencement of the investigation a number of interested parties, including Member of Parliament and then Labour Health Spokesperson Lianne Dalziel, Canterbury Health, Christchurch Hospitals' Medical Staff Association and the Ministry of Health, suggested draft terms of reference for an inquiry proposed under section 47 of the Health and Disability Services Act 1993. I considered the various draft terms of reference during the course of deciding how to conduct this investigation. I formed the view that the investigation under the Health and Disability Commissioner Act would be sufficiently broad in scope to substantially address the issues raised in those draft terms of reference. The terms of reference for this investigation were whether any action of Canterbury Health was in contravention of the Code of Health and Disability Services Consumers' Rights.

THE INVESTIGATION TEAM

As Commissioner I conducted the investigation and have issued this final report. In addition to the existing resources of the Health and Disability Commissioner's office, the investigation team consisted of:

- Ms Jocelyn Peach, Director of Nursing and Midwifery, Auckland Healthcare;
- Ms Lynanne Stanaway, Pharmacist and formerly Manager of Surgical Services, then Manager of Service Development at Capital Coast; and
- Dr John Buchanan, Associate Professor of Haematology, University of Auckland and Auditor of Clinical Standards.

Other experts were engaged to assist in the investigation of particular services at Christchurch Hospital, as follows:

- Dr Edward Brentnall, Emergency Physician, Emeritus Consultant in Emergency Medicine, Box Hill Hospital, Melbourne;
- Dr Peter Rothwell, Consultant Physician, Clinical Sub Dean, Waikato Academic Division, University of Auckland; and
- Mr Barry Partridge, Consultant General and Vascular Surgeon, Tauranga Hospital.

THE INVESTIGATION PROCEDURE

Section 59 of the Act enables me to conduct an investigation in public or in private and generally to regulate my procedure as I see fit.

To assist me in deciding whether the investigation should be conducted in public or in private, or partly in public and partly in private, I requested the views of interested parties. I received submissions from Canterbury Health, Christchurch Hospitals' Medical Staff Association, Lianne Dalziel, and a number of other interested parties. After consideration of the range of views expressed, I decided to carry out

the investigation in private and not to hold public hearings. However, the public would participate by having the opportunity to provide information. I also decided to make this report public.

I concluded that this approach would be more likely to lead to a fair, simple, speedy and efficient resolution of the issues. Accordingly, interviews were conducted in private, and written information was also provided on a private basis.

I was conscious at the outset of the investigation of the need to conduct the investigation in a legally fair and sound manner. In particular, I was aware of the need to ensure that any person about whom I might make adverse comment had a reasonable opportunity to consider those comments and the basis for them, and to respond.

I met these requirements during the course of the investigation by raising with the relevant persons matters which appeared to be possibly relevant and material, as they came to my attention as well as through interviews (and on occasions a series of interviews) and written requests for comment on specific matters. Finally, I conducted a formal process, in accordance with section 67 of the Act, of forwarding adverse comments to the persons concerned so that they had a reasonable opportunity to respond. Responses from parties have been taken into account in finalising this Report.

THE EVIDENCE

I wrote to every member of staff at Christchurch Hospital. To protect these individuals' privacy a mailing house was used to deliver the letters. I also distributed letters to Christchurch general practitioners through Pegasus, the local independent practitioners association, and wrote to the local Members of Parliament, the City Council and professional colleges. Meetings were held at the Hospital with staff to explain the investigation before the Commissioner's Investigators began their formal interviews at Christchurch Hospital in March 1997. I also held a public meeting to explain the purpose of the investigation and public notices were issued in the local media inviting information from staff and the public on a confidential basis. Two investigators spent a week in the Hospital as observers before they commenced formal interviews.

I sought information from a wide range of people and organisations who had or may have had information relevant to the investigation. The people and organisations included:

(a) patients of Christchurch Hospital;

(b) former and current nursing staff at Christchurch Hospital, including casual nurses, Clinical Nurse Facilitators and Patient Care Managers;

(c) current and former Clinical/Medical Directors at Christchurch Hospital;

(d) Christchurch Hospital support staff;

(e) junior medical staff;

(f) former and current senior managers of Canterbury Health;

(g) staff of the Christchurch Medical School (University of Otago);

(h) former and current directors of Canterbury Health;

(i) officials from the Ministry of Health and the Crown Company Monitoring Advisory Unit;

(j) former independent contractors to the Crown Company Monitoring Advisory Unit, Canterbury Health and the Minister of Health;

(k) representatives of the New Zealand Nurses Organisation and the Resident Doctors Association;

(l) Southern Regional Health Authority officials; and

(m) the Christchurch Hospitals' Medical Staff Association Executive.

As part of my investigation I also investigated the deaths of seven Christchurch Hospital patients who were the subject of inquests and findings by the Coroner. The patients concerned are:

(a) Ms Bridget Monique Garnett (date of finding 20 November 1996);

(b) Mrs Nancy Joyce Malcolm (date of finding 9 May 1997);

(c) Mr Brian Raymond Brown (date of finding 9 May 1997);

(d) Mr Brian Gardiner (date of finding 9 May 1997);

(e) Mrs Brenda Merle Watson (date of finding 10 July 1997);

(f) Mr Moresby Fonoti (date of finding 3 October 1997); and

(g) Mrs Patricia Anne Humphrey (date of finding 15 October 1997).

My opinion on these deaths is in relation to the application of the Code of Rights and has been formed based on the evidence given to the Coroner and additional information from families and medical records.

The investigation team interviewed approximately 230 people during the course of the investigation. Most of the interviews by the team members took place from March to June 1997 with additional interviews by me occurring from July to September. I did not have to use the Commissioner's powers to summon witnesses. The exact format of the interviews varied, but each was characterised by an introduction to the investigation, the Code and the Commissioner's role, and the recording of notes which interviewees were asked to sign as a record of the substantive points made by them, unless a verbatim transcript was taken.

Material was passed to the investigation team at the time of interview and subsequently, and submissions were received directly from some organisations and individuals. Medical records have been considered where appropriate. Documents received included contracts, reports, memoranda, correspondence, minutes of meetings, policy documents, and Board papers and minutes. In total, more than 5,000 documents were gathered during the course of the investigation.

CANTERBURY HEALTH LIMITED

Canterbury Health Limited ("Canterbury Health") is one of 23 Crown Health Enterprises which deliver healthcare to the people of New Zealand. It is one of three Crown Health Enterprises in the Canterbury region, the others being Healthlink South Limited and Health South Canterbury Limited. These Crown Health Enterprises provide health services to the 450,000 people in the Canterbury province.

Of the three Canterbury Crown Health Enterprises, Canterbury Health is the main provider of acute care hospital services, chiefly through Christchurch Hospital. A total staff of 4,000 are employed by Canterbury Health. Christchurch Hospital treats 40,000 inpatients annually. Patient numbers have been increasing steadily at about the rate of 5% annually. Most of the patients treated at Christchurch Hospital are elderly and the numbers are continually growing as the population ages. The Hospital's Emergency Department is the busiest in New Zealand, seeing 65,000 patients per year.

At the time of the investigation Canterbury Health was responsible for seven hospitals as follows:

(a) Christchurch Hospital - 600 beds;

(b) Ashburton Hospital/Turangi Home - 122 beds;

(c) Burwood Hospital - 140 beds;

(d) Darfield Community Hospital - 10 beds;

(e) Waikari Community Hospital - 11 beds;

(f) Akaroa Community Hospital - 7 beds; and

(g) Ellesmere Community Hospital - 10 beds.

Christchurch Hospital is one of New Zealand's four major teaching hospitals, training doctors and specialists in conjunction with the Christchurch School of Medicine which is based on the same site. Canterbury Health also provides some specialist services for the whole of the South Island through Burwood Hospital's Spinal Injury Unit and the Christchurch Hospital Bone Marrow Transplant Service. Canterbury Health's mission is to provide quality health care and disability support services for the people of Canterbury and elsewhere. It also undertakes community-focused activities in addition to secondary care services.

THE 1993 HEALTH REFORMS AND THE FIRST YEAR OF CANTERBURY HEALTH

Commencement

In 1993 changes to the structure of the health sector were implemented, with the commencement of the Health and Disability Services Act 1993 coming into force on 1 July. At the core of the changes was the establishment of a purchaser/provider split and the introduction of commercial principles into the management of Crown owned providers. It was considered that restructuring public hospitals into independent and separate business units which competed against other providers of care from the private and voluntary sectors would provide the necessary tension and incentives to enhance their performance. The 14 Area Health Boards which had been responsible for secondary but not primary care were disestablished.

Regional Health Authorities

Four Regional Health Authorities were set up to act as the Government's purchasing agents for publicly funded health and disability services for the people in their regions.

The objectives of Regional Health Authorities were to:

(a) promote the personal health of people;

(b) promote the care of and support for those in need of personal health services or disability support services;

(c) promote the independence of people with disabilities; and

(d) improve, promote and protect public health to the extent enabled by their Funding Agreements.

The functions of Regional Health Authorities were to:

(a) monitor the need for public health, personal health and disability services for the people described in their Funding Agreements;

(b) purchase such services for those people; and

(c) monitor the performance of providers with whom the Regional Health Authority entered into Purchase Agreements.

On 1 July 1997 the four Regional Health Authorities merged into one national body called the Transitional Health Authority. The Transitional Health Authority was designed to manage the transition from the four Regional Health Authorities to a new funding agency, the Health Funding Authority, that came into being on 1 January 1998. The Health Funding Authority, through its divisional offices, purchases and funds health and disability support services on a regional basis.

Crown Health Enterprises

Crown Health Enterprises provide health and disability services in New Zealand. They are established as companies under the Companies Act 1993 and owned by the Crown, with the Ministers of Crown Health Enterprises and Finance as shareholders. The Ministers appoint directors to the boards of the Crown Health Enterprises. The Crown Health Enterprise's principal objective is to provide health and disability services in accordance with its Statement of Intent and any purchase agreement entered into by it, while operating as a successful and efficient business.

A Crown Health Enterprise is required to provide services in accordance with its Statement of Shareholders' Expectations.

The Ministry of Health

The Ministry of Health is responsible for:

advising the Minister of Health and the Government on policy for health and disability support services and on health implications of policies in other sectors;

acting as the Minister's agent for administering public funding to the sector, negotiating Funding Agreements with Regional Health Authorities and managing their performance;

protecting, promoting, and improving public health, and reporting annually on the state of public health; and

monitoring the overall performance of the sector.

Crown Company Monitoring Advisory Unit

The Crown Company Monitoring Advisory Unit is responsible for monitoring and advising shareholding Ministers on state owned companies including Crown Health Enterprises. Specifically in the health sector, the Crown Company Monitoring Advisory Unit is responsible for:

(a) advising the Government on ownership objectives and targets for Crown Health Enterprises, the Crown's investment in Crown Health Enterprises, and the impact on Crown Health Enterprises of proposed health policy options;

(b) monitoring and advising the Minister for Crown Health Enterprises on Crown Health Enterprise performance against objectives and targets; and

(c) managing, on behalf of the Minister, appointments of directors and the process of assessing the performance of Crown Health Enterprise Boards.

Statement of Achievements

In the annual report for 1993/1994, the Chief Executive compared Canterbury Health's performance against its stated objectives. The Chief Executive reported that "*good progress was made in steering Canterbury Health through the Health Reform transition and establishing it in a form capable of prospering in the future"*. Among the achievements that Mr Frame listed in the 1993/1994 year were the introduction of new information systems and a major reduction in the number of collective employment contracts at Canterbury Health.

CANTERBURY CHE DEBATE

Christchurch's Two Crown Health Enterprise Debate

There was much debate over the number of Crown Health Enterprises to be established in Christchurch. It was a contentious issue. In general the senior medical staff at Christchurch Hospital were opposed to the creation of two Crown Health Enterprises. The Canterbury Association of Physicians, representing senior physicians in the Canterbury area, undertook what it described as a "*campaign for a co-ordinated health service in Christchurch*".

Before the Canterbury Crown Health Enterprise Advisory Committee (CHEAC) recommended to the National Interim Provider Board that two Crown Health Enterprises be established in Christchurch, there had, according to the Canterbury Association of Physicians, been two other committees considering this issue. The two committees recommended that there be one Crown Health Enterprise in Christchurch.

The former Chairman of Canterbury Health, Dr Layton, advised that Crown Health Enterprise Advisory Committee was the only committee to consider the matter. However, following vigorous objections and lobbying by Canterbury clinicians, the National Interim Provider Board commissioned two reviews to consider the clinical viability of two Crown Health Enterprises.

The Canterbury Association of Physicians raised arguments against the creation of two Crown Health Enterprises based on a range of clinical and philosophical issues. The Association was particularly concerned about the effect on continuity of care of having Older Persons' Health, which was based at The Princess Margaret Hospital, separated from the rest of General Medicine at Christchurch Hospital. The Canterbury Association of Physicians also pointed out to the Canterbury Crown Health Enterprise Advisory Committee that there would be two Boards, two General Managers, essentially double of everything and that the bureaucracy seemed unnecessary. During the process the Association became concerned about whether a decision had already been made by the Canterbury Crown Health Enterprise Advisory Committee to recommend the establishment of two Crown Health Enterprises. The nature of the questions asked by the Canterbury Crown Health Enterprise Advisory Committee during the submissions left the Association's representatives with that impression.

The final decision, recommended by the Canterbury Crown Health Enterprise Advisory Committee and approved by Government, was to establish two Crown Health Enterprises in Christchurch.

One other aspect of the Canterbury Crown Health Enterprises Advisory Committee's deliberations came to light in December 1992. The Canterbury Association of Physicians obtained, under the Official Information Act, the Canterbury Crown Health Enterprises Advisory Committee's recommendations about the number of Crown Health Enterprises which should be established in Canterbury. A further recommendation was that those who made strong representations of doubt regarding the creation of two Crown Health Enterprises should have their contractual status reviewed. The recommendation stated

> "*CHEAC believes that the continued opposition by this small group of staff can be managed by CHE Boards, whose first priority should be to address the issue of formal employment contracts for these staff with the CHE".*

The Canterbury Association of Physicians reported that Dr Layton, who was a member of the Canterbury Crown Health Enterprise Advisory Committee and became the first Chair of Canterbury Health, said there would be no discrimination against those who criticised the setting up of two Crown Health Enterprises in Christchurch. However, the mere knowledge that the recommendation had been made caused concern among senior clinicians about the approach the new Crown Health Enterprise might adopt to relationships with clinical staff.

In December 1997, some services were reconfigured with the transfer of women's health and community based services from Healthlink South to Canterbury Health.

Healthlink South

The second Crown Health Enterprise in Christchurch is Healthlink South Limited ("Healthlink South"). It too services the people of Canterbury and is unique among the Crown Health Enterprises in that it does not have as its core activity a comprehensive, 24 hour acute general hospital service. At the time of the investigation Healthlink South was separated into four divisions covering family health (208 beds), intellectually disabled persons' health (450 beds), mental health (220 beds) and women's health (162 beds). Healthlink South had a staff of around 2,900 and operated through 10 hospitals as follows:

(a) The Princess Margaret Hospital;

(b) Sunnyside Hospital;

(c) Templeton Centre;

(d) Christchurch Women's Hospital;

(e) Queen Mary Centre;

(f) Lincoln Hospital;

(g) Rangiora Hospital;

(h) Lyndhurst Hospital;

(i) Kaikoura Hospital; and

(j) Oxford Hospital.

Health South Canterbury

The third Crown Health Enterprise in Canterbury is Health South Canterbury Limited ("Health South Canterbury") which provides service to the public in South Canterbury. It provides a comprehensive range of health services delivered from Timaru Hospital, with limited sub-specialisation.

The Canterbury Area Health Board had also been responsible for services in the Chatham Islands. However, from 1 July 1993 the responsibility for these services was transferred to Hawkes Bay Health Limited.

CLINICAL INPUT IN THE FIRST YEARS OF CANTERBURY HEALTH

Changes to Health Board Advisory Functions

Canterbury Health made a number of decisions about the appropriate structure and function of clinical advisory input to the Board and management. The Medical Advisory Committee and the Health Professional Advisory Committee included nursing and allied health professionals. These committees, which had provided advice to the General Manager of the Canterbury Area Health Board, were disbanded. Groups that were established to provide clinical input were:

(a) medical and surgical policy groups (June 1993); and

(b) Medical Advisors' breakfast meetings (August 1994).

The view of clinicians was that these groups fulfilled a different role from the structures which had provided advice to the Area Health Board.

Medical Advisors

For the first year of Canterbury Health's existence, the General Manager, Christchurch Hospital Services acted as advisor to the Chief Executive Officer. In June 1994 the Crown Health Enterprise appointed three Medical Advisors to the Chief Executive Officer. The position of Chief Medical Advisor was rotated on a six monthly basis among the three Medical Advisors.

Canterbury Health described the major benefits of appointing three Medical Advisors as:

(a) "*There will always be someone available;*

(b) *A wider range of medical staff to consult with over a particular issue (three people rather than one);*

(c) *The areas of medicine, anaesthesia/surgery and paediatrics will be well covered; and*

(d) *A variety of skills to the position*".

The principal objectives of the Medical Advisors were described in their job descriptions and were as follows:

(a) to assist the Chief Executive Officer, General Managers and the medical staff in professional medical issues;

(b) to work with the General Manager and Clinical Director of each speciality in the appointment of senior medical personnel; and

(c) to assist the Chief Executive and General Managers to provide health care in a manner consistent with the policies and procedures adopted by the Board of Canterbury Health and with the direction of the management.

Among their key tasks they were to:

"*be responsible for enabling Canterbury Health to establish appropriate standards of conduct for its medical staff and for ensuring that the medical staff comply with these standards;*

advise Clinical Directors and Management to ensure that appropriate professional standards and quality improvement programmes are established and operated within Canterbury Health; and to

be responsible for providing advice and information relevant to legal and occupational issues relating to the medical staff and for managing and/or undertaking investigations of actual practice as required".

In addition, the Chief Medical Advisor's duties included:

(a) "*Supervision of death certification ...*

(b) *Link with Coroner and other medico-legal matters ...*

(c) *Supervision of peer review activities ...*

(d) *Key role in audit and quality assurance activities essential for continuous improvement by medical practitioners ...*

(e) *Review of complaints against doctors in the institution"*.

In August 1994 fortnightly Medical Advisors' breakfast meetings with senior managers began. From late 1994 the Chairman of the Christchurch Hospitals' Medical Staff Association and the Resident Medical Officer advisor attended. From May 1996 the Deputy Chair of Christchurch Hospitals' Medical Staff Association was also invited to participate in these meetings.

Medical and Surgical Policy Groups

In June 1993 meetings of a Medical and a Surgical Policy Group began. The General Manager, Christchurch Hospital Services set up the meeting structure and organisation of these groups. Clinical Directors of the various departments attended these meetings to provide input at an operational level. While neither of these groups had formal written objectives, the Surgical Policy Group's objectives were described at the first meeting to be:

"*To ensure that surgery, anaesthetics and theatres worked in a co-ordinated and effective manner.*

To provide advice and policy guidance for surgery.

To discuss and implement operational and strategic issues that were relevant to surgery".

It was explained at the first meeting that the Surgical Policy Group had been created "*in order to get together the relevant staff to discuss the surgical and perioperative services*". (Dr Coughlan)

Canterbury Health was not able to produce the minutes of the first Medical Policy Group meeting, and it is therefore unknown what its objectives were.

Dr Layton advised that other clinical input in the first years was provided by:

- the Professional Advisor, Nursing and Midwifery Services;

- the professional nursing unit;
- the Chairman's advisory committee of senior clinicians which operated until the new Chief Executive arrived and helped shape the organisational and management structure;
- the presence on the Board of an eminent physician;
- clinicians and nurses who provided input into the original 1993/96 business plan drawn up by the establishment unit. All senior clinicians and nurses had the opportunity to draft written material and attend meetings as part of the process.

FINANCIAL PRESSURES - A CROWN HEALTH ENTERPRISE IN WORKOUT

A Work Programme

In 1994 Canterbury Health had an operating loss of almost $29 million. The Crown Company Monitoring Advisory Unit designated Canterbury Health as a Crown Health Enterprise in "workout" in October 1994, and a partner in Coopers & Lybrand was appointed as an observer at Board meetings on behalf of the shareholding Ministers. Generally Crown Health Enterprises were placed in workout if, following balance sheet restructuring, the deficit forecast was considered to be unacceptable. Equity injections were provided to Crown Health Enterprises on the basis that boards would follow a work programme set by the Minister for Crown Health Enterprises. Crown Health Enterprises in workout were assessed in relation to their performance against the work programme on a weekly basis.

Workout involved the Crown Health Enterprise identifying the issues it needed to address to produce a satisfactory business plan. The interest of shareholders and the role of the Crown representative was to:

- ensure that there were processes in place to address these issues;
- monitor progress in addressing the issues; and
- clarify shareholder expectations.

The work programme for Canterbury Health focused on resolution of the Crown Health Enterprise/Regional Health Authority contract, cost control and the production of a revised business plan. The Directors of Canterbury Health were responsible for implementing the work programme and were held accountable against the performance targets determined in the business plan. The workout for Canterbury Health ended in May 1995 when it had developed a business plan which met the shareholders' objectives.

The Crown Company Monitoring Advisory Unit was in regular contact with the Board and senior management of Canterbury Health during the workout. The observer provided a weekly review of the performance of Canterbury Health against the work programme.

A Business Plan

The shareholding Ministers, through the Crown Company Monitoring Advisory Unit, directed Canterbury Health to prepare a business plan which would resolve Canterbury Health's financial problem. The business plan developed by Canterbury Health "*outline*[d] *a path to Canterbury Health Limited (CHL) achieving commercial viability by 30 June 1997. The forecast for the year ended 30 June 1995 is for CHL to make a net operating loss of $27.2 million. Through the successful*

implementation of the initiatives in this plan, CHL intends to convert that loss to a $8.0 million operating surplus for the year ended 30 June 1997".

The plan required:

(a) "*Significant cost savings to be achieved in all service areas over the next three years;*

(b) *Notices of intended exit to be issued to the SRHA for all services for which it was unwilling to pay the price an 'efficient' CHE would need in order to stay in the activity in the long-run;*

(c) *Renegotiation of the payment for post entry clinical training with the Clinical Training Agency;*

(d) *The end of subsidisation of the Christchurch School of Medicine; and*

(e) *The provision of increased services to private fee paying patients*".

It was in the context of meeting this business plan that Canterbury Health put together a proposal to restructure the organisation of patient care at Christchurch and Burwood Hospitals.

WORKLOAD ISSUES

Medical Advisors' Concerns, May to August 1995

Shortly after decisions about the business plan had been made, the Medical Advisors expressed their concerns about the impact of workload on quality of services. In May 1995 the Medical Advisors warned that their investigations "*of several recent complaints have found that often communication within the organisation is poor*" and that there were "*system stresses inherent in attempting to maintain services with the current levels of available staff. Proper care and communication can be achieved with normal levels of activity. Our point is that frequently, levels of activity are above normal*". The letter concluded:

"*In summary, the organisation's current clinical staffing levels are often at a sub-optimal level in respect of providing effective patient care and meeting the broader needs of patients and their relatives. Any further economies in the staffing of patient related services would be highly undesirable".*

The letter was sent to the Chief Executive and copied to the General Manager, Christchurch Hospital Services.

Winter 1995 brought increased demand for hospital services. Some staff found winter 1995 more of a problem than winter 1996, which is discussed later.

Taskforces

In June 1995 Canterbury Health established three "Taskforces". One related to Radiology, another to Pharmacy and the third to Pathology. The Radiology and Pharmacy Taskforces were chaired by the General Manager, Christchurch Hospital Services and the General Manager, Diagnostic and Support Services respectively and the Pathology Taskforce was chaired by a Medical Advisor. The three taskforces were primarily made up of doctors rather than nurses. The terms of reference for the taskforces were to:

(a) implement the development of protocols for best practice pathology and radiology testing and pharmacy prescribing in high volume/high cost areas to promote efficient use of resources;

(b) assist in the education of all medical staff, especially junior staff in generation of appropriate prescribing, pathology and radiation requests;

(c) advise and educate staff of any new developments in pharmacy, pathology and radiology to ensure their efficient integration with existing technology.

(Minutes of Pharmacy Taskforce Meeting, 14 June 1995)

In addition, the Radiology and Pathology taskforces were to:

approve any new tests and request for services;

re-evaluate radiology and pathology request forms to ensure the appropriate information is on the form and available to those requesting these tests;

develop/consider/encourage other initiatives which may result in more efficient use of radiology and pathology testing.

The Radiology Taskforce was also required to determine the appropriate process of finance in the radiology services from hospital services and other sources.

(Minutes of Radiology Taskforce Meeting, 9 June 1995 and Pathology Taskforce Meeting, 7 June 1997).

Based on the sets of minutes provided, the final meeting of:

(a) the Radiology Taskforce took place on 11 August 1995;

(b) the Pathology Taskforce took place on 30 August 1996;

(c) the Pharmacy Taskforce took place on 19 June 1996.

Matters discussed at the Radiology Taskforce meetings included:

the development of inter-departmental guidelines for sending radiology requisitions;

the lack of, and difficulties associated with the provision of, detailed information to clinicians and management. The group agreed that clinical teams needed to be benchmarked as to the numbers of radiology tests per diagnosis or treatment and ongoing monitoring mechanisms developed;

guidelines for revenue options for private radiology services; and

the lack of radiology staff and orderlies.

At the Pathology Taskforce meetings the following issues arose:

(a) reporting requirements and the results reporting system;

(b) the inclusion of pathology guidelines in the revision of the 'Blue Book' medical guidelines and the development of guidelines for surgical specialities;

(c) duplicate ordering of reports;

(d) the development of a mechanism to facilitate the ongoing development of any other initiatives that may result in the more efficient use of pathology testing; and

(e) the pathology budget and the provision of data for analysis by budget holders.

The Pharmacy Taskforce meetings referred to:

(a) the introduction, efficacy and monitoring of new drugs;

(b) best practice prescribing protocols and projects;

(c) comparative drug usage information for departments and teams and the recording of specific patient information;

(d) pharmaceutical costs and the link between Pharmacy and the Clinical Casemix Centre; and

(e) initiatives to continue to develop drug policies and to make them more readily available, establish a reasonable rate for results audit, publish more bulletins on drug information, increase the presence of clinical pharmacists on wards and to employ additional staff.

Meetings were also held at the initiative of clinicians in departments such as Emergency in order to review developments and identify improvements.

Patient Management Think Tanks

Between August and September 1995 a series of patient management "Think Tank" meetings were held as a result of various issues raised by the Medical Advisors in relation to patient safety, number of beds and staffing. The think tank meetings were chaired by the General Manager, Christchurch Hospital Services with the Chief Executive attending. They were essentially a series of general discussions involving a group of professional staff and some local general practitioners to consider whether Canterbury Health could "do things better" and if so, how this could occur.

The terms of reference for the think tank meetings were to:

(a) discuss admission, treatment and discharge processes;

(b) discuss the medical day unit, acute admitting ward and inpatient ward;

(c) discuss other models of patient care processes and discharge pathways;

(d) consider the development and implementation of patient care plans; and

(e) consider the patient workload and to determine whether Christchurch Hospital was appropriately staffed (including seasonal variations).

The first think tank meeting concentrated on pre-hospital care. The group resolved to further investigate the following matters:

(a) communication between general practitioners and consultants;

(b) access to hospital services by general practitioners, particularly for outpatients;

(c) after hours services offered by general practitioners;

(d) the need for an assessment area;

(e) the need for base wards and teams for continuity of care; and

(f) the need for data to be collected on the appropriateness of admissions and discharges within 24 hours.

Subsequent discussions were about the advantages and disadvantages of acute admitting wards, allied health staff levels and discharge planning. Members stressed the need to ensure that beds were available at The Princess Margaret Hospital in 1996. Staff and occupancy levels were also discussed. Mr Frame, Chief Executive at the time, thought that 80 - 90% was the target occupancy level.

Post Think Tank Meetings

As a result of the think tank meetings two further meetings were held to look at the flow of patients through the Hospital. These meetings were co-ordinated by a Medical Advisor. This group made a number of observations and recommendations which are discussed later in this report.

New Zealand Nurses Organisation

The New Zealand Nurses Organisation, which has a role as a professional advisory body and an industrial advocate, wrote to the Canterbury Health Human Resources Manager in August 1995 about a mechanism to address "*the absence of consultation and the lack of any meaningful involvement by management of nurses, NZNO and Unit Managers in processes that would address the very real problems facing nurses at Christchurch Hospital*". This mechanism was considered by Canterbury Health to be unnecessary, and the reply from the Human Resource Manager, which was written shortly before the restructuring proposals were circulated, stated "*we have been exploring most of the issues that you have raised in consultation with a wide range of nursing staff*".

PROPOSALS FOR CHANGE, AUGUST 1995

Background to Publication of Proposals for Change

The 1995-1998 Canterbury Health business plan provided the impetus for the restructuring proposals. In particular, the plan anticipated "process re-engineering" as a key aspect of intended efficiency gains. The proposed efficiency gains were part of the strategy to convert a budgeted loss of $27.2 million for the year ended 30 June 1995 to an operating surplus of $8.0 million for the year ended 30 June 1997. The "process re-engineering" project involved the anticipated use of patient care teams, case management and the clustering of wards. The business plan, which anticipated a 10% reduction in direct expenses, foreshadowed certain elements of the Proposals for Change published in August 1995.

It was in the context of meeting the business plan that the Chief Executive put forward a proposal to restructure the organisation of patient care at Christchurch and Burwood Hospitals. It was anticipated that the management and organisational restructure would assist the introduction of case management and patient care teams.

Drafting of Proposals for Change

On 31 August 1995 the draft of the restructuring proposals called "Proposals for Change" was circulated for consultation purposes in accordance with Canterbury Health's contractual obligation to its employees. The Proposals for Change included a Proposal for Nursing, a Proposal for Managing Christchurch Hospital, and the introduction of a case management model of service delivery. The team that created the proposals included the General Manager, Special Projects (a registered nurse), Canterbury Health's Professional Advisor, Nursing and Midwifery Services, the General Manager, Christchurch Hospital Services (a registered medical practitioner) and the Manager, Human Resources (a registered nurse). The Chief Executive was also "*intimately involved*". Canterbury Health decided not to seek

the involvement of its Medical Advisors or clinical committees in developing the Proposals. Staff were given 30 days to make submissions on the Proposals.

The Proposals suggested changes to the method of service delivery and management structure at Canterbury Health and expressly recorded that:

"*This proposal is for consultation within the wider work force. No decisions about it have been made and we cordially seek your response to them (*sic*)*".

Proposal for Nursing

The Proposal for Nursing proposed the following changes.

(a) The appointment of nine Patient Care Managers who would have senior managerial responsibility. Each Patient Care Manager would manage groups of between four and five wards of up to 120 patients.

(b) Supporting the Patient Care Managers would be Clinical Care Leaders. The Clinical Care Leaders would head a team of nurses and would co-ordinate the care of between 10 and 12 patients. The anticipated number of Clinical Care Leaders was not specified in the Proposal.

(c) Disestablishment of the Unit Nurse Manager positions. "Unit Nurse Manager" was a successor title to the "Charge Nurse" position. These nurses had overall responsibility for each of the wards. Canterbury Health employed around 30 Unit Nurse Managers as at 31 August 1995.

(d) Disestablishment of the Professional Nursing Unit. The Professional Nursing Unit provided quality control, training and education services for Canterbury Health's nurses. These functions were to become a line management responsibility.

The Proposal for Nursing also made the following reference to the use of unskilled or newly qualified nurses:

"*Nurse Practitioners, Beginning Practitioners, Enrolled Nurses and Nurse Aides would, over time as the care delivery system developed, increasingly work in care teams managed by Clinical Care Leaders on a daily basis with overall management by the senior nurse Patient Care Managers*".

Proposal for Managing Christchurch Hospital

The proposal for managing Christchurch Hospital suggested:

(a) Nine Service Managers be appointed to manage between two and four clinical specialities each. Service Managers were to be accountable for the financial, contractual and administrative aspects of their departments.

(b) Medical Directors be appointed to lead each of the 25 clinical practice areas. The Medical Directors were to focus on strategic clinical matters.

Case Management

The introduction of a "case management" model of service delivery was proposed. The only explanation as to what was meant by case management was:

"[case management is] *service delivery which is centred on the patient and delivered in a way which utilises care planning and continuity of care and co-ordination …*".

The Proposal for Managing Christchurch Hospital stated that the "case management model" included the development and use of care paths/care plans.

Four pages of the Proposal for Nursing document were devoted to setting out the anticipated benefits of the case management model. These benefits included:

(a) recognition of nursing skills;

(b) provision of direct care leading to enhanced autonomy for nurses;

(c) involvement of nurses in the co-ordination of a multi-disciplinary team;

(d) the provision of continuity of care by nurses as a consequence of their responsibility for groups of patients from "entry to exit";

(e) the promotion and strengthening of "collegial relationships" between nurses in a team;

(f) job enrichment for nurses;

(g) improvement of quality of service provided by nurses;

(h) provision of clinical career pathways for nurses.

Although the Proposal for Nursing set out in some detail the anticipated benefits of case management and the use of care planning, it did not define either of these terms.

CONSULTATION ON PROPOSALS FOR CHANGE

Chief Executive's Update

On 25 September 1995 the Chief Executive circulated among all Canterbury Health staff an information update which addressed the matters which Canterbury Health management identified as being the principal issues raised during the consultation process. These issues were:

(a) understanding why Canterbury Health needed to change;

(b) clarification of the relationship between Patient Care Managers and Clinical Care Leaders;

(c) concerns that the Proposals meant a return to "task allocation" and/or "team nursing";

(d) concerns that the Proposals anticipated the introduction of untrained staff;

(e) questions about professional support;

(f) understanding how co-ordination at ward level would be achieved;

(g) setting a time frame;

(h) concern that the proposed groupings of units/services may not be practical.

The update dealt with the first four concerns. The other concerns were merely acknowledged but they were not elaborated on or directly addressed.

Update: Why Canterbury Health Needed to Change

In addressing this issue, Mr Frame commented that Canterbury Health was required by the Health and Disability Services Act to provide health services "*as efficiently as possible*". He further stated that to meet the expectations of the Southern Regional Health Authority, Canterbury Health must "*be satisfied that all of its care is provided in the most efficient and effective way possible*". Case management was identified as a means to achieve this goal. The update suggested that certain of the other changes suggested in the Proposals were orientated to the introduction of case management. This was expressed as follows:

> "*The Case Management Model of nursing, although allowing autonomous practice to flourish, is different to the way nurses currently practice.... A new management structure whereby existing units are aggregated into larger units is proposed. This management structure, we believe, would best support the Case Management Model*".

Update: Patient Care Managers and Clinical Care Leaders

Patient Care Managers were described in Mr Frame's September 1995 information update on the Proposals as "*Nursing Executives managing the nursing workforce, facilitating nursing practice and supporting the Clinical Care Leaders*". It was not anticipated that Patient Care Managers would provide direct nursing care, although they would work closely with the Clinical Care Leaders. Patient Care Managers were to "*provide the Chief Executive and Senior Management team with advice about nursing and organisational development*".

Clinical Care Leaders were described as the nurse leaders at the direct patient care level. It was anticipated that they would be expert clinical nurses who would work with a team of qualified nurses to provide individual patient care according to care plans. Each Clinical Care Leader was to be responsible for the overall care co-ordination of between 10 and 12 patients.

Update: "Task Allocation" or "Team Nursing"

The update stated that there was "*no intention of returning to 'task orientated' or 'team nursing'*". 'Team nursing' or 'task orientated' nursing provides care to a group of patients by co-ordinating the registered nurses, enrolled nurses and hospital aids under the supervision of one nurse, the team leader. One nurse leads the team while the members perform the assigned tasks. It was anticipated that nursing care would be delivered by nurses practising autonomously. Nurses were to provide continuity of care, and independent practice was stated to be the norm.

Update: The Introduction of Untrained Staff

The update stated that Canterbury Health management specifically did not propose introducing untrained staff. The update went on to say that "*we envisage that a mix of skills would be incorporated into the qualified nursing workforce in our model, e.g. larger units would provide Beginning Practitioner and Nurse Practitioner ones with broader experience*".

Meetings Between Management and Staff Regarding Restructuring in September 1995

In the period between publication of the Proposals for Change in August 1995 and publication of the Restructuring Plan in November 1995, meetings were held between senior management and:

(a) senior nursing staff;

(b) divisional support staff, hospital services; and

(c) Burwood nursing and allied health staff.

The issues raised by the senior nursing staff generally reflected matters that had been raised in the written submissions provided to management during the consultation period. In particular, the senior nurses were critical of the disestablishment of Unit Nurse Managers and questioned the efficacy of case management. The nurses also raised the question of whether the restructuring proposals had been driven by cost savings in general and the $12 million deficit in particular.

Management responded that the Proposals were driven by cost savings and a need for greater efficiency. Mr Frame emphasised that Canterbury Health was constrained by the funding received from the Southern Regional Health Authority and consequently there was a need to focus on delivering care in the most efficient way possible. However, he specifically denied that the $12 million deficit was driving the restructuring proposals.

The issues raised at the meetings with Burwood nursing and allied health staff and divisional support staff included the undesirability of the disestablishment of Unit Nurse Manager positions, the implementation of case management and the role of Patient Care Managers. In response to the questions raised, management essentially reiterated the content of the Proposals themselves. The need to operate more efficiently or save costs was not raised at these two meetings.

Written Submissions on the Proposals for Change

Around 130 written submissions were received by Canterbury Health in response to its Proposals. Almost all of the submissions expressed criticism of the Proposals. The 10 concerns which dominated the submissions (in order of frequency of reference) were:

(a) disestablishment of Unit Nurse Managers (68%);

(b) casualisation/detrimental alteration of skill mix (28%);

(c) restructuring not justified as a particular unit or ward is already running well (27%);

(d) span of control of Patient Care Managers too wide (23%);

(e) lack of consultation (21%);

(f) case management not universally appropriate throughout hospitals (19%);

(g) Proposal is poorly written/researched (18%);

(h) disestablishment of Professional Nursing Unit (18%);

(i) patient safety (17%); and

(j) grouping of wards inappropriate (9%).

Disestablishment of Unit Nurse Managers

The single issue which dominated the submissions made by the medical and nursing staff was concern at the disestablishment of the Unit Nurse Manager position. The following quote from the submission by the New Zealand Nurses Organisation summarises the commonly held perception of the role:

"*UNMs are on-sight* (sic) *to monitor and maintain standards of practice, to facilitate orientation of new nursing, medical and allied health professionals, to write staff appraisals that assist with career development, to investigate critical incidents and implement quality*

improvements, to resolve interpersonal conflicts, to handle patient complaints, to liaise with community groups such as the Cancer Society, to participate in wider professional and CHE committees and action groups, to assist nurses with clinical activities, to provide a vital communication link between nurses and the wider organisation, to respond appropriately to the ever changing staffing and patient needs. They enable nurses to remain in direct patient care and provide an appreciation of the bigger picture".

The general concern was that the disestablishment of Unit Nurse Managers would mean the loss of an identified co-ordinator at unit level that would not be adequately compensated for by either the establishment of Patient Care Managers (who would be too overburdened with administrative and managerial work to support nurses in the wards) or Clinical Care Leaders (who were to be team, and not unit, focused). The comment was made that the Proposal for Nursing would "*fragment professional teams, adversely affect the quality of care delivery and lead to inefficiencies*". It was also felt that Unit Nurse Managers, due to their close relationship with the nursing staff and their leadership experience, were best placed to manage the proposed changes. In particular, the Unit Nurse Managers had co-ordinated implementation of previous restructuring at Canterbury Health and therefore were experienced at managing such a process.

Casualisation and Detrimental Alteration of Skill Mix

The concern regarding the introduction of casual, unskilled or newly qualified nurses apparently originated from the passage of the "Proposal for Nursing" document set out above in paragraph 7.3. Submissions made by nurses in the Clinical Haematology and Intensive Care Units and various acute wards outlined several aspects of nursing care which could not be provided by unskilled or newly qualified staff. As such, these submissions stated that the reduction of skilled staff would undermine the standard of care and thereby compromise patient safety.

Typical of the comments made in the submissions were the following:

"*We feel that the introduction of untrained and less qualified staff would seriously compromise acutely ill patients, their significant others and the standard of care afforded to both. This "skill mix" will greatly impede our ability to optimise situations for our patients and to maintain the extremely high standards of practice currently being delivered in Intensive Care. "Skill mix" would also decrease accountability, professionalism and autonomy potentially making an unsafe work environment. Ultimately this will put patients and families well-being at risk*".

"*The proposed review of skill levels will impact greatly on our patients* (sic) *welfare. A subtle deterioration in condition, unobserved by the untrained eye can quickly render a detrimental or even fatal consequence... Any reduction in skilled staff will no doubt result in a rise in the mortality rate*".

Restructuring Not Justified

Many of the submissions recorded that specific wards or units were already operating at optimal levels of efficiency and effectiveness and that further restructuring was unnecessary. Many submissions linked this statement with the comment that the Proposal did not clearly set out the nature of existing problems that the restructuring sought to address. The New Zealand Nurses Organisation commented:

"*there are many areas which have been constructively addressing … issues and have subsequently developed innovative models of care delivery which are highly efficient, suitable to the particular clientele and environment and have provided the benefits outlined in the*

proposal. Your attention is drawn to the submissions from Wards 27, 25, 14, ICU and clinical haematology to name a few.

The introduction of a new system would destroy the gains already made, punish and demoralise staff for being professionally and fiscally responsible and responsive and disrupt excellent systems which continue to develop to meet the goals of Canterbury Health Ltd and which have the commitment of the staff. A global solution as proposed would not focus resources and attention on areas most in need or address specific problems. Optimal outcomes cannot be achieved by use of a blunt instrument such as this".

Similarly, the Executive of Christchurch Hospitals' Medical Staff Association stated :

"*Over the past two years many CDs* [Clinical Directors] *and Unit Nurse Managers have made strenuous efforts to achieve efficiency and clinical excellence within their departments. These efforts need more recognition than is implied in your document".*

Patient Care Managers Over-extended

The volume of work, responsibility and span of control of the proposed Patient Care Managers was considered to be untenable. Typical comments included the following:

"*The PCM's proposed span of control is not realistic* [and] *some of the tasks of the PCMs will be neglected to the detriment of patient care*".

"*Given the enormity of the Patient Care Manager's job … human resource management will take a priority and quality issues will become secondary*".

"*It is obvious to nurses that the ability of one person to effectively fulfil the* [Patient Care Manager] *role is impossible*".

Lack of Consultation

Although it was expressly stated in the Proposal for Nursing that the document was drafted for consultation with staff and that no decisions had been made about it, considerable concern was expressed that no consultation had been entered into prior to drafting and circulating the documents. Typical comments were as follows:

"*The way the "Proposal for the Change - Canterbury Health" document was released in late August, with no previous warning nor clear indication as to why a change was necessary, belies a <u>team</u> approach to health delivery in the 90s".*

"*The* [Proposal has been introduced in a] *covert way ... Health care professionals have freely given their expertise and made comments, but with one exception, none have been involved in the development of these proposals*".

"*There has been an increasing trend over the last twelve months for management decisions to be made in isolation from clinicians and for documents in various states of preparedness to be circulated around for "consultation". This has lead to some degree of cynicism on the part of senior clinicians …*".

"*Your lack of prior discussion with health professionals before recently circulating a set of highly developed proposals has been damaging to morale among nursing and medical staff*".

"*There was no discussion … prior to the proposal being put out.....this immediately put all staff involved (who have been threatened with disestablishment) on the back foot and made them defensive and emotionally involved*".

There was also considerable doubt expressed that the submissions would be taken into account in any final decision.

Case Management

A number of submissions stated that the "case management" patient care model was inappropriate for introduction throughout Burwood and Christchurch Hospitals. Several submissions expressed the view that the existing primary nursing model provided the same benefits to patients as those set out in the proposal for case management. In addition, many of the submissions that raised this issue considered that "case management" meant a return to "task based nursing". As such, these submissions considered that the case management model would undermine job satisfaction for nurses and quality of care to patients.

In addition to general comments regarding the inappropriateness of case management, a suggestion was made that the model be subjected to a pilot study to assess whether it was suitable for use at Christchurch Hospital.

Typical comments in this area were as follows:

"*The direct attack on primary nursing is inconsistent with the literature which supports primary nursing as the pre-cursor to case management. As ward 25 demonstrates when primary nursing is implemented well with appropriate resources it works. In primary nursing there is a group of nurses who plan care with and for the patient, with the multidisciplinary team. This is a very supportive net work which is intrinsically linked with all staff in the unit*".

"*We recommend that primary nursing be retained rather than the implementation of case management in this area. Case management will mean less choice and flexibility with the shifts and rostering leading to decrease in morale. … primary nursing enables the nurses to support, assist and help their colleagues during busy and stressful times*".

"*... my great concern at the introduction of a completely new model of patient care service delivery system to an <u>entirely</u> "acute" hospital (Christchurch) when all overseas models have brought in the case management system as outlined in the proposal, to <u>one</u> unit of a non-acute hospital ...".*

"*Case management is most appropriate in non-acute or community care areas. Many acute hospitals use managed care with primary nursing as the care delivery system*".

"*There are many aspects to your proposals that have merit and may be applicable to certain disciplines and professional teams. Any implementation of change needs to be flexible and to recognise the different needs of both health professionals and patients in different disciplines".*

"*...there is not an adequate description of* [case management] *and how it is to* [be] *implemented".*

Proposal Poorly Prepared

A number of the submissions stated that the document was poorly written, did not sufficiently explain the case management concept, failed to explain why the changes were necessary, was poorly researched and made claims that were unsupported by the academic literature. Typical comments were as follows:

"*The document is quite appallingly written and is easily the worst example of "management speak" that I have read. ... If this was a submitted scientific medical paper, it would never see the light of day. I find the whole tone of the document insulting to the great tradition of nursing. If it wasn't so sad, I would have thought the preparation of this document must have been a joke".*

"*The proposal is so poorly researched and written I don't think it's worthy of a submission".*

"*… no analysis or study of the current models operating has been done by the authors of this proposal …*"

"*This proposal has been poorly presented to the staff of Christchurch and Burwood Hospitals resulting in increasing levels of stress and anger amongst staff".*

Disestablishment of Professional Nursing Unit

There was concern that the disestablishment of the Professional Nursing Unit would considerably erode support services for nurses, especially when combined with the disestablishment of the Unit Nurse Manager ("UNM") positions. Several submissions pointed out that the Professional Nursing Unit ("PNU") provided important services for educating and supporting nurses. Disestablishment would adversely affect nursing education and morale. The following were typical comments:

"*A central support service such as the current PNU facilitates has assured quality nursing education. Along with the removal of UNM positions, it is my opinion that this proposal removes vital nursing resources without replacing them with an equal or better option".*

"*I was disappointed to learn that the Professional Nursing Unit would be disestablished. Why disestablish the Professional Nursing Unit when it could help support/guide people through such changes?*"

Patient Safety

The link between the effects of restructuring and a reduction in patient safety was directly expressed in relatively few of the submissions. References to a reduction in the quality of patient care or a compromising of patient safety standards arose in the submissions in the following contexts.

(a) As a consequence of the anticipated reduction or dilution of the numbers of skilled nursing staff. The issue of compromised patient care was most frequently raised in connection with the anticipated introduction of unskilled or newly qualified nursing staff.

(b) As a consequence of the disestablishment of Unit Nurse Managers. The concern here was that the removal of skilled Unit Nurse Managers and the consequent increased workload on those nurses with direct responsibility for patient care would compromise patient safety.

(c) As an isolated statement unsupported by any reference to any specific effect of the restructuring. These submissions merely made the statement that the Proposals would result in compromised patient care or safety.

Typical comments included the following:

"*The only reason for adding in* [unskilled or newly qualified nurses] *is to add in a lower tier of person who is capable of delivering a lower quality of care to the patients at a lower cost and I perceive this to be a safety issue …*"

> "*I fear that if the* [charge nurse's] *role ... is diminished or diluted then our communication process with the nursing staff will also be compromised, and as a result patient care will be compromised".*
>
> "*I have read the proposals and am concerned that they* ***will*** *result in a decline in standards of patient care. This is especially clear in regard to the suggested changes to nursing structures, but is also likely if your other proposals were implemented".*

Grouping of Wards Inappropriate

This criticism focused on the groups of wards and units which would be aggregated to form one unit under the control of a Patient Care Manager. Submissions which addressed this issue commented that the proposed units required the grouping of incompatible medical specialities or were inappropriate given the geographical location of the composite wards.

Summary of Issues Raised in Written Submissions

Most of the concerns raised regarding the effect of restructuring related to the operational aspects of the restructuring (such as the disestablishment of Unit Nurse Managers and the Professional Nursing Unit, the imposition of the case management model of patient care, the span of control of Patient Care Managers etc). Only 15 of the submissions made specific reference to patient care or safety concerns. This figure represents only 12% of all submissions received and 17% of the submissions which raised specific concerns regarding the restructuring.

Of the submissions that raised patient care concerns, two thirds were in connection with the anticipated reduction in skilled staff. This suggestion was subsequently clarified by management in meetings held with senior nursing staff to discuss the Proposals, where it was emphasised that no such reduction was contemplated. The other specific submissions regarding patient care either linked the issue to the disestablishment of the Unit Nurse Managers, or made the statement that patient care would suffer under restructuring without specifically attributing it to any particular aspect of that process.

RESTRUCTURING PLANS, 6 NOVEMBER 1995

Publication

In November 1995 the restructuring plan was published. The plan expressly described the major issues raised during the consultation process. However it did not consider in any further detail the adverse consequences of restructuring which had been mentioned in submissions, the concerns raised regarding casualisation of the nursing staff or patient safety.

Response to Consultation Concerns

In response to the concerns raised during the consultation process, the plan commented as follows:

> "*… a number of modifications have been made to the Proposals which include:*
>
> (a) *additional resource within the wards on a project basis, with regular reviews;*
>
> (b) *expansion of the Human Resources section in the areas of education, training and staff development;*

(c) *a flexible approach to managing doctor departments with a modified Clinical Director model in some, and a Medical Director model in others;*

(d) *regrouping of the clusters of wards and departments;*

(e) *recognition that Case Management and Care Plans may have limitations in some clinical settings;*

(f) *development of Case Management on a progressive basis over a two year time frame;*

(g) *introduction of a wider and more formal communications structure".*

Modifications to the Proposal for Nursing related to case management and changes to nursing. The restructuring plan also contained minor changes to the Proposals for Managing Christchurch Hospital.

Case Management

The plan described case management as:

"*developing a specific plan for the diagnosis, treatment and rehabilitation of each patient and then making one person, or a small team, responsible for co-ordinating the multi-disciplinary components of care involved in that plan".*

The plan contemplated that "care plans" would be used to implement the case management model. Care plans were treated as a concept distinct from that of case management. Care plans were defined as:

"*A guideline consisting of key events of inter-disciplinary processes which must occur in a timely sequence to achieve patient outcomes while effectively managing costs".*

The restructuring plan recognised that "*case management cannot be introduced overnight and* [it] *may have limitations in some clinical settings*". The plan also anticipated the continual assessment of care plans to ensure that they were appropriate in their particular clinical settings. Also set out was a detailed implementation plan which included the establishment of a case management/care planning steering group and a nursing case management steering group to plan and co-ordinate the introduction of case management.

The concern that case management meant a return to task based nursing was addressed as follows:

"*Nursing case management relies on the collaborative practice of groups of nurses with various skill levels providing care to a specific number of patients. Each nurse within the group will provide care according to the nurse's level of practice as defined by the Clinical Career Pathways for nurses at Canterbury Health. Nursing case management is <u>not</u> team nursing".*

Changes to Nursing

In order to address the perceived need for nurse leadership at ward level, the plan introduced the position of Clinical Nurse Facilitator. Half of the role of the Clinical Nurse Facilitators was anticipated to be the introduction of case management to the ward. Clinical Nurse Facilitators were also to have responsibility for the day to day support and co-ordination of the ward nurses. It was anticipated that Clinical Nurse Facilitators would be introduced on to each ward for a period of 18 months. After this time, it was expected that the Clinical Nurse Facilitators would become "Patient Care Co-ordinators". Patient Care Co-ordinators were seen as "*expert clinical nurses, who provide direct nursing care and support nurses in their practice and provide a major team co-ordination role*". It was anticipated that there would be up to three Patient Care Co-ordinators on each ward.

The plan also emphasised that, whereas the Patient Care Managers were to have responsibilities at "hospital level", Clinical Care Leaders would have responsibility at "ward level". However, the new Clinical Care Leaders would be responsible for fewer staff than the existing Unit Nurse Managers. Clinical Care Leaders were to be responsible for small teams of nurses, rather than an entire ward. Ward co-ordination was to be the responsibility of Clinical Nurse Facilitators.

Concerns regarding the span of control of Patient Care Managers were addressed by revising the clinical groupings for which Patient Care Managers would have responsibility. The restructuring plan stated that:

> "*we have taken the span of control issue raised in the feedback very seriously and believe the configuration of Service and Patient Care Managers with the revised clinical groupings is appropriate at this time and keeps management layers to a minimum*".

In order to address concerns regarding the loss of the Professional Nursing Unit, the restructuring plan stated that:

(a) quality management in nursing would be the responsibility of the Patient Care Managers and Clinical Nurse Facilitators; and

(b) speciality-specific nurse training and education courses would become the responsibility of the Patient Care Managers, Clinical Nurse Facilitators and General Managers.

The plan also anticipated adding a further in-service staff educator to the two people already employed to support education and training initiatives for nurses.

Cost Savings

The restructuring plan did not refer to any intention to save money or cut expenditure. However, the following comment was made:

> "*There is a major difference between becoming more efficient, and cost cutting. Cost cutting involves doing the same things in the same way as they have always been done, but for less money - in the short term at least. Becoming more efficient on the other hand, is a forward looking process that involves adopting new technologies and systems of care in order to be more efficient in the long run.*
>
> *Canterbury Health is embarking on restructuring plans that focus on changing our systems of care in order to be more efficient in the long run*".

Implementation of Restructuring

The Board approved the restructure project at its October Board meeting, including a project plan that suggested all appointments would be made within six weeks (i.e. by 15 December). From November 1995 the implementation of the restructuring plan commenced. Patient Care Managers, Service Managers and Clinical Nurse Facilitators were appointed and most assumed their new roles by February 1996. The Unit Nurse Manager positions were disestablished in February, as the new structure was implemented.

Critical Pathways Report

As a postscript to the discussions on case management, on 28 August 1996 an explanatory memorandum was circulated by the General Manager, Christchurch Hospital Services entitled "Critical Pathways". This document sought to clarify what was meant by the terms "case management", "care plans" and

"critical pathways". The document acknowledged that "*the Proposal did not effectively outline exactly what was meant by the concept of case management/care plans/critical paths*".

The Critical Pathways Report appeared to use the terms "care plan" and "critical pathway" interchangeably. Essentially, the document proposed that the term "critical pathways" be substituted for the terms "case management" and "care plans". The inference is that these three terms are all synonymous. By contrast, the restructuring plan clearly treated the terms "case management" and "care plans" as distinct concepts.

The Critical Pathways document contained the following definitions of care plans and critical pathways:

"*A guideline consisting of key events of inter-disciplinary processes which must occur in a timely sequence to achieve patient outcomes …*"

"*Systematically developed statements to assist practitioners in patient decisions about appropriate healthcare for specific circumstances".*

"Clinical tools intended to optimise the management of a variety of medical problems through a multi-disciplinary approach".

"*Critical Pathways are plans for the provision of clinical services that have expected time frames and resources targeted to specific diagnoses and/or procedures. Critical Pathways can be viewed as inter-disciplinary practice guidelines with pre-determined standards of care".*

MANAGEMENT/STAFF ISSUES, SEPTEMBER 1995 - JULY 1996

Relationships between Parties

In April 1995 the minutes of the Annual General Meeting of Christchurch Hospitals' Medical Staff Association, which represents senior medical staff of Christchurch hospitals, documents an "*improvement in relationships between managerial staff and the clinical staff*". However, some senior medical staff considered that there was a poor relationship between management and clinicians before the release of the Proposals for Change in August 1995. Others noted the Chief Executive's style of management altered during 1995.

It is clear that the Proposals for Change and the way they were introduced in August 1995 significantly affected staff attitudes to management. Both clinicians and Canterbury Health management expressed their concerns and opinions about the nursing restructure and each other in the Christchurch media.

Canterbury Association of Physicians

In September 1995 the Canterbury Association of Physicians wrote to *The Press* expressing their concern over nursing restructuring. In November 1995 the Canterbury Association of Physicians issued a press statement criticising Canterbury Health for ignoring health professional advice and stating that the Association had passed a motion of no confidence in Canterbury Health's Board and management. The motion declared:

"*This Association has lost confidence in Dr Brent Layton, Chairman of Canterbury Health, and his board because of their failure to obtain the funding necessary for this tertiary and training centre to maintain its clinical services to the people of Canterbury.*

We have also lost confidence in Mr Ian Frame [the Chief Executive] *and his management group who proposed major changes which will have a deleterious effect on the delivery of clinical care in Christchurch and now plan to implement them irrespective of "consultation".*

The Board and management have imposed an approach to planning which ignores health professional advice, has undermined standards and morale, involves the suspension of services and is not in the best interests of the provision of health care in Christchurch".

The Chairman of the Board publicly rejected these charges, stating that all staff members had been asked to respond to the restructuring plan and that the suggestion that advice had been ignored was wrong.

The Canterbury Association of Physicians also sent the motion of no confidence to the Minister of Health, who informed the Chairman of the Canterbury Association of Physicians that "*the prime responsibility for CHEs falls within the portfolio responsibilities of the Hon. Paul East, Minister for Crown Health Enterprises*", and suggested that any further concerns should be drawn to his attention. The Hon. Paul East replied on 11 December 1995:

"*You may not be aware Government's purchase interests in Health remain the responsibility of the Minister of Health who delegates her powers to "purchasers" - in the main, the four Regional Health Authorities ..... It is the Southern RHA which decides on the range and extent of clinical services to be provided in the Canterbury area and not the board or management of Canterbury Health".*

The letter concluded "*I have every confidence in the board of Canterbury Health to effectively manage the company through the far-reaching changes required at this time*".

Board/Staff Meeting, 5 December 1995

This meeting was a significant event for the majority of the medical staff interviewed during the investigation. Liaising with staff regarding restructuring was identified as a priority at the Board meeting of 22 November 1995. Accordingly, the Board requested the Chief Executive to organise a meeting with clinical staff. This was originally due to take place on 1 December 1995 but the Minister of Health came to Christchurch that day to address staff so the address by the Chairman was delayed until 5 December 1995. The meeting was well publicised and attended by about 200 people. When the Chairman was asked at the meeting whether, if he had his time over again, there would be something he would do differently, his reported response was that he would have disestablished the role of Unit Nurse Managers straight away and that the appointment of temporary Clinical Nurse Facilitators was an unnecessary compromise. This comment was widely reported by staff interviewed that Clinical Nurse Facilitators "*were just an unnecessary sop to the doctors*". The former Chairman stated that at the meeting "*there was a considerable amount of anger evident amongst the clinical staff*" and that the clinical staff "*expressed theatrically exaggerated shock and offence when* [he] *indicated that the aspect of the restructuring he regretted was that it had proved necessary for the Clinical Nurse Facilitator role to be established, at least temporarily*".

Another matter raised at the meeting was Canterbury Health's proposal to close down elective surgery for a period of about 12 weeks. The Chairman was reported to have been asked by a surgeon what the surgeon should do with his cancer patients who needed surgery and the reported reply was to the effect that "*if the operations can't be done before the close-down, the patients will just have to wait*".

Following the 5 December meeting, the clinicians reacted in various ways. On 9 December, 25 surgeons sent an open letter to *The Press* informing:

"*the people of Canterbury of their deep concerns about the restructuring of services ... we are concerned for* [the public's] *safety. Whilst all the health professionals will continue to try to do their best,*

in the circumstances the level of patient safety will be reduced. We believe that these experiences in Christchurch have demonstrated the poverty of the Government inspired system of management which is isolated from effective health professional input into policy and planning".

On 12 December 1995, approximately 60 surgeons and physicians signed a letter which was delivered to the Minister of Crown Health Enterprises, Hon. Paul East and the Minister of Health, Hon. Jenny Shipley advising that:

"*We are deeply concerned that these statements* [by the Chairman] *have caused loss of public confidence in Canterbury Health. As a matter of urgency, we ask you to inform us whether you have continued confidence in the current leadership of the Board of Canterbury Health".*

Dr Layton issued a statement to staff on 22 December 1995 stating that his comments had been misunderstood. Dr Layton's statement said:

"*I am aware from what I have read in the media that comments I made at a meeting with clinicians and managers on Tuesday 5 December, 1995 have been misunderstood to indicate I believe patients with bowel cancer should wait for surgery. I cannot recall making these comments during a meeting in which I spoke for nearly 90 minutes. However, I accept that statements I made disturbed and offended many of those present.*

In view of the offence I have obviously given, I wish to clearly state my views. The responsibility to purchase health care on behalf of the public using taxpayers money rests with the Regional Health Authority. Despite this, however, Canterbury Health has an ethical responsibility to provide services which are immediately necessary, irrespective of whether the Regional Health Authority has discharged its responsibility by purchasing them or not. Canterbury Health also has a responsibility to inform the Regional Health Authority when it believes its purchases fail to meet the needs of the public for urgent treatment.

I deeply regret the distress some comments I made at the meeting, and the wide circulation of them in the media, has caused".

Establishment of Professional Advisory Group

The Medical Advisors wrote to the Chief Executive on 5 December 1995 expressing their concerns about the relationship between staff and management. That letter recommended the establishment of a Professional Advisory Group to give advice on policy matters to the Chief Executive.

"*The role of this Committee would be to consider major decisions that have a potential impact on patient care standards and healthcare delivery within Canterbury Health. Currently, the Medical Advisors have a limited role in these areas....*

... The Medical Advisors believe that the formation of a Health Professional Advisory Committee would be particularly helpful to yourself, and in turn the Board, in relation to major matters affecting patient care. We would envisage that the Medical Advisors would continue in their day to day role, some of which includes giving advice on certain matters ....

You recently have clearly stated the need for better consultation and clearer communication. We believe the formation of such a committee would go a long way to improving the consultation and communication, as well as being an invaluable resource to yourself and management".

The Chief Executive, Mr Frame, responded positively to this suggestion :

> "*I have given consideration to your suggestion regarding a Health Professional Advisory Committee and believe that such a committee would be of benefit. As expressed, we intend to work closely with the clinical and medical directors in 1996 to develop effective performance measurement and planning strategies. While that line management structure is essential for accountability, the Advisory Group could provide an additional dimension for advice on policy matters and for developing innovative ideas on a "think tank" basis. I understand the representatives would be chosen for their ability to participate on that basis. We would need to consider which management staff should also attend for the committee to be effective".*

The Medical Advisors response was to advise Mr Frame:

> "*We have informed all senior medical staff about the key issues discussed ... relating particularly to the establishment of the Health Professional Advisory Committee and also the future role of the charge nurses.*
>
> *... There is a good deal of positive comment about the possibility of establishing a Health Professional Advisory Committee. In addition, there is some cautious optimism about the statement made concerning the future of the Clinical Nurse Facilitator on each ward.*
>
> *We think it is important to follow up your initiative by establishing more precisely how the Health Professional Advisory Group will work. This includes the terms of reference, the membership and how it relates to line management, and in particular the CEO/Manager meetings.*
>
> *We would like your views on the membership and the exact relationship of this body to line management. This would be very helpful. This further information will be crucial in our further communications with the staff.*
>
> *We believe there should be further discussions with us as Medical Advisors and also with the senior medical staff including Clinical Directors/Medical Directors, about these concerns".*

Christchurch Hospitals' Medical Staff Association Input to Professional Advisory Group

Christchurch Hospitals' Medical Staff Association (CHMSA) held a special general meeting on Friday 9 February 1996. The former Chief Executive advised the Commissioner that he offered to speak at the meeting and this offer was declined. At this meeting CHMSA voted against the establishment of Mr Frame's proposed committee, and voted for the establishment of another form of committee described as the Senior Staff Action Subcommittee. This was to be a stand-alone committee made up of the following members, elected by their representative bodies:

CHMSA	-	one member
Surgery	-	two members
Physicians	-	two members
Pathology	-	one member
Paediatrics	-	one member
Support Services	-	two members
Nursing Staff	-	two co-opted members

There were to be no representatives from Healthlink South. It was decided that CHMSA should take the initiative in establishing this committee and the motion stated that the "*Christchurch Hospitals' Medical Staff Association seeks that this Committee has direct access to the Board and the Chairman* [of the new committee] *has observer status immediately* [at the Board]". This motion was carried by 47 votes from a total membership of 274. There were seven abstentions. The Chief Medical Advisor was also requested to be a constitutional member of this group.

Following the special general meeting of 9 February 1996, Mr Frame met with the Executive of the Association and one of the Medical Advisors. The outcome of this meeting was reported at the next CHMSA meeting on 23 February 1996 as:

> "*Mr I Frame* [called the meeting] *to find out what were the implications for him with respect to the motions that were passed at the meeting of the Christchurch Hospitals' Medical Staff Association on 9 February. Mr Frame explained that to be able to function as the CEO, he needed to receive medical advice that he trusts, respects and feels will not be released immediately to the news media. ..... With the structure put in place under the Companies Act, he did not see that the Board would be in a position to be able to accept advice over and above him. Mr Frame had asked the Executive how he could proceed.... Mr Frame still said he needed to obtain regular advice. He was then advised that he needs to set up the structures that allow him to get that advice. He saw the Professional Advisory Group as serving that purpose and would proceed with it*".

Mr Frame advised the Commissioner that in relation to this meeting *"I would have made clear to the CHMSA Executive that the Board expected to hold the Chief Executive accountable for the day-to-day operation of Canterbury Health and would therefore expect me to provide a balanced view including an appropriate medical input to my recommendations and in reporting to them. I could not do this if communications on medical issues bypassed me."*

Following discussion about the meeting with Mr Frame and the Professional Advisory Group (PAG) proposal, the following motion was passed by CHMSA:

> "*That the Executive and coopted members should seek to negotiate with the CEO the composition of PAG and then report to the members"*.

There was a concern amongst the group of senior clinicians present that the structure being proposed by Mr Frame was "*merely advisory to the Chief Executive who appears to have effective executive control of it*". It was contended that "*planning and policy is a separate function (from line management) and this should be reflected in the terms of reference of any Advisory Group*".

Following the meeting on 23 February 1996, senior clinicians met with Mr Frame and Dr Coughlan on 4 March 1996 to negotiate the composition of the Senior Medical Officer representation on the Professional Advisory Group and a compromise was agreed. The Secretary then polled the membership on acceptance of the Professional Advisory Group with the changed method of staff election. Just over two-thirds of those who returned the circular containing the voting paper were in favour of proceeding with this proposed make-up of the Professional Advisory Group.

In his report of 29 March 1996, the Chairman of CHMSA also reported that at a meeting on 12 March, Mr Frame presented a number of proposals aimed at improving relationships with staff. Mr Frame reportedly indicated at that meeting that he had changed his previous position regarding access of staff to the Board and now felt that this had merit. Mr Frame's initiative to establish a Professional Advisory Group was put to the Board at its meeting on 20 March 1996. The Board asked for further information about the proposed size of any group of representatives meeting with the Board and the proposed agenda items. The Medical Advisors and the Chief Executive were "*asked to obtain information from other CHEs as to what the nature of relations were between staff and Boards and*

in particular, what was the nature of any staff involvement with the Board, advice to the Board, observer status, etc.". Following the Board meeting, the Chairman of CHMSA reported to the Association that the substantial area of progress was the agreement for staff to meet with the Board. The Chairman of CHMSA considered that the Association now had:

"*an opportunity to move forward in regard to relationships with management .... Ian Frame has agreed to form an advisory group and the staff have agreed, by majority, to accept the proposed method of medical staff election to the PAG. Some staff still have misgivings about the PAG, but I believe it's a vehicle for our involvement in the major decisions about our Hospital, and a structure that can be modified in time, once trust between management and staff has been restored. We need to get this structure underway as soon as possible ... I believe we should put our past grievances aside and I ask you to support the Executive in taking the opportunities that are now presented to us".*

There was vigorous debate at the meeting and a number of clinicians did not support the structure. Some did not believe that an advisory committee would resolve the problems between staff and management and felt that greater changes were needed. CHMSA finally agreed that two motions be put to the members in a postal ballot. The motions were:

Motion 1 "*Do you support the surgeons in their expert opinion that the nursing restructuring compromises clinical safety?*"

Motion 2 "*That a planning and policy committee of the medical staff (called the Executive Committee Planning and Policy ...) be formed by the CHMSA. This committee is to work with the CEO in all decisions related to clinical practice and give final approval to such decisions. Members of this committee will attend board meetings".*

In relation to Motion 1, 129 members voted 'yes', six voted 'no' and 20 abstained. For Motion 2 there were 142 'yes' votes, three 'no' votes and 10 members abstained.

CHMSA Election, April 1996

On 26 April 1996 a new Executive of CHMSA was elected. It was "*one of the most keenly contested elections for the Executive in recent memory*". The new Executive described its mandate as the questions sent to the membership of CHMSA following the meeting on 29 March 1996. A new Chair was elected.

Proposed Establishment of a Clinical Board, May - June 1996

Shortly after his election as Chair of CHMSA, Mr Stuart Gowland wrote to Dr Layton asking for an urgent meeting with the Board of Canterbury Health and the Chief Executive to discuss ideas relating to the management of Canterbury Health. The Executive of CHMSA was invited to attend the Board meeting on 8 May 1996. At that Board meeting the issue of nurse restructuring and shared decision making on clinical issues was raised. Immediately after that meeting Mr Gowland issued a press release to *The Press* confirming CHMSA had met with the Canterbury Health Board and that the Board was following up on the issues raised.

On 20 May 1996 Dr Layton held a meeting with representatives of all health staff groups - nurses, allied health professionals, CHMSA and the Dean of the Medical School. At this meeting a proposal was developed and agreed in all respects other than that the clinical board would be advisory only.

Dr Layton wrote to Mr Gowland on 22 May 1996 reporting that "*the Board of Canterbury Health has decided that a Clinical Board would indeed add to our approach to management and we are keen to*

get the necessary procedures under way so that the Clinical Board can be up and running as soon as possible". The Board's decision was that a Clinical Board should be formed with the following composition:

The Chief Executive;

Two Directors of the Board;

Four elected representatives of senior medical staff working for Canterbury Health;

Two elected representatives of the nursing staff;

One elected representative of the allied health staff; and

The Dean of the Christchurch School of Medicine.

The Board advocated that the:

> "*elected representatives would be appointed annually by their colleagues via direct election. However, the request of Christchurch Hospitals' Medical Staff Association that the Clinical Board have a decision-making role would not be workable and is contrary to the recognised principles of good governance. In any organisation it is necessary for there to be clearly defined roles and responsibilities for management. The Board of Canterbury Health believes it is impossible for Canterbury Health to be run by a Committee".*

The outline of the membership and function of the new Clinical Board made it clear that the ultimate decision-making responsibility and accountability to the Crown would remain with the Chief Executive and the Board. A series of press releases from CHMSA and Canterbury Health followed Dr Layton's 22 May 1996 letter and on 13 June Dr Layton wrote again to Mr Gowland asking when Canterbury Health might expect a response from CHMSA to the letter of 22 May.

On 14 June 1996, following a meeting that day between the Chairman and the Chief Executive of Canterbury Health and CHMSA Executive, lasting only a few minutes, CHMSA issued a press release headed "Canterbury Health Chairman Brent Layton says "A Flat No"". On Monday 17 June, Dr Layton responded with an open explanatory letter to all staff stating:

> "*The stalling point seems to be over the issue of decision-making. The group of clinicians is demanding that the Clinical Board of 11 people should, in effect, run Canterbury Health by making all decisions by consensus on wide ranging clinical matters. ...trying to run an organisation of this size and complexity by the consensus of a committee of 11 would be impossible, and would soon lead to paralysis. ... they* [CHMSA] *now plan to start on the next stage of their agitation campaign. Two of them have already been to Treasury and the Business Round Table to try to persuade them that they could make cost-savings at Canterbury Health if they were in charge, which only gives Treasury a good excuse to see our revenue is cut accordingly. While efficiency gains are always achievable, even in the best run organisations, the claims they are making are so exaggerated as to be complete nonsense. ... That the clinicians directly involved in the orchestrated agitation are largely part-timers or university staff means that they are to a considerable extent insulated from the consequences of suggesting further cost-cutting to Treasury.*
>
> *One can only wonder at their motives for their continuing campaign. An obvious conclusion is that they are motivated by a desire for power. This small group of clinicians want to run Canterbury Health and have the power to decide what money gets spent where. ...*

> *a small group of clinicians have said that they are driven by their concern for patient safety and the quality of care ... It can't be patient safety ... They've been saying this for eight months now and yet they have not been able in that time to provide one example of patient safety being compromised. ...*
>
> *What the public is being exposed to now is the territorial behaviour of a small group of clinicians who have been trying to stake out a claim".*

CHMSA disagreed with Canterbury Health's interpretation of their demands. They stated through the media that:

(a) "*The clinical board proposed by Brent Layton is advisory only.*

(b) *Senior medical staff at Canterbury Health voted by 142 to 3 (with 10 abstentions) for joint decision making in clinical matters (CHMSA meeting 26/4/96)*

(c) *The Executive of CHMSA has made it crystal clear to Brent Layton that what is required is shared decision making in clinical matters only*".

On 10 July 1996 Mr Frame reported to the Director General of Health, Dr Poutasi, that:

> "*At this stage, I am unable to confirm that the issue of relationships is resolved. Despite intense efforts by the Board and management of Canterbury Health we have been unable to reach agreement with the medical staff representatives about a consultative and advisory structure. The Christchurch Hospitals' Medical Staff Association (CHMSA) continues to insist upon joint decision-making power concerning any matter that has an impact on clinical practice.*
>
> *We have found this demand unacceptable stating that, while we fully support joint consultation and high-level advice, the decision-making authority must rest with the individuals who are held accountable for the outcomes. In some circumstances they will be clinicians, in other situations they will be managers.*
>
> *Our position has been totally unacceptable to the CHMSA and they have admitted to Brent Layton and myself that they want a 10 person committee, essentially comprising clinicians, to take over the task of the Chief Executive. There would be a nominal Chief Executive who would be the administrative person on their committee. In essence this would be a return to a form of triumvirate, but skewed heavily in favour of the Doctors.*
>
> *Despite the frustrations in dealing with the CHMSA representatives we continue to develop our staff relations with both doctors and nurses working at the bedside and to manage issues of patient safety in the most appropriate manner. Fortunately we are receiving extremely good co-operation from the professional staff working at this level.*
>
> *I suggest that we continue to keep you informed of further developments and I assure you that we are giving patient safety the maximum attention possible. We will continue to seek ways to effectively bridge the gap between the CHMSA representatives and Canterbury Health Board and management*".

On 11 July 1996 Mr Frame wrote to the Director General of Health advising that Canterbury Health had proposed the establishment of a Clinical Board to improve involvement and communications between management and clinical staff but that this proposal had been rejected.

Surgeons' Postal Survey

A postal survey of views of Canterbury Fellows of the Royal Australasian College of Surgeons provided a further indication of clinicians' views about the restructuring. It was undertaken between December 1995 and February 1996. 50 out of 64 Canterbury Fellows listed by the College responded.

Two statements were responded to:

(1) "*.... Management structures should include elected health professionals in an equal partnership to provide for the delivery of the best possible medical treatment for the people in Canterbury*".

AGREE: 46/50 92%

DISAGREE: 0/50 0%

(2) "*The Unit Nurse Manager positions are crucial to patient safety and high-quality care. The Canterbury Surgeons strongly disapprove of the disestablishment of the Unit Nurse Manager positions. We believe that without them there will be a reduction in nursing standards, patient care and safety*".

AGREE: 41/50 82%

DISAGREE: 0/50 0%

Management commented at the time that "*the so-called 'survey' must surely be flawed as in our opinion, it makes inadequate attempt to eliminate bias".*

Medical Advisors' Survey

The Medical Advisors also arranged a questionnaire of Senior Medical Officers regarding the restructuring proposals. 185 questionnaires were sent out on 17 January 1996 and 127 were returned. The questions and responses were as follows:

1. "*What is your opinion of the consultation process that took place between management and healthcare professionals between the release of the proposals (28/8/95) and the final plan (6/11/95)?*

Totally Unsatisfactory	*Acceptable*	*Perfect*	*Abstain*
101	*10*	*1*	*15*

2a *Do you think that Medical/Clinical Directors via line management, plus the Medical Advisors, can provide all the medical input into Canterbury Health Management that is required?*

Not at all	*Partly*	*Completely*	*Abstain*
62	*50*	*8*	*7*

2b *Do you think that a broadly representative "think tank" advisory group to the CEO should be formed in addition to 2a?*

Strongly Disagree	*Possibly*	*Strongly Agree*	*Abstain*
29	*45*	*40*	*13*

2c *Do you think that a broadly representative healthcare professional advisory group which has formal links to the CHE Board, the CEO and senior management should be formed in addition to 2a?*

Strongly Disagree	*Possibly*	*Strongly Agree*	*Abstain*
14	*30*	*78*	*5*

3. *How important do you think it is to have one nominated nurse in charge of a unit/ward area?*

Unnecessary	*Desirable*	*Essential*	*Abstain*
2	*26*	*91*	*8*

"

A Medical Advisor commented that:

> "*The responses to questions 1 and 3 are unambiguous and indicate clearly the staffs* (sic) *views. Question 2 is more complex, but I interpret the response to mean that SMOs wish to have a more significant role in line management at all levels of* [the] *CHE organisation. Virtually no one thinks that the initial proposals were adequate (2a), and a majority believe that they will need to be supplemented by changes based on 2c".*

Further Press Comments

On 2 March 1996 an article by Mr Frame entitled "The Changes Occurring at Christchurch Hospital and Why They Must Work" was published in *The Press.* In this article Mr Frame described "*the doctors, including many of the University fraternity,* [becoming] *vocal opponents of anything to do with the* [health] *reforms".* He described how the management of Canterbury Health had been charged with driving efficiency and that there were "*two ways to approach the task. One was to throw the problem over to the professional staff; the other was to promote its own initiatives. Canterbury Health management chose the latter".* He described managing health professionals as an "*almost impossible task*" and stated that "*the person who claimed that managing doctors is like herding cats was not wrong".* His explanation of why there was such a violent and public reaction taking place within Canterbury Health was "*that professional and commercial cultures have come face to face in a way that has not happened before*". He ended his article quoting Mr John Simpson, Chairman of the New Zealand Committee of the Royal Australasian College of Surgeons, "*I don't think the people of Canterbury should be afraid to seek medical treatment at Christchurch Hospital. Far from it, it is one of the excellent hospitals of New Zealand".*

There was a follow up to that article written by Professor Hornblow, Dean of the Christchurch School of Medicine, and John Campbell, Dean of the Faculty of Medicine, University of Otago on 6 March 1996. The crux of their response was that essentially "*the sour relations between managers and doctors at Canterbury Health are not caused by any bloody minded resistance to change but the way in which the managers have tried to introduce it*".

As a result of this article, the Board discussed the Chief Executive's performance regarding communication with staff.

Requests for Specifics on Patient Safety Issues

The response of Canterbury Health to expressions of concern by staff about patient safety was to encourage them to provide specific details so that concerns could be addressed. For example, the Deputy Chair of Canterbury Health, Professor O'Donnell, raised this issue in his address to staff at the meeting on 1 December 1995 at which the Minister of Health spoke. Professor O'Donnell invited staff to report patient safety issues to Clinical Directors in the first instance and, if they were not satisfactorily

resolved, advised that concerns should be put in writing and sent to the Chief Executive and copied to him.

This was the approach Mr Frame advised that he adopted when, immediately prior to the 9 December 1995 surgeons' letter to *The Press*, the Head of the Academic Department of Surgery, Professor Bagshaw, contacted him to request an urgent meeting on 7 December to discuss generic safety issues. Mr Frame advised Professor Bagshaw he was not available to meet with the surgeons at that time and requested he put his specific concerns in writing so that Mr Frame "*could be clear as to the exact issue*". Professor Bagshaw did not do so. According to Professor Bagshaw, Mr Frame said he had "*rung around the surgeons, there were no such concerns and no desire to meet with* [Mr Frame]". Mr Frame reportedly said that there was "*a lot of rubbish going on*" and "*he was too busy to see* [the surgeons]".

Mr Frame's file note on the matter indicated that he spoke to certain surgeons who were not aware of problems and that in discussion Professor Bagshaw had agreed to respond in writing. After *The Press* reported the matter, Mr Frame called a special meeting on 13 December which Professor Bagshaw and other surgeons declined to attend. Mr Frame advised the Commissioner that he expressed concern at the political nature of some of the staff's behaviour and noted it was difficult for Canterbury Health to hold Professor Bagshaw and others accountable for their actions as they were technically employed by the University and not Canterbury Health.

On 13 December 1995 Mr Frame sent a memorandum to all staff reiterating the position of management and the Board in relation to patient safety issues.

> "*Patient safety is as important to the Board and management as it is to yourselves and takes high priority in our decision-making. Any staff person who has genuine and serious concerns about patient safety should discuss the issue with their immediate clinical leader (e.g. Clinical or Medical Director or nursing manager). If the concerns cannot be satisfactorily resolved at that level, and are supported by peers, then the staff person should state the specific issue in writing and forward that, with supporting detail, to the General Manager of the relevant Division, with a copy to me as Chief Executive and a copy to the clinical leader. Only by your doing this can we take appropriate advice and decide what action needs to be taken".*

On 22 December 1995 staff were invited to a meeting to discuss "*safety issues that any staff member has regarding the restructuring and delivery care plan ..".* Mr Frame reported that no specific reasons for reduced patient safety were raised by Professor Bagshaw. "*Any such issues were very broad in nature and related to retaining existing staff structure and individuals*". On 14 December Professor Bagshaw and other surgeons had signed a letter to *The Press* which in its ultimate sentence referred to *"this clinical crisis"*.

Each time Canterbury Health requested specific information about patient safety concerns from medical staff, medical staff would decline to give specifics for fear of reprisal and on the basis that they "*saw the cases simply as examples of the problem*". No evidence of reprisals was shown to the Commissioner, though the letters to the School of Medicine discussed below were interpreted as reprisals.

This situation of clinicians stating that they had concerns about patient safety, without giving patient names and specific incidents, and management and the Board insisting that such concerns needed to be specified to management in order for them to be resolved, continued, with few exceptions.

Canterbury Health's Interaction with the School of Medicine

Many staff believed that the employment position of various members of the clinical and nursing staff was affected by their vocal opposition to the 1995 nursing restructuring and felt that the way discontent

was treated by management appeared to be heavy handed. An example given was the way in which Canterbury Health tried to influence the School of Medicine in relation to some of its employees who do clinical work within Christchurch Hospital. On 9 February 1996 Mr Frame wrote to the Dean of the Christchurch School of Medicine asking for Professor Bagshaw to be disciplined as a result of his public statements about the restructuring, in particular the letter from 25 surgeons that appeared in *The Press* stating that "*Patient safety will be put at risk as a result of Canterbury Health restructuring its services*".

Mr Frame complained that Professor Bagshaw had failed to place his specific concerns in writing and was "*engaged in an ongoing campaign using his professional standing to lend credibility to malicious and unsubstantiated claims"*. Mr Frame said that he was "*not seeking to gag Mr Bagshaw, however, neither* [was he] *going to stand by and allow misinformation to be continued to be put forward in a public forum raising public concern unnecessarily*". He asked that Professor Bagshaw's activities be placed on the agenda for discussion at the next Joint Relations Committee of Canterbury Health and the School of Medicine.

Professor Bagshaw responded to Mr Frame's letter by stating to the Dean of Christchurch School of Medicine that he was acting on behalf of a large group of people. The group as a whole had decided to proceed with the press release. He explained his actions and rejected the criticisms in Mr Frame's letter.

At the Joint Relations Committee the issue of Professor Bagshaw was discussed and Canterbury Health indicated it would hold further discussions before deciding if it wished the University to conduct a formal or informal inquiry process.

The University of Otago, of which the Christchurch Medical School is part, held an audit in mid-1996 to review the activities of Professor Bagshaw and a colleague, in relation to their involvement with the Academy of Endosurgery. The Vice Chancellor confirmed to the Association of University Staff of New Zealand (Inc.) that the audit had been prompted by suggestions from "*CHE quarters*" that there may be some impropriety in the Academy and that the University should investigate. Professor Bagshaw considered that the University of Otago audit into the financial affairs of the Academy of Endosurgery, and his and his colleague's role in that private charitable institution, was another attempt to silence his opposition to the changes at Canterbury Health. The review concluded that there was nothing untoward in the activities of the Academy of Endosurgery.

In June and July 1996 Mr Frame wrote to the Dean of the Christchurch School of Medicine raising questions about the behaviour of the Head of the Department of Medicine. Mr Frame also criticised the public comments of another Christchurch School of Medicine employee, and an Executive Member of Christchurch Hospitals' Medical Staff Association. Mr Frame stated that "*continuation of this public activity by members of the University of Otago staff can only lead to a serious deterioration in the relationship between Canterbury Health and the Christchurch School of Medicine*".

Clinical Performance and Loyalty Memo

There was protracted correspondence between the Chairman of the Christchurch Hospitals' Medical Staff Association, Mr Gowland, and the General Manager, Christchurch Hospital Services, relating to Mr Gowland's performance. It commenced on 18 June 1996 with Dr Coughlan advising Mr Gowland that "*it has come to our attention through the media and through discussions with Treasury that you may be in breach of various express and implied terms of your contract of employment with Canterbury Health*". He requested a meeting with Mr Gowland to clarify matters.

The ensuing correspondence centred on the distinction between Mr Gowland's conduct as elected Chair of the Christchurch Hospitals' Medical Staff Association and as an employee of Canterbury Health.

On 18 June 1996 Mr Frame circulated a memorandum to all staff about the concept of loyalty.

"*In simple terms Canterbury Health as an employer has a number of obligations to staff and staff likewise have certain obligations. Generally, many of the more important obligations are contained in the employment contracts which each and everyone of you has with Canterbury Health. This contract sets out certain clear obligations on the part of both Canterbury Health as the employer and you as the employee. There are also other documents which will have an impact on the employer/employee relationship such as our Policy & Procedures Manual. Overriding this documentation though is an important principle which in fact, although it is unsaid, is the fundamental aspect of the employment relationship, namely loyalty by the employee to the employer. I too as Chief Executive am bound by that same principle of loyalty to Canterbury Health as any other employee.*

The reason that I raise the matter of loyalty is that we are currently faced with several situations where loyalty is at issue. It is not my intention to debate here the specific issues, but rather to convey in broad terms my concerns. At the outset, I think it is important to state my belief that the majority of employees are loyal to Canterbury Health in all respects and recognise the importance that the success of Canterbury Health and their livelihoods go hand-in-hand. In other words, our success as an organisation ensures we are able to offer employment on an ongoing basis to a large number of staff.

My message is <u>not</u> to be interpreted as a method of gagging people - the right to speak out has been specifically enshrined in a number of employment contracts which set out the parameters. Nor is my message to be seen as an attempt to prevent medical staff undertaking private practice - again, the parameters are set out in employment contracts. Rather my message is that I ask each and every one of you to consider your obligations to Canterbury Health as your employer and not to act in a manner which could undermine the viability of Canterbury Health. Plainly, if our viability is threatened, either generally or in specific areas, this will lead to a risk to jobs. Like you, I am keen to avoid any "unnecessary" risks to be added to those which we face in any event as a consequence of the market in which we operate.

In the event you feel I have overlooked our patients in this, I assure you I have not. Just as Canterbury Health's success and employment opportunities go hand-in-hand, so to does delivery of quality health care to a broad range of patients. Ultimately that is the fundamental reason that Canterbury Health exists and loyalty will not only preserve Canterbury Health's existence, but will ensure we thrive as an organisation to the benefit of our patients".

Despite Mr Frame's statement that his "loyalty" message was not to be interpreted as a method of gagging people, many clinicians and nurses felt that Canterbury Health was trying to silence their opposition to the restructuring of Christchurch Hospital.

Royal Australasian College of Surgeons

The Christchurch Fellows of the Royal Australasian College of Surgeons approached the College about their concerns. There was a teleconference on 23 February 1996 with the New Zealand Committee of the College in which management were not invited to participate. Following this conference the College sent an "open letter" to Canterbury Health. The College of Surgeons commented in its open letter on the importance of ameliorating the relationship between staff and management stating that:

"*recent events at Canterbury Health may result in profound and potentially serious effects on both the surgical team and the 'clinical management team'*" and that "*the existence of a close and trusting relationship between the CHE management and their senior professional staff is an absolute prerequisite for the delivery of safe and appropriate clinical care".*

The open letter raised three matters that they felt required consideration by management:

the relationship between clinical staff and management;

the loss of experienced members of the clinical team; and

the exclusion of senior medical staff from the decision making process.

Mr Frame advised all staff in a memorandum on 26 February 1996 that even though the College had not sought comment from Canterbury Health, he supported the open letter because he felt it gave three clear messages:

(a) "*that there is not an immediate safety issue to be addressed,*

(b) *that there is a potential quality issue related to team work,*

(c) *that the issue should be resolved between management and staff on-site*".

Dr Layton also issued a media release welcoming the College's letter "*and its strong emphasis on the importance of team work in delivering quality care to patients*", and he accepted the call to resolve the issues raised.

The College also sent a "closed" letter to Dr Layton, Professor O'Donnell and Mr Frame, copied to the senior clinicians who had raised the issues. The closed letter was more explicit than the open letter. The key concern of the College was its view that relationships had broken down in a way that was unique for a major city in either Australia or New Zealand, such that if the situation persisted, there must be ongoing concerns about clinical safety.

The contents of the closed letter were discussed at a meeting on 29 February 1996 between representatives of the College and Canterbury Health. Canterbury Health disagreed with aspects of information provided by medical staff to the College but all parties acknowledged the need for better communication.

THE FIRST MINISTRY OF HEALTH INQUIRY, FEBRUARY/MARCH 1996

Invitation by the Chief Executive

On 12 February 1996 Mr Frame invited officials from the Ministry of Health to be "*briefed by management and staff on the restructuring changes and the service delivery model being introduced, and to form a view as to whether these changes had created a situation of reduced patient safety*". According to Dr Layton, Canterbury Health made contact with the Ministry as a result of the rejection by Christchurch Hospitals' Medical Staff Association of the Professional Advisory Group initiative and their continuing accusations in the media. According to the Ministry of Health their early involvement in Canterbury Health in February 1996 was at the request of the Minister of Health. In response to media reports, the Ministry was requested to prepare a report on the safety issues raised by Canterbury clinicians. Officials contacted the Chief Executive who issued an invitation to the Ministry of Health to meet clinicians and managers.

The Ministry's Chief Medical Advisor, Dr Colin Feek, and Chief Nursing Advisor, Ms Gillian Grew, met with management and nursing staff of Christchurch Hospital on 23 February 1996. On 1 March 1996 they again met with the medical staff, this time with a management consultant external to the Ministry, Ms Christine Tuffnell. One of the Medical Advisors gave a presentation to Dr Feek, Ms Grew and Ms Tuffnell regarding the restructuring at Christchurch Hospital and his observations about case management.

Memorandum to Minister of Health

As a result of the meetings on 23 February and 1 March 1996, Dr Feek and Ms Grew prepared a memorandum dated 4 March 1996 for the Minister of Health, Hon. Jenny Shipley. This memorandum set out what they saw as the key issues following the implementation of the restructuring plans. In their view, the key issues were:

> ***"Restructure***
>
> *1. Concerns by the clinical staff as to whether nursing case management was an appropriate model for Christchurch Hospital. The view of the clinical staff is that such a model may have some validity but this should be trialed in a pilot study in a selected number of services. Such a model should be fully evaluated before implementation and may not be applicable to all services in the hospital.*
>
> *2. Consultation process by management was deemed to be more than unsatisfactory by the clinical staff. Whilst the staff were technically consulted they felt their advice had not been listened to, nor incorporated into the final proposal.*
>
> *3. Restructuring of nursing staff has resulted in a loss of 39 unit nurse manager positions and whilst 29 of the individuals concerned have been reappointed in other posts there is serious concern over the loss of about 10 skilled senior nurses.*
>
> *4. Both nurses and medical staff are concerned that restructuring proposals mean the disestablishment of all senior nurse positions at ward level. There is concern that loss of a senior ward nurse will lead to loss of clinical accountability within the ward structure. As an interim measure the unit nurse manager has been temporarily replaced by a clinical nurse facilitator. It is expected that in 18 months to two years time this post will be disestablished and two or three case managers will replace the unit nurse manager position. Management is aware of the concern that this issue has raised and is prepared to discuss some options with clinical staff.*
>
> *5. The introduction of nurse case management requires the joint development of "care plans" or "critical pathways" between nurses and medical staff. For this to be achieved it will require considerable buy-in from clinical staff and this factor is obviously missing at this time. There needs to be an agreement between management and clinicians over how case management is going to work, definition of data and the process of its evaluation. There are serious concerns over liability and accountability in a multidisciplinary team that need to be resolved before full implementation.*
>
> ***Issues of Safety***
>
> *Out of all the staff interviewed, none could substantiate that the restructuring arrangements are unsafe. However, this may be a difficult proposition for the staff to prove and they therefore expressed the view that there was potential for the hospital to be unsafe in the future. Some of the clinical staff commented that they felt that the media campaign had unnecessarily undermined patient confidence in Canterbury hospitals.*
>
> *During the meetings the clinical staff raised issues on other aspects of restructuring that were of some concern in relation to safety, namely:*
>
> *1. Increased casualisation of nursing staff, reducing staff available with particular skill mixes on highly specialised wards such as neuro-surgery.*

2. *The withdrawal of registrar cover at Burwood Hospital has resulted in a failure to meet standards set by the Department of Anaesthesia in 1992.*

3. *The restructuring of the laboratory services there has resulted in a reduction of clinical and technical supervision. The main area of concern was a failure to detect an error in the reporting of laboratory results which fortunately did not lead to an adverse patient outcome although inappropriate care was given on the basis of the erroneous results.*

4. *Lack of clinical input into planning and purchasing of equipment in areas such as paediatrics and neuro-surgery has the potential to impact on safety.*

Issues of Staff Morale and Relationships with Management

There is no confidence in the Chair of the Board. The clear and constant message we received from clinical staff is the serious breakdown in trust between management and the clinical staff. The staff, particularly medical staff, felt totally marginalised from, and not involved in the decision making process in Canterbury Health. There is no effective clinical input into service management and this has the potential to impact on safety. There is no clinical input into the interface with the RHA and its purchase process. The inappropriate management style is adversely affecting the relationship with the School of Medicine. We consider management style is a serious issue for the organisation of the CHE. The Ministry will therefore be meeting with the management of Canterbury Health and its clinical staff to attempt to facilitate a resolution of this problem.

Conclusion

The investigating team found no evidence that safety at Canterbury Health Ltd is compromised as a result of the recent restructuring to introduce nursing case management at Christchurch and Burwood Hospitals. However, we are seriously concerned about the breakdown in communication between management and clinicians. Furthermore, we also have some concerns over increasing casualisation of nursing staff over the past few years, withdrawal of registrars at Burwood Hospital and laboratory service restructuring. We would therefore wish the management of Canterbury Health to address these issues urgently".

The memorandum made a number of specific observations and recommendations to the Minister. These were signed off by the Minister on 23 April 1996 and included the note that:

"*the visiting team intends to recommend to the management of Canterbury Health that nursing case management be introduced employing pilot studies before more widespread implementation*

...

that introduction of nursing case management may not be applicable to all service areas of Canterbury Health".

Oral Briefing

The memorandum was not initially released to any party other than the Minister of Health although an oral briefing was given to management, the Board and staff on 5 and 6 March 1996. The New Zealand Nurses Organisation attempted to obtain the memorandum under the Official Information Act 1982. Although the Ministry of Health informed the Commissioner it did not object to the release of the memorandum, Canterbury Health objected to the memorandum being disclosed on the basis that "*the information is extremely sensitive and ... would cause both serious and unnecessary concern to the public of Christchurch, if released out of context*". The refusal to release the written report caused

suspicion of a "whitewash". It was not until November 1996 that the memorandum was released by the Ministry of Health to the New Zealand Nurses Organisation, Christchurch Hospitals' Medical Staff Association and political parties. The Ministry of Health informed me that the Minister of Health herself released the report to *The Press* before November 1996.

Response to Canterbury Health by Ministry

Following the memorandum to the Minister of Health by Dr Feek and Ms Grew, the Director General of Health (Dr Karen Poutasi) wrote to Mr Frame on 12 March 1996 stating that:

"*The review team found no evidence that safety at Canterbury Health Ltd is compromised as a result of the recent restructuring to introduce nursing case management at Christchurch and Burwood Hospitals. It is, however, quite clear that there needs to be an improvement in relationships between clinicians and managers. It is clearly the responsibility for managers, clinicians and the Board of Canterbury Health to resolve these issues and I believe the review team have conveyed their assessment to you all.*

While I am satisfied that currently there is no additional risk to patients at Canterbury Health as a result of its restructuring, I would be concerned if you were unable to restore relations between management and clinical staff. I would therefore be grateful if you could provide commentary to me in three months time to assure me that you all have made the progress I expect in resolving these issues.

.....

None of the staff interviewed could substantiate that the restructuring arrangements are unsafe. However, this may be a difficult proposition for the staff to prove and they therefore expressed the view that there was potential for the hospital to be unsafe in the future if relations between staff and management could not be resolved".

Dr Poutasi asked Mr Frame to respond to a series of questions. The questions in relation to Christchurch Hospital were:

(i) "*Whether the current nursing staff strategy provides for a sufficient skill mix on specialised wards to ensure the quality delivery of services.*

(ii) *Whether the restructuring of laboratory services allows for adequate clinical and technical supervision. Concern was raised over a recent failure to detect an error in the reporting of laboratory results.*

(iii) *Whether clinical staff and management have an agreed and well planned process for the purchasing of capital equipment".*

Reporting to the Ministry

The Director General of Health requested in her letter of 12 March 1996 that the Chief Executive of Canterbury Health report back, giving assurance that progress had been made in resolving the relationship between clinicians and management. The letter requested Mr Frame to report back within a month in response to the series of questions put to him. The letter stated that Southern Regional Health Authority was being copied the letter *"so that the purchaser may pursue its interest in these matters in any way that seems appropriate"* and suggested that "*at some stage, it would be useful for yourself or a representative from SRHA and Chris Tuffnall* (sic) *to revisit Canterbury Health to assess whether there has been any improvement in relations between clinicians and managers*". The Chief Medical Officer to the Ministry of Health, Dr Feek, wrote to Mr Winston McKean at Southern

Regional Health Authority raising concerns about Canterbury Health. The Commissioner was advised that there was no formal response by Southern Regional Health Authority to this letter, however there were several conversations between Dr Feek and Mr McKean, who advised that Southern Regional Health Authority were aware of the communication difficulties between clinicians and managers at Christchurch Hospital and were bearing this in mind, as one factor among a range of factors, during the contracting process.

On 10 July 1996 Mr Frame wrote to Dr Poutasi stating that he was unable to confirm that the issue of relationships was resolved.

SOUTHERN REGIONAL HEALTH AUTHORITY'S ETHICS COMMITTEE, MARCH - AUGUST 1996

Advice to Ethics Committee and Initial Responses

On 8 March 1996 Professors Bagshaw and Richards wrote to the Chairman of the Southern Regional Health Authority's Ethics Committee (the "Ethics Committee") outlining Canterbury Health's restructuring plans and querying whether their implementation was within the Ethics Committee's remit.

As a result of this letter, the Ethics Committee wrote to Mr Frame on 27 March 1996 saying:

> "*It has been brought to the Committee's attention that clinicians employed by Canterbury Health Limited are concerned about patient safety in the light of the restructuring of Christchurch and Burwood Hospitals.*
>
> ....
>
> *Given its brief and the concerns expressed by clinicians, the Committee wondered whether the ethical aspects of the restructuring were considered by Management, and has extended to you an invitation to comment on why it was not consulted before the restructuring plans for Christchurch and Burwood Hospitals were put in place".*

Mr Frame responded by letter dated 24 April 1996 expressing surprise that re-organisation of management structure should have been referred to the Ethics Committee:

> "*Any suggestion that perhaps the Ethics Committee should have been consulted before we proceeded with these changes raises the question of what boundary is appropriate between those issues that should and should not be submitted to the Ethics Committee for consultation or approval*".

Mr Frame suggested a meeting between the Ethics Committee, senior management and professional advisors to discuss and clarify matters.

Christchurch Hospitals' Medical Staff Association Meets Ethics Committee

Christchurch Hospitals' Medical Staff Association wrote to the Ethics Committee on 16 May 1996, advising that it believed the current nursing restructuring constituted an experiment and should be undertaken according to a declared protocol, subject to ethical approval and evaluated on prescribed parameters.

Christchurch Hospitals' Medical Staff Association representatives met with the Chairman of the Canterbury Ethics Committee and the Ethics Administrator on 6 June 1996 to brief the Chairman about the impact of restructuring within Canterbury Health. The Christchurch Hospitals' Medical Staff Association advocated the position that it was inappropriate to apply case management across all

areas of a hospital because it is normally used in areas with routine and standard treatment. The Christchurch Hospitals' Medical Staff Association did not advise the Ethics Committee that Canterbury Health had indicated to staff in the November 1995 restructuring document that case management *"may have limitations in some clinical settings"*. The Christchurch Hospitals' Medical Staff Association outlined what case management involved, the case management structure, the other countries which use case management and the advantages and disadvantages of case management. The Christchurch Hospitals' Medical Staff Association also believed patient safety would be compromised because case management would give Patient Care Managers the primary responsibility for patients as opposed to clinicians. The Christchurch Hospitals' Medical Staff Association advised that these issues had been raised during consultation by clinicians and nursing staff but had not been addressed to the satisfaction of the majority of clinicians or nursing staff employed by Canterbury Health. As a result of the failure of the consultation process, the Christchurch Hospitals' Medical Staff Association believed management changes could be described as untested research and as such should be submitted to the Ethics Committee for approval.

The Ethics Committee advised the Christchurch Hospitals' Medical Staff Association that the meeting with Canterbury Health on 12 June would have a narrow focus and would be predominantly jurisdictional. The Ethics Committee advised that they would consider which aspects of restructuring had ethical implications and would then report to the Christchurch Hospitals' Medical Staff Association.

Canterbury Health Meets the Ethics Committee

The Ethics Committee met with management of Canterbury Health on 12 June 1996. The Ethics Committee then wrote to the Christchurch Hospitals' Medical Staff Association's Executive asking the Association to submit a detailed written submission outlining concerns about the nursing restructuring, particularly in relation to patient safety.

The Christchurch Hospitals' Medical Staff Association's Submission

In a letter dated 21 June 1996, the Christchurch Hospitals' Medical Staff Association set out its concerns regarding Canterbury Health's Proposals for Change, the consultation period, and the restructuring plan. The submission was supported by the New Zealand Nurses Organisation and the Association of Salaried Medical Specialists. The Royal Australasian College of Surgeons also made a submission, principally supporting the Christchurch Hospitals' Medical Staff Association's view that evidence was lacking for the introduction of case management throughout an acute hospital and it was "*an innovative procedure*" which should be submitted for ethical consideration. In the College of Surgeons' opinion the following steps were crucial:

(a) "*the process of consultation is acceptably rigorous;*

(b) *the new process (case management) is evaluated in a thorough and scientific manner; and*

(c) *ethical approval is sought and given"*.

The Ethics Committee provided a copy of the Christchurch Hospitals' Medical Staff Association's submission to Canterbury Health on 1 July 1996 and requested that Canterbury Health provide a written response to the submission to the Ethics Committee by 10 July 1996.

Canterbury Health's Response to the Christchurch Hospitals' Medical Staff Association's Submission

On 8 July 1996 Mr Frame wrote to the Ethics Committee advising that Canterbury Health was considering the issues raised in the Christchurch Hospitals' Medical Staff Association's submission and taking advice on them. By letter dated 25 July 1996, Canterbury Health advised the Ethics Committee that it had

taken the Association's concerns seriously and that patient safety was of paramount importance to Canterbury Health.

"*In view of the concerns raised in the submission, we thought it appropriate to obtain external legal advice. We enclose for your information a copy of a letter from our Solicitors, Chapman Tripp Sheffield Young. You will see that they are having difficulty advising CHL in regard to this matter given the lack of detail which would be necessary to investigate and form a view on. These concerns (namely lack of detail) have already been expressed by CHL to the Association"*.

The letter went on to require specific details of the concerns raised and noted that Canterbury Health had made a considerable effort to obtain the details previously.

Canterbury Health set out the background against which the concerns had been expressed to the Ethics Committee. The background included:

(a) The particularly virulent flu strain during the winter of 1996.

(b) The Southern Regional Health Authority's failure to resolve the discharge planning/pathway issues for patients who were no longer in an acute condition, but had to remain in hospital.

(c) The Christchurch Hospitals' Medical Staff Association's demand for an "independent" inquiry which would require an "internal" inquiry prior. An internal inquiry could not proceed until Canterbury Health was aware of the specific incidents and/or procedures relating to patient safety.

(d) 1996 was an election year and as early as October 1995 Canterbury Health had been faced with Union Groups stating publicly that their "activities" were a demonstration against Government health reforms.

(e) There was a significant "power" issue between management and clinicians which unfortunately had resulted in communication at times between those parties being "strained".

Canterbury Health felt that it was conceivable that the "power" issue had been dressed up as a "safety" issue and that the Ethics Committee "*may be used as a "vehicle" to further issues other than genuine safety issues having ethical ramifications*".

Ethics Committee Meets to Discuss Issues

The Ethics Committee sent Canterbury Health's response to Christchurch Hospitals' Medical Staff Association and advised that an Ethics Committee meeting would be taking place on 12 August 1996 to discuss issues raised in the Association's submission and the Canterbury Health response. Canterbury Health and the New Zealand Nurses Organisation were also advised of the meeting and invited to participate.

The Ethics Committee's Report

The Committee released its findings on 28 August 1996. In relation to its jurisdiction, the Committee stated:

"*It is acknowledged by all parties that this Committee has a proper interest in ethical aspects of the delivery of health and disability services, research and innovative treatments within the Canterbury area. The primary objective of this Committee is to safeguard the rights of health and disability support service consumers and participants in health research and to protect them from harm".*

The Committee decided that:

"*... ethical approval is not required for the restructuring of nursing positions by Canterbury Health Ltd, but the way this has been managed has raised matters of ethical concern;*"

"*the introduction of case management on a limited basis does not require ethical approval if it is implemented in a collaborative fashion with clinical and management staff working together at the service level;*" but

if Canterbury Health "*were to introduce case management on a hospital-wide basis, encompassing diagnosis, treatment and rehabilitation of all patients according to certain critical pathways, then this would be new to New Zealand and it is likely that the Committee would view it as an innovative procedure requiring full ethical approval".*

The Committee acknowledged Canterbury Health's statement that the nursing restructuring and the proposed introduction of case management was intended to improve health care. However, the Committee found that the way changes had been implemented and the seemingly inadequate consultation process had created an adverse relationship. This had eroded public confidence and had given rise to a number of ethical concerns.

The Ethics Committee had six main areas of concern. These were:

(a) **The consultation process regarding the changes**

The Committee felt the consultation process was flawed

"*because it failed to take into account and properly and openly address genuinely felt clinical and community concerns about the restructuring*".

(b) **The relationship between management and clinical staff**

The Committee was

"*saddened that things have reached such an impasse that the only way forward was to bring the matter to the attention of an outside body...*

It is also an ethical concern that patient safety incidents are occurring but clinical staff do not feel they can report them because of the current climate within the organisation. The Committee strongly believes staff have an ethical obligation to report such incidents, despite any fear of reprisal whether or not that fear is justified".

The Ethics Committee supported management initiatives to improve communications. The Ethics Committee commented that it did not believe that resorting to the media was helpful for either party, the patients or the community.

(c) **The Role of the Clinical Nurse Facilitators**

"*The Committee notes that there is considerable professional unease about the lack of direct responsibility for the management and co-ordination of activities within a ward if these positions were to be disestablished".*

The Committee advised management to reconsider the decision to remove Clinical Nurse Facilitators.

(d) **Case Management**

The Committee found

> "*no ethical objection to the introduction of case management on a limited basis. Indeed there is recognition from CHMSA* [the Christchurch Hospitals' Medical Staff Association] *and the Nurses Organisation that there are certain wards and areas where it is appropriate and would be an improvement on existing systems. However the Committee notes that case management may not be suitable for applying on a hospital-wide basis and this was acknowledged by each of the parties to some extent. Consequently the Committee believes case management should be introduced only in those areas where management and clinical staff mutually agree that it is appropriate"*.

(e) **Lack of an Impact Monitoring System**

The Committee indicated there was a need for baseline data collection and ongoing monitoring - objective data was necessary to decide the success or otherwise of case management and nursing restructure.

(f) **Ethical Input**

The Committee acknowledged Canterbury Health's assurance that the ethical implications of management decisions are taken into account at regular meetings of Canterbury Health management and the Medical Advisors. The Committee suggested "*that management consider also approaching the Canterbury Ethics Committee as an accredited and impartial source of ethical comment*".

The Ethics Committee's Recommendations

The Ethics Committee made the following recommendations:

(a) "*That the introduction of case management be implemented in a collaborative fashion with clinical and management staff working together at the service level; and that it be introduced only in those areas where management and clinical staff mutually agree that it is appropriate.*

(b) *That management reconsider removing the Clinical Nurse Facilitator positions across the board; and that the clinical staff and management together identify situations where it would be in the best interests of patients to retain them, and instances where it would not.*

(c) *That clinical staff be reminded that they have an ethical obligation to report patient safety incidents, despite any fear of reprisal, whether or not that fear is justified.*

(d) *That a genuine effort be made to improve communication between management and clinical staff.*

(e) *That an Impact Monitoring System be designed and introduced which includes data on patient safety, patient and staff satisfaction, as well as the routine economic and statistical data normally collected for monitoring purposes.*

(f) *That Canterbury Health Ltd give consideration to seeking ethical comment from the SRHA Ethics Committee (Canterbury) or some other independent ethical source when planning major changes to systems that affect the delivery of health care".*

The Ethics Committee requested a report in three months from all parties concerned to see if the issues that had been raised had been resolved.

The Ethics Committee Report had been issued "in committee" and was intended to be confidential between Canterbury Health, the Christchurch Hospitals' Medical Staff Association and the Committee itself. However, following its release, there were repeated references to the report in the media. Canterbury Health sought the release of the report and asked the Ethics Committee to censure the Christchurch Hospitals' Medical Staff Association for breaching confidentiality. The report was subsequently released in full to avoid selective reporting or misrepresentation.

Neither party reported back to the Ethics Committee on these issues by 30 November as requested. However, on 28 February 1997, the Christchurch Hospitals' Medical Staff Association wrote to the Ethics Committee advising that Canterbury Health's management style continued to be "top down" and that the adversarial relationship was *"even more entrenched"*. It disagreed with the Ethics Committee's comments on the use of the media and called for the Ethics Committee to support an independent public judicial ministerial inquiry into the issues relating to patient safety at Christchurch Hospital.

WINTER 1996 AND PATIENT SAFETY

Seasonal Overload

The winter of 1996 was particularly severe in Christchurch. Patient numbers were high and many of the managers were new to their role and were managing the winter pressure for the first time. Staff sickness was also high. Canterbury Health had relied on Southern Regional Health Authority to purchase additional Accident Treatment and Rehabilitation beds from Healthlink South. However, on 7 June 1996, the Chief Executive of Southern Regional Health Authority, Mr Victor Klap, informed Mr Frame that his organisation was not in a position to purchase those beds.

Emergency Medicine Warnings

On 3 July 1996 a Senior Lecturer in Emergency Medicine wrote to the General Manager, Christchurch Hospital Services, Dr Coughlan, setting out his concerns regarding the seasonal overload and patient safety. He was particularly concerned about the ability of the Hospital to deal with acute admissions. He stated:

> "*I am unaware of any specific disasters occurring but this I suspect is in part due to good luck and in large part due to the fact that the medical and nursing staff are compensating by keeping patients in the Emergency Department more often and admitting them to the Intensive Care Unit more readily. If we wait for hard data to support a safety issue then we will have allowed problems to occur that may otherwise have been avoided.*
>
> *In summary I am concerned about the lack of appropriate beds for acute admissions and the lack of nursing numbers and at times their level of experience".*

Dr Coughlan replied to this letter on 9 July 1996 stating that he had commissioned a review of all space plus a projection of bed requirements for the future.

On 19 July 1996 the Clinical Director of General Medicine wrote to Dr Coughlan on behalf of all 22 general medical physicians, stating:

"*that planning for the expected rise in acute medical admissions during the winter of 1996 has been inadequate and that the current arrangements for caring for such patients in General Medicine is unsafe and inefficient*" and that "*...under these conditions we cannot provide an adequate standard of care for these acutely ill patients. We do not have time to observe the requirements of the Patients' Code of Rights introduced on July 1, 1996*".

Included with that letter to Dr Coughlan was a detailed memorandum from medical registrars working in General Medicine to the Clinical Director of General Medicine. The memorandum and the letter described the situation of the hospital during June and July 1996 as follows:

"*The number of general medical patients each day in Christchurch Hospital has risen from 140 to 220.*

The acute admitting system has broken down leading to acutely ill patients being admitted all over the hospital with every acute team having 25 - 30 patients distributed over 10 - 15 wards. The major effect of this, combined with the casual pool system used for nurses, is that the available nurses are not adequately trained to manage acutely ill medical patients. In addition the reports go astray and patients are difficult to find. The computer tracking system is inadequate.

Up to 14 patients at any one time have been cared for in the former medical day unit area. This is unsafe. Patients lie on trolleys 18" apart. Most have infections such as meningitis, pneumonia, diarrhoea and vomiting and cross-infection is impossible to prevent. Others may have attempted suicide and obviously need seclusion. The elderly and sick are likely to fall off the narrow trolleys.

ICU has been intermittently closed.

Patients are all over the hospital but staff do not know exactly where. Emergency Department/admitting procedures not adequate to track patients properly.

Results go astray.

Nurses in many non-medical wards are not competent to deal with acute medical patients and there is no reason why they should be. [They]:

don't realise when the patients are sick;

don't understand the treatments given;

don't appreciate the significance of abnormal results.

Doctors sometimes unable to deal with the workload presented to them.

This all symbolises the breakdown of the collaborative doctor/nurse team so essential for good quality medical care and the avoidance and correction of mistakes".

The memorandum from the medical registrars included approximately 30 issues. Examples included:

"*1. Distribution of Patients*

- *33 patients on 15 wards; 16 patients on 11 wards; 42 patients on 11 wards.*
- *21 admissions during one evening sent to 11 different wards.*

....

2. Results going astray ...

- *Patient with a potassium of 7.3 not seen by the team for 48 hours.*

....

3. MDU ...

- *Clustering of inappropriate patients [suicides, pneumonia, campylobacter, meningitis, heart failure] which is an obvious cross-infection risk.*
- *Severe pneumonia, no antibiotics given for 12 hours while waiting for someone to take blood cultures.*

....

4. Individual problems ...

- *One day of IV antibiotics missed with a meningitis patient.*

....

5. Emergency Department ...

- *Three more patients admitted via ED without medical registrar being notified.*

...".

New Zealand Nurses Organisation Warns of Patient Safety Issues

On 10 June 1996 the Area Manager of the New Zealand Nurses Organisation responsible for Christchurch, Mr Trevor Warr, wrote to Ms Gillian Grew at the Ministry of Health with his continuing concerns about patient safety at Canterbury Health. Mr Frame advised the Director General of Health, Dr Poutasi, in a letter dated 9 July 1996 that Canterbury Health had been unable to substantiate the New Zealand Nurses Organisation's allegations concerning patient safety. This was because that Organisation would not provide detailed information. The Organisation's basis for withholding detailed information was to protect Canterbury Health's employees. Mr Warr stated that "... *to disclose information that would ultimately place your staff and our members in a position where they can be identified will simply increase the stress and unease felt by many*".

Ministry of Health Questions Staffing and Loading

In response to this, on 11 July 1996, Dr Poutasi required from Mr Frame information about the systems and processes in place at Canterbury Health which would alert management when staffing levels were inadequate for patient loading and acuity.

Mr Frame provided the following information on 16 July 1996 in response to Dr Poutasi.

"*Core nursing staffing levels were set in 1994/95, based on each area's bed occupancy and acuity. Maximum provision was allowed for non-productive leave. Sick leave or other unexpected short term absences are met from either Canterbury Health's own casual pool or from external agencies.*

We have in place a comprehensive incident reporting system which provides a system for monitoring trends and a rapid response mechanism for immediate identification and resolution of incidents or situations which may compromise patient safety.

Extraordinary events may mean that, despite the above monitoring and adjustment systems and processes, prioritising decisions may need to be taken which mean staffing on a shift-to-shift basis may not always be ideal.

The current influenza outbreak has impacted on staff in four ways:

high demand for nursing due to very high bed occupancy and highly dependent patients;

very high staff numbers succumbing to the flu;

a number of mothers in the workforce needing to care for their sick children;

reduced numbers of CHL casual and bureau staff being available as they also have contracted the flu.

None of this has been detrimentally affected by any recent organisational restructuring".

This letter detailed the specific services at Christchurch and Burwood Hospitals and how each hospital reviewed patient numbers, acuity and staff numbers and skill mix. The letter also explained a number of departments and advised what accreditation standards had been obtained within each department, and what checks individual departments had to perform to maintain or improve the standard.

The Christchurch Hospitals' Medical Staff Association's Meeting with Management, 14 July 1996

A meeting between the Executive of the Christchurch Hospitals' Medical Staff Association and the senior management team was held on 14 July 1996 to discuss patient safety issues. There were no agreed minutes of this meeting and the Commissioner has reviewed both the Association and the management team's records of the meeting, which do not differ materially.

The Christchurch Hospitals' Medical Staff Association advised the Commissioner that the Association presented "*a series of themes with examples, 50-60 situations in total. About 20 where people have complained about an unsafe environment. About 30 very serious examples*". According to the Executive of the Association, "*concrete examples*" were presented in categories without identifying either the patients or staff, for fear of either having the staff blamed or compromised. It was made clear, according to the Association, that "*Today's catalogue is not a planned programme of collection. Examples were sent mainly to NZNO, some to us*".

According to the Christchurch Hospitals' Medical Staff Association minutes of the meeting, the following "*themes of safety*" were presented with examples:

(a) understaffing in both allied health and nursing (relating to "*numbers, quality, unreliability of pool replacements and CNF* [Clinical Nurse Facilitator] *performance*");

(b) systems failures (lack of contingency planning, the effect of restructuring, poor performance of the nursing pool);

(c) tasks forced on inappropriately trained staff (use of casual nurses, particularly new graduates);

(d) inappropriate staffing ("*4 physicians each have 20-30 patients treated in up to 15 wards*"; in ward 23 "*up to 30 patients covered by 2 new staff nurses on night shift*");

(e) safety checks lost ("*Emergency - admission list inaccurate - registrars noted 6 patients not on the list at 9.00pm - potentially disastrous…'96 apparent increase in falls - no data had been collected for months after QA Fall prevention programme disestablished*"); and

(f) under resourcing ("*Emergency Department - patients in corridors - if there is an emergency these areas not geared with rescue facilities. Report from medical ward no privacy for interviews (endoscopy) ... no oximeter, no oxygen and suction facilities - acute patients left on trolleys ... admission of female patients to male wards…Friday, 21 June 1996 - male*

> *patient early 60's admitted with severe LVF* [left ventricular failure] - *requiring c-pap* [continuous positive airways pressure] - *IV nitrates etc. etc. ICU was full with no patients able to be transferred. Nurse special was requested. Duty manager said none available and did not wish for us to take it further lest her position be compromised. Patient placed on ward 24* [not a cardiology ward] *compromising both his own safety and that of other patients on the ward as he required full time nursing care ... Monday, 5 June 1996 - 86 year old admitted with fast A fib* [atrial fibrillation - irregular heart beat] *chest pain…In 12 midday. Seen by medical staff at 9.40pm on ward 14*".)

Management's file note recorded the writer's impression that the meeting had been "*long on rhetoric and short on substance*". Further, it stated that it was his impression that "*a large number of issues had been 'cobbled' together and put to us, many of which (and probably the majority) were clearly outside the basis for the supposed concern, namely that of the nursing restructuring ..".* However the file note began by noting that the meeting "*had been called by Stuart Gowland to discuss patient safety issues*". According to the Association's minutes, the Chairman of the Christchurch Hospitals' Medical Staff Association refused to give management a copy of the material presented, stating "*we need to consider patient privacy and the security of staff* - [the] *correct forum for presentation is an independent enquiry*".

The Christchurch Hospitals' Medical Staff Association minutes of this meeting record that towards the end of the meeting the Chief Executive of Canterbury Health stated "*it's time we finished - from a management perspective you have given us no hard detail we can go away and work on*". The Chairman of the Association replied "*it will be made available to an independent review*".

According to management's minutes, the Chairman of the Christchurch Hospitals' Medical Staff Association, Mr Gowland, stated that there were two things that needed to happen from the meeting:

(1) "*The clinicians must meet the full Board of Directors in order to present these examples to them;*

(2) *We need to agree upon the terms of reference for a review and that the clinicians are suggesting the College of Physicians and the College of Surgeons jointly undertake the review".*

To the Association's request "*to meet the Board urgently to address these issues*" the General Manager, Christchurch Hospital Services responded "*the Board sees it as a management issue*". Management minutes recorded that management have "*no problem with the concept* [of going to the Board] *but we'd like to form a view on the problems before the matter is referred to the board. To do this* [the Chief Executive] *would need specific details*".

According to the Association minutes, the Chief Executive asked Mr Gowland "*what happens when the Board turns to John* [Coughlan] *and myself and says to what degree do you support what's being said*?" Mr Gowland replied "*we expect trust in the evaluation of senior nurses and doctors*".

Mr Frame requested specific details (i.e. dates, times, places) of incidents raised by the Christchurch Hospitals' Medical Staff Association. The Association stated that it would be happy to provide such details if privacy issues were addressed. The clinicians asked for an "amnesty" to be put in place for a prescribed period so that staff would feel less threatened by coming forward. Management stated that they were wary of words like amnesty.

There was a further meeting between management and the Association on 16 July 1996 which included the two Board Directors with clinical experience.

Clinical Input to the Board

Clinical input was very rarely given directly from clinicians to the Board. However, the Clinical Director of the Department of General Medicine was invited by the General Manager, Christchurch Hospital Services to attend a Board meeting on 7 August 1996. The Clinical Director was not sure of the agenda of the meeting as he did not receive papers either in advance or at the meeting yet he was asked to support a proposal which had been put to the Board for approval. On 13 August 1996, following his attendance at the Board meeting, the Clinical Director wrote to the General Manager, Christchurch Hospital Services for some information regarding the meeting he had attended:

"*I would like to have a copy of what was sent to the Board to make sure I know exactly what I was supporting..... It was slightly unusual to be speaking about a proposal that I had not seen but I am sure that I would support any review which I assume will address the above problems*".

THE SECOND MINISTRY OF HEALTH INQUIRY

Systems Failure Report, September 1996

On 6 September 1996 the Minister of Health attended a meeting at Christchurch Hospital at the invitation of the Christchurch Hospitals' Medical Staff Association and Christchurch representatives of the New Zealand Nurses Organisation. Ministry of Health officials were invited by the Minister to be in attendance. On 12 September 1996 a report entitled "Systems Failures Threatening Patient Safety at Christchurch Hospital" was delivered to the Minister of Health, the Hon. Jenny Shipley. The report was prepared by the Christchurch Hospitals' Medical Staff Association and the Christchurch representatives of the New Zealand Nurses Organisation.

The report opened with a summary stating that "*since restructuring was introduced in February 1996 there has been a series of serious systems failures which have threatened patient safety*".

The report then detailed concerns regarding a purported drop in safety standards at Christchurch Hospital. Numerous non-specific examples of understaffing, inappropriate staffing, inappropriate patient location leading to unsafe practices, failure to meet established standards and loss of quality indicators were given. The examples were stated to have been selected from a total list of nearly 60 reports held on file by the Christchurch Hospitals' Medical Staff Association and the New Zealand Nurses Organisation.

In a letter accompanying the report to the Minister of Health, the Chairman of Christchurch Hospitals' Medical Staff Association stated that "*we believe the situation outlined in our report clearly requires an independent review of management systems at Christchurch Hospital"*. The "Systems Failures" report lead to another inquiry by the Minister of Health.

According to Mr Gowland, the clinicians did not know of any of the deaths outlined in the 'Patients are Dying' Report when they met with the Minister in September 1996.

Minister requests Canterbury Health to Investigate "Systems Failure"

On 16 September 1996 the Minister of Health wrote to the Chairman of Canterbury Health enclosing a copy of the "Systems Failures" report. The Minister requested Canterbury Health "*to fully investigate this matter and to report to the Director General of Health, Dr Karen Poutasi, whether safety is or is not compromised either as a result of inadequate nursing staff or an inappropriate skill-mix of nurses deployed in the Crown Health Enterprise*". Specifically, the Canterbury Health report was to

enable the Director General of Health to decide whether an independent inquiry was required. Canterbury Health was required to report to Dr Poutasi by 1 October 1996.

The Minister required Canterbury Health's report to address the following issues:

(a) "*Does Canterbury Health have an adequate system for matching nursing care to workload. If not, what system should be put in place to match the level of nursing care to workload to ensure safety?*

(b) *Is the current level of staffing by nurses at Canterbury Health adequate for the current workload? If not, is safety compromised in any way?*

(c) *Is the current skill mix of staffing by nurses at Canterbury Health appropriate for the current workload? If not, is safety compromised in any way?*"

Dr Layton provided Canterbury Health's response to the Minister's questions to Dr Poutasi on 30 September 1996. Dr Layton's report also commented on the allegations contained in the Christchurch Hospitals' Medical Staff Association's report and enclosed documentation on restructuring and critical care pathways.

Ministry of Health Inquiry

Both the Christchurch Hospitals' Medical Staff Association's report and Canterbury Health's response were delivered to Ms Christine Tuffnell. Ms Tuffnell was requested "*to advise whether there is a systems problem at Canterbury Health in the deployment of nursing staff and whether Canterbury Health have systems in place to determine an adequate level of nursing staff and an appropriate skill-mix of nurses to meet their current workload".*

After reviewing the documentation, on 5 October 1996 Ms Tuffnell made the following observations in her report:

1 The Cases

"*.... some of the cases presented indicate that staffing was insufficient in terms of the patient/nurse ratio, staff mix and/or likely nurse intervention required for those patients".*

2 Nursing Staff Structure (Nursing Establishment/Full Time Equivalents)

"*Canterbury Health can demonstrate that its establishment staffing ... is adequate and compares well with other New Zealand hospitals. However, the cases quoted by the medical staff and nurses showed that these establishment levels are not always available in practice".*

3 Measurement of Nursing Intervention Required

"*Canterbury Health does not appear to have an appropriately dynamic system for estimating nursing intervention and allocating nurse staffing in response*".

4 Variance Analysis of Planned Nursing Intervention/Actual

This data was not presented with Canterbury Health's response and was therefore not addressed by Ms Tuffnell.

5 Skill Mix of Nursing Staff

Canterbury Health's staff mix was comparable with other hospitals. Ms Tuffnell commented that "*While the mix figures provided indicate that the skill mix of staff is acceptable, I would*

need to be convinced regarding the role of Hospital Aids in acute care areas and in contemporary nursing practice where holistic care, rather than task oriented care is important for optimal patient positive outcomes".

6 The Casual Pool

Canterbury Health's casual pool of nurses was approximately 10% of their nursing staff (110 nurses). Ms Tuffnell found that there was no information provided by Canterbury Health as to whether agency nurses were included in the casual pool or whether they were an additional casual workforce that Canterbury Health used. Therefore Ms Tuffnell was not able to adequately assess the ratio of casual to permanent staff.

7 Management of the Nursing Workforce

Canterbury Health had an acceptable structure for managing nursing workload. However Ms Tuffnell queried whether the support structure worked in practice. Some of the cases quoted in the Christchurch Hospitals' Medical Staff Association report indicated Patient Care Managers or Service Managers were not called in to assist at times of workload peaks or staffing troughs. Several of the cases highlighted that insufficient staffing was available at the start of each shift. Ms Tuffnell commented that Canterbury Health's response regarding current nursing structure and roles did not clearly identify who was responsible for ensuring adequate staff on the wards/units.

8 Clinical Input into Service Decisions

Ms Tuffnell found that Canterbury Health had "*taken initiative in efforts to involve clinical staff in discussion on issues and other aspects of service delivery*". However, Ms Tuffnell noted that it was evident from the Christchurch Hospitals' Medical Staff Association report that some clinical staff had not participated in the initiatives by Canterbury Health at the date of her report.

Ms Tuffnell found that the nurse staffing issue needed to be further addressed to protect patient safety and free up clinical staff's time to devote to direct patient care.

9 Reporting Incidents

Canterbury Health had an "*appropriate incident reporting system*". However, she noted that there appeared to be an under-reporting of incidents. Ms Tuffnell recommended audits of the effectiveness of actions taken in response to reported incidents.

Ministry of Health Recommendations

Ms Tuffnell made a series of recommendations at the close of her report which were as follows:

(a) "*That responsibility and accountability for managing the nursing workforce, including rostering and shift to shift assignment of staff be clearly defined and communicated to all clinical staff.*

(b) *That Canterbury Health design, in consultation with nursing staff in all areas, a nursing intervention workload measurement system (NIMS).*

(c) *That the NIMS be implemented and used as the basis for nursing staff allocation.*

(d) *That variance between planned and actual nursing intervention (in nursing hours) is monitored and limits set regarding acceptable variation.*

(e) *That the proportion of casual shifts worked to shifts worked by permanent staff be monitored, ensuring that casual staff form no more than 30% of the staff in an area on any one shift.*

(f) *That an assessment be made of the availability of casual staff to be called in to work at short notice to ensure that the casual pool is an available casual pool. Availability of casual staff should be subject to ongoing monitoring.*

(g) *That the mix of staff in each patient care area be monitored and action taken to ensure areas are staffed with an adequate mix of staff, depending on the type of competencies required for the specific nursing interventions needed by patients in that area.*

(h) *That, in the context of the above monitoring, Canterbury Health also monitor support provided to nurses by Patient Care Managers, Clinical Nurse Facilitators, and Nurse Specialists out of hours and at weekends.*

(i) *That a Nurse Staffing Project Team of two senior nurses (elected by the Senior Nurses' Forum) and two NZNO representatives (elected by the nursing workforce) be released from normal duties and given the necessary resources and support to implement recommendations 1-8 above.*

That the project team report to the Chief Nurse, the General Manager of Christchurch Hospital, and an assigned project guidance person in the Ministry of Health.

It is envisaged that the project would take up to six months to complete.

(j) *That patient flow bottle-necks be addressed.*

(k) *That NZNO and the Christchurch Hospitals' Medical Staff Association be supported to ensure that their members report all incidents. In view of the lack of detail in the cases provided in the "Systems Failure" report it is recommended that a format be agreed on for reporting such incidents. This would enable such incidents to be followed up promptly and preventive action taken in order to better protect patient safety.*

(l) *That management (service/clinical as appropriate), ensure corrective action has been initiated immediately upon receiving the report for urgent incidents and within five days of receiving the report for non-urgent incidents.*

Management should not be required to report back on corrective action to each person filing an incident form, but a summary of incidents and action specific to a service area should be available for discussion at the regular meetings of staff in the area concerned".

On 11 October 1996 Dr Poutasi wrote to Canterbury Health making 17 recommendations. Dr Poutasi agreed with Ms Tuffnell's 12 recommendations and added the following five recommendations:

(a) "*Canterbury Health define responsibilities and accountabilities for management of nursing workforce including casual and agency staff on units/wards. They should develop policies on use of casual and agency staff and in particular, how skill mix of casual or agency staff are appropriately matched to the clinical needs of units or wards.*

(b) *Canterbury Health develop policies to ensure adequate mentoring of registered casual nurses and supervision of enrolled nurses.*

(c) *Canterbury Health develop policies to ensure adequate ongoing professional education and development of permanent and casual staff.*

(d) *Canterbury Health develop mechanisms to ensure that staff are able to resolve issues and concerns regarding clinical practice.*

(e) *Canterbury Health ensure that its policies and procedures are understood by nursing as well as other clinical staff, so that they can be implemented".*

Dr Poutasi required Canterbury Health's views and position on the 17 recommendations by 18 October 1996. Dr Poutasi also noted that further information was required by the Minister in relation to a specific claim in the "Systems Failures" report. Dr Poutasi required a report on the matter from Canterbury Health by 30 October 1996. She concluded the letter in the following terms:

"*In view of the lack of detail provided by the Health Professionals I am reluctant to hold a further independent enquiry into this matter at this stage. However, I need to be satisfied that the above recommendations are addressed. I reserve my right to take any action that I feel is necessary.*

I would like to thank you and your board and the management of Canterbury Health for assistance in this matter. I hope that clinicians and management will work together to ensure quality services are provided at Canterbury Health and I do not need to remind you all that you are collectively responsible for patients in your care".

Christchurch Hospitals' Medical Staff Association Responds to Ministry of Health Inquiry

On the same day, 11 October 1996, Dr Poutasi wrote to the Chairman of the Christchurch Hospitals' Medical Staff Association advising that she had "*made several recommendations to Canterbury Health concerning their systems and policies in relation to workforce management of their nursing staff*", and that she had asked Canterbury Health to respond to her recommendations by 18 October 1996. Dr Poutasi advised the Christchurch Hospitals' Medical Staff Association that once Canterbury Health responded, she would be prepared to "*provide your association with copies of reports from Canterbury Health, Ms Chris Tuffnell and the Ministry of Health for your comments also. Indeed I would wish to visit Canterbury Health to discuss these issues with you, senior nursing staff and management in the following week*". She also asked the Christchurch Hospitals' Medical Staff Association to provide further information about specific claims made in the "Systems Failures" report.

On 16 October 1996 Mr Gowland responded to the request for further information, saying the request "*indicate*[s] *either a failure or a refusal to recognise that the cases outlined in our report "Systems Failures Threatening Patient Safety at Christchurch Hospital" are representative only... These are the tip of the iceberg, the full extent of which would be revealed to a properly constituted independent inquiry with appropriate terms of reference and indemnities*".

On 17 October 1996 the Acting Chief Executive Officer of Canterbury Health, Mr Trevor Sew Hoy, responded in detail to Dr Poutasi about all of the 17 recommendations, advising that "*many of the recommendations have already or are in the process of being implemented*".

On 25 October 1996 the New Zealand Nurses Organisation wrote to the Ministry stating it "*fully endorsed the recommendations made in the letter"* of 11 October 1996 and that "*our membership do not at present support the concept of an inquiry* [under section 47 of the Health and Disability Services Act 1993]*".*

A meeting was arranged between Canterbury Health's Chief Executive and the Ministry of Health. On 11 November 1996 Dr Poutasi wrote to the Southern Regional Health Authority enclosing "*a copy of the Ministry of Health's enquiries*" into the safety concerns at Christchurch Hospital. Dr Poutasi undertook to keep the Southern Regional Health Authority informed of the meeting's outcome "*so that*

you will be able to monitor the quality of service provision in order to satisfy yourself that the services at Canterbury Health are as safe as they can be."

A Specific Investigation

Following the request by Dr Poutasi to investigate a specific claim made in the "Systems Failures" report, Dr Coughlan commenced an investigation to identify the patient listed as Patient 2(d) in the report. Patient 2(d)'s case was that:

> "*In the step-down ward from Coronary Care, a lady in her early 60s was recovering from an uncomplicated mild heart attack. It is reported she had a recurrent chest pain which was not recognised as being significant by the casual nurse attending her. She subsequently died. This was reported as a potentially avoidable death".*

Dr Coughlan's enquiries extended to all patients who had died in the Coronary Care Unit or the attached step down unit. Canterbury Health believed that the patient referred to in the Systems Failures report was the same patient that had been referred to by Professor Nicholls at the meeting between Canterbury Health and the Christchurch Hospitals' Medical Staff Association on 14 July 1996. Using the information from that meeting and the information in the Systems Failures report (clause 2(d)), Dr Coughlan commenced his investigation.

According to Dr Coughlan, the patient that most closely fitted the description was admitted on 22 January 1996 and died on 25 January 1996. Dr Coughlan noted that this was prior to the date that the nursing restructuring had been implemented and noted that the patient was 68 years of age, not 60 as stated in the Systems Failures report. The number of patients between the ages of 60 and 70 that had been admitted to the CCU or the step-down unit during the period investigated was only three.

Dr Coughlan further stated in a letter to the Director General that the patient had been seen on the morning of her death by a staff nurse and the patient "*had no chest pain or shortness of breath since transfer to the ward*". She had been given paracetamol for a high temperature. Further, the patient was seen four hours later by a house surgeon and there were no signs of chest pain.

Dr Coughlan concluded that "*To me this does not appear to be an eventual avoidable death. Secondly there is no indication ... that there was inappropriate management"*. Dr Coughlan stated that he had discussed his findings with a cardiologist who agreed with his conclusion.

According to the Chairman of Canterbury Health, Dr Layton, the fact that the case of patient 2(d) could not be substantiated "*undermined the credibility of the CHMSA*" during the second Ministry of Health inquiry.

Ministry of Health Advises No Public Inquiry

On 21 October 1996 Dr Poutasi advised both Canterbury Health and the Christchurch Hospitals' Medical Staff Association that there was no evidence of a safety issue and therefore there was no need for a public inquiry. She appealed to staff to move forward. Dr Poutasi reminded staff that withholding evidence of matters relating to patient safety was a serious professional and ethical issue.

Dr Poutasi's appeal did not mollify the Christchurch Hospitals' Medical Staff Association, who continued to request an independent inquiry. Dr Poutasi again told the Christchurch Hospitals' Medical Staff Association on 21 November 1996 that she still had not identified a factual basis for a further independent inquiry.

A CLINICAL COMMITTEE JULY - OCTOBER 1996

Facilitation

There were several meetings between the Christchurch Hospitals' Medical Staff Association and Canterbury Health from July to October 1996 on the subject of establishing a clinical advisory body.

An advisor to the Minister of Health, Mr Doug Martin, facilitated these meetings. Mr Martin was employed to "trouble shoot" between clinicians and management, as a result of the stalemate reached over the format of a Professional Advisory Committee/Clinical Board.

Mr Martin advised that the proposition that emerged from the discussions was that there should "*be a joint/clinical management committee to make recommendations on matters relating to the clinical management of the hospital. The CEO would have been on this committee, which would have advised the Board*".

Stumbling Blocks

An Executive Committee Planning and Policy has been proposed by the Christchurch Hospitals' Medical Staff Association since April 1996. At the time of the facilitated meetings with Mr Martin, certain members of the Christchurch Hospitals' Medical Staff Association accepted that personalities had come into play in relationships with management and offered not to put themselves forward as representatives to be on the Executive Committee Planning and Policy as an act of good faith.

The Christchurch Hospitals' Medical Staff Association initially insisted on the committee having joint decision making power on any matter which impacted on clinical practice. A definition of clinical practice was not put forward, but, according to Mr Martin, the senior medical staff were clear that they did not want a say in everything but only to consider issues with a substantial clinical effect.

Mr Martin advised the Commissioner that at one point the parties had come close to resolution. It appears from the minutes of a meeting held on 30 October 1996 that the parties had reached agreement on:

(a) membership of the Committee;

(b) appointment of members from staff groups; and

(c) the period of appointment.

However there were some fundamental points on which Canterbury Health and the Christchurch Hospitals' Medical Staff Association could not agree. These were described by Mr Martin as "*stumbling blocks*". They were:

whether there should be direct access to the Board from the committee; and

the innate distrust between the parties.

In Dr Layton's view, one contributing factor to the failure to reach agreement was the question of who would chair the committee. The Christchurch Hospitals' Medical Staff Association indicated that the Chairman should be chosen by members of the committee annually, whereas Canterbury Health indicated that the Chief Executive should chair the committee.

Dr Layton advised the Commissioner that the offer by certain members of the Christchurch Hospitals' Medical Staff Association not to put themselves forward was never conveyed to him. He further said that "*the CHMSA did not just "want a say", they insisted that the Executive Committee Planning and Policy*

hold the decision making power. What they were offered and rejected repeatedly was the opportunity to "have a say"."

New Chief Executive

Mr Martin also commented that the appointment of the new Chief Executive of Canterbury Health, Mr Richard Webb, designate from October 1996, may have hindered resolution. Mr Martin commented that Dr Layton had wanted to keep the options open for the new Chief Executive.

Clinical Policy and Planning Committee

Since April 1997 there has been a Clinical and Planning Policy Committee at Canterbury Health. Two of the senior members of this Committee were former Executive members of the Christchurch Hospitals' Medical Staff Association who lost the contested election in April 1996. It is an advisory body to the Chief Executive on clinical planning and policy issues. The proposed membership of this Committee was to be:

"*Chief Executive, Canterbury Health (Chair)*

General Manager, Christchurch Hospital Services

1 x Board Member

Chief Nurse

Chief Medical Advisor

3 x Elected Clinical/Medical Directors

3 x Elected Representatives - Senior Medical Staff

3 x Elected Representatives - Nursing Staff

1 x Elected Allied Health Representative

University Representative".

The Christchurch Hospitals' Medical Staff Association has not elected its three representatives. The "sticking points", according to the Christchurch Hospitals' Medical Staff Association, were as follows.

(a) All representatives on the committee are not democratically elected (Medical Advisors and Clinical Directors are appointed by management rather than elected by all the senior medical staff. The Clinical Director representatives on the Committee were elected by the other Clinical Directors only).

(b) If three people disagree with a decision of the committee they should be able to take their concerns to the Board (currently the Chief Executive decides whether a matter is to go to the Board).

(c) The Christchurch Hospitals' Medical Staff Association believes that it is vital to the efficacy of the committee that there is an adequately qualified administrative assistant to the committee, located on the hospital site to ensure constant availability, to help the committee with research. (The company secretary has been proposed for this function and the Association are of the view that he would not have the time or appropriate skills to fulfil this function).

(d) Christchurch Hospitals' Medical Staff Association does not believe that it is appropriate for Canterbury Health's Communications Manager to be present at meetings (because it is an advisory committee and that advice needs to be approved by the Board).

Although Christchurch Hospitals' Medical Staff Association has advocated a small committee, they have conceded that the General Manager and Director of Nursing will be on the committee. They do not believe it is appropriate for a Board member to be on the committee. It has been agreed that the Medical Advisor and Clinical Director representatives will stand down, the former for at least a trial period.

Having an Executive Committee on Policy and Planning to advise the Board is important to Christchurch Hospitals' Medical Staff Association "*because of the history of what has happened at Christchurch Hospital*". Canterbury Health advised that the Committee has been very frustrated by the Christchurch Hospitals' Medical Staff Association's attitude and requests. This was particularly due to the fact that many of the Christchurch Hospitals' Medical Staff Association's objections have been in relation to initiatives agreed by the committee itself (such as the committee's idea for the Communications Manager to attend all meetings so that the decisions reached are promulgated to the staff).

THE PATIENTS ARE DYING REPORT, 24 DECEMBER 1996

The Second Report by the Christchurch Hospitals' Medical Staff Association

On 24 December 1996 the Christchurch Hospitals' Medical Staff Association delivered to Canterbury Health, the Director General of Health and the Minister of Health a report entitled "Patients are Dying: A record of system failure and unsafe healthcare practice at Christchurch Hospital" (the Patients are Dying Report). The letter to Canterbury Health accompanying the report stated:

"*The accompanying material documents lack of planning and poor communication within Canterbury Health. Four cases of death since June are recorded that have been reported to CHMSA and also to management. It appears that in three of the cases, systems failure lead to the patient's death.*

A number of other cases involving systems failure at Canterbury Health are documented. Some of these reports are from letters written to CHMSA from patients not satisfied by management's response to their complaints. Other reports are from junior nurses and doctors who have asked that their identities remain confidential for fear of recrimination.

This is justified. The corporate style of this CHE was foreshadowed by its predecessor. A statement [by the Crown Health Enterprise Advisory Committee] *secured under the Official Information Act on the formation of Canterbury Health said:*

"*We believe that continued opposition by a small group of staff can be managed by CHE Boards whose first priority should be to address issues of formal employment contracts for their staff with the CHE*".

Quite clearly, at the time of the nursing restructuring, nurses who had spoken out or were prepared to, were not reappointed.

Suggestions to improve the systems and warnings about the failures go back two years and the advice and warnings have almost completely gone unheeded. This advice from multiple sources included the management of winter.

The advice and warnings have come from:

Clinical Directors

Individual nurses

The Board's Professional Medical Advisors

The Association of Physicians

Christchurch Hospitals Medical Staff Association

New Zealand Nurses Organisation

The Resident Medical Officers

Members of the Professional Nursing Unit.

Compromised safety has been a serious issue for at least a year and CHE Board and management have refused to accept the problem. The response time is unacceptable as are the excuses of winter and other factors, such as lack of sufficient detail in the previous case reports.

It is not acceptable to simply replace the Chief Executive Officer and expect someone new to the public health system to be able to correct the underlying problems without independent assistance.

We add in this document four cases, some of which have been known to management for months. A systems failure has been the major factor in three of the deaths and a significant factor in the fourth. These are the same system failures which have been repeatedly identified since May of this year, without significant action being taken on the technicality that the patients' names and dates were not known. This approach is not acceptable.

The staff voted last week, 2:1 for partnership decision making on all these issues, which has continued to be unacceptable to yourself and all the Board.

An independent review of all these cases is now justified".

The Patients are Dying Report consisted of five parts.

"**Part 1: 4 Deaths**" consisted of four brief summaries of the events surrounding the deaths of four unidentified individuals at Christchurch Hospital, together with several related letters.

"**Part 2: A litany of complaints**" substantially incorporated the "Systems Failures Threatening Patient Safety at Christchurch Hospital" report prepared by the Executive of the Christchurch Hospitals' Medical Staff Association and Christchurch representatives of the New Zealand Nurses Organisation and sent to the Minister of Health on 12 September 1996. There were some minor changes in wording, together with additions annotated as having been made on 23 December 1996.

"**Part 3: Unheeded staff advice on Systems and Safety"** contained four examples of unheeded staff advice, together with associated correspondence. Examples include a Proposal to Pilot Patient Management System Nursing Modules (purportedly presented to management in November 1994) and a New Zealand Nurses Organisation proposed joint working party with Canterbury Health (supported by correspondence dated August 1995). The minutes from meetings, on 28 September 1995 and 4 October 1995, to discuss ways of improving the efficiency of admitting, processing and discharging acute medical patients and a statement from the Canterbury Association of Physicians containing four recommendations concerning the restructuring of nursing at the Christchurch Hospital (contained in a letter dated 23 November 1995) were also included.

"**Part 4: Unheeded warnings on compromised patient safety**" consisted of eighteen examples relating to concerns regarding the Proposals for Change and compromised patient safety. The examples are mainly various correspondence, dated between 31 August 1995 and 26 November 1996, from a variety of sources with a variety of recipients.

"**Part 5: Conclusion**" concluded that despite strenuous endeavours by medical and nursing staff, standards of care at the Christchurch Hospital had deteriorated to the point where potentially avoidable deaths had occurred.

Medical Advisors Review the Four Deaths

On 30 December 1996 the Medical Advisors were asked by the Chief Executive and the General Manager, Christchurch Hospital Services to review the four patient deaths reported in the Patients are Dying Report. The Medical Advisors released their preliminary findings to Canterbury Health on 6 January 1997. The Medical Advisors stated that "*we believe that the four patients named in the report, together with the rest of the report do identify a breakdown in systems which appear to be fuelled by lack of staffing, inappropriate deployment of staff to cover busy periods, and placements of patients in inappropriate ward areas*".

Following the review by the Medical Advisors, Canterbury Health wrote to the Ministry of Health on 8 January 1997 requesting an independent inquiry.

Prior to receiving the Patients are Dying Report the Ministry of Health felt it had insufficient information to recommend that the Minister of Health hold a formal inquiry. However on 14 January 1997 the Director General advised the Minister that the resolution of outstanding issues was not possible without significant official involvement. The Ministry's involvement was suspended when it became apparent that the Health and Disability Commissioner would conduct an investigation.

INTRODUCTION

1.1 This section is divided into four parts**:**

(a) patient deaths mentioned in the Patients are Dying Report;
(b) other deaths dealt with by the Coroner during the course of the inquiry;
(c) patients' comments about services; and
(d) the complaints procedure at Canterbury Health.

PATIENT DEATHS MENTIONED IN THE PATIENTS ARE DYING REPORT

Mr Moresby Fonoti

Background

Mr Fonoti was a Samoan man aged 36 who had immigrated to Christchurch with his family. On the night of 25 October 1996, Mr Fonoti and his wife attended a function at the Nga Hau E Wha national marae in Christchurch along with other members of the Samoan community. In the early hours of 26 October 1996, Mr Fonoti intervened in a fight that had broken out and was seen to be trying to calm those involved. Without warning he was punched in the face and collapsed to the ground. He struck his head heavily on the chipseal surface and then lost consciousness for approximately five minutes.

Circumstances of Admission and Management of Care

Mr Fonoti was taken to Christchurch Hospital by ambulance and admitted to the Emergency Department at 0240 hours. The ambulance officers observed that communication with Mr Fonoti was difficult but that his Glasgow Coma Score (GCS) was 15 (normal) at about 0220 hours.

Mr Fonoti's triage code was assessed at level 3, indicating he was an urgent patient who ideally should be seen by a doctor within 30 minutes of his arrival at Christchurch Hospital. According to the Coroner this code was appropriate for someone with moderate trauma.

An Emergency Department computer printout revealed that 191 patients were seen in the Emergency Department on Saturday 26 October. In the 18 minutes prior to Mr Fonoti's admission, three patients who had been at the same function as Mr Fonoti were admitted with stab wounds to the neck and thorax. Two of these were critically injured and fell into triage category 1, requiring immediate resuscitation. Because these two critically injured patients required resuscitation, Mr Fonoti was not seen by a doctor until 60 minutes after his arrival. In the opinion of the Coroner's Assessor this delay was not in itself crucial to the outcome.

A nurse recorded Mr Fonoti's Glasgow Coma Scale as 11 at 0240, 0300, and 0330 hours. At 0300 hours Mr Fonoti had equal and reactive pupils (three millimetres). Mr Fonoti was seen by a doctor at 0345 hours and assessed as 11/15 on the GCS. This was a clear reduction from the assessment of 15 made by the ambulance officers.

At the time of his arrival at Christchurch Hospital, Mr Fonoti appeared to be intoxicated and was uncooperative. The Coroner found Mr Fonoti had consumed up to 12 cans of beer over the course of the evening. His perceived lack of co-operation in examination was attributed to his being drunk and having a head injury. The doctor who initially assessed Mr Fonoti thought that Mr Fonoti might have

been speaking in Samoan. However, Mrs Fonoti advised the Commissioner that his comments were neither Samoan nor English and that she had not been able to understand him. Mrs Fonoti disputed the account of the house surgeon who first saw Mr Fonoti in the Emergency Department. The Coroner recorded "*As far as she knew he had only had about eight cans of beer at the function and she and her husband had been there for a long time"*.

On the death of Mr Fonoti four days after admission, Dr Sage, a forensic pathologist, requisitioned a blood sample from Mr Fonoti taken at 0355 hours on the day of his admission. This sample showed a blood alcohol level of 85 milligrams of alcohol per 100 millilitres of blood (which, for the purposes of comparison, is six milligrams over the legal limit for driving). Dr Sage thought the likely alcohol level on admission "*may have been substantially greater*".

Mr Fonoti was transferred from the Emergency Department at 0503 hours and admitted to Ward 14, a specialist urology ward whose staff do not ordinarily deal with neurological cases. There was some discussion in the Coroner's finding as to the responsibility for the decision to admit Mr Fonoti to Ward 14. Evidence was given to the Coroner that "*if a doctor is worried about a serious head injury, then there is a mechanism where they can refer such a patient to a neurosurgical ward"*. The evidence was that "[t]*he overall responsibility as to placement therefore rests with the doctor"*.

The policy for patients such as Mr Fonoti is that they are admitted under the general surgical team rather than the neurological surgical team if there is no evidence of serious head injury that would require immediate intervention. Mr Fonoti was assessed as being drunk and having a head injury, but he did not show any sign of having a serious brain injury.

A skull x-ray was ordered "*en route to the ward*", but this x-ray was never performed. It is not clear from the evidence provided to the Commissioner why the skull x-ray was never performed. However the Clinical Director, Emergency Department, told the Coroner that "... *its my underst*[a]*nding th*[a]*t on the night in question x-ray was overloaded and it w*[ou]*ld h*[a]*v*[e] *b*[ee]*n safer for a patient to be observed in a dep*[artmen]*t or a ward rather than be left in a queue in the x-ray dep*[artmen]*t*". A skull x-ray does not have a high diagnostic value in the absence of external evidence of a severe head injury. Although there is a Computerised Tomography (CT) scanner in the Radiology Department, Mr Fonoti was not scanned immediately because he had shown no obvious signs of having a neurological injury.

At approximately 0500 and 0600 hours a Glasgow Coma Scale assessment of 7 was recorded by the nurse on Mr Fonoti's observation chart in the ward. It was also recorded that both pupils were significantly dilated at six millimetres, yet reacting normally to light. This indicated that his condition had deteriorated seriously. The Coroner found that the duty night surgeon was not alerted to this deterioration, but only that Mr Fonoti had arrived at Ward 14. The reduction in the Glasgow Coma Scale was the key finding indicating serious deterioration.

At 0600 hours the house surgeon attended Mr Fonoti. He found only the right pupil to be dilated. After reviewing Mr Fonoti's notes, speaking with his wife, and performing a neurological examination, it was apparent that Mr Fonoti's condition had deteriorated significantly. The house surgeon immediately contacted the surgical registrar who arrived shortly afterwards. The surgical registrar subsequently contacted the neurosurgical registrar and the anaesthetic registrar. An urgent CT scan was arranged. The CT scan at 0748 hours revealed a large right-sided extradural haematoma.

Mr Fonoti was then taken to the operating theatre where an emergency craniotomy and evacuation of intra-cranial haematoma was performed. Mr Fonoti was nursed in the Intensive Care Unit until 2145 hours on 30 October 1996, when, after discussion with the family, his ventilatory support was withdrawn and he died.

Coroner's Findings

The Coroner reached the following conclusions:

(a) Mr Fonoti's perceived lack of co-operation on examination was likely to have been attributed to a combination of the effects of alcohol, pain in the head and recent concussion.

(b) The decision to defer the CT head scan "*though perhaps not ideal, was a reasonable option*" and that "*One might expect that an experienced senior clinician might be consulted over (whether a CT scan should have been ordered)*". The decision not to call in a specialist emergency physician, given the sudden heavy loading the Emergency Department was under, was a matter of judgement on the part of the staff in the department.

(c) If the Emergency Department guidelines that are now in place had been in operation in October 1996, Mr Fonoti would have met the criteria for an urgent or semi-urgent CT head scan and for admission to a neurosurgical ward. The fact that the Emergency Department guidelines for the admission of head injured patients had not been updated since October 1984 was a contributing factor to the decisions made following the medical assessment at 0345 hours. The old guidelines contained no reference to the use of CT scans.

(d) Part of the reason the house surgeon was not alerted to Mr Fonoti's deterioration was the weight given to the history of the consumption of alcohol. "*Where there is doubt, the better course is to assume head injury, not alcohol, is responsible for functional deterioration. The expert evidence is that the assessment of such a patient following a head injury and in the presence of alcohol is particularly difficult*".

(e) Because Mr Fonoti's primary language was not English, it is possible that this created difficulties in interpreting his verbal responses. Mrs Fonoti was present throughout and might have assisted. Christchurch Hospital has an interpretation service and there is a method of getting access to that service. However evidence was given that "*it would not have been practicable to employ it in this particular case*".

(f) Given the shortage of beds in Christchurch Hospital at the time, and symptoms being displayed by Mr Fonoti, the admission of Mr Fonoti to a general surgical ward with a nurse separately observing him fell within accepted practice.

(g) Mrs Fonoti's expressions of concern about her husband's deteriorating condition to nursing staff at about 0400 hours and again in the ward about an hour later were given insufficient weight.

(h) While it was not possible to say with certainty that Mr Fonoti would have survived if the correct diagnosis had been made immediately following the deteriorating neurological observations at 0300 hours, the likelihood of Mr Fonoti surviving emergency surgery would have been considerably enhanced.

The Coroner found Mr Fonoti's cause of death to be "*closed head injuries causing severe extradural haemorrhage and subsequent complications*".

Coroner's Recommendations

The Coroner made the following recommendations:

(a) that medical staff working on rotation through the Emergency Department have specific instruction on the management of head injury cases;

(b) that the interpreter service at Christchurch Hospital be examined to ensure, as far as is practicable, that access to it is available 24 hours a day;

(c) that guidelines be introduced for the measurement of blood alcohol levels of patients who are admitted to the Emergency Department with head injuries or who are known or suspected to have been drinking alcohol; and

(d) that there be regular in-service nursing training in the assessment, recording and interpretation of neurological symptoms and signs.

Concerns of the Patient's Family

Mrs Fonoti was concerned about the care that her husband received while he was in Christchurch Hospital. Mrs Fonoti stated that she did not feel comfortable with the way that Mr Fonoti was dealt with in the Emergency Department. Mrs Fonoti believed that Mr Fonoti "*may not have been given the priority he was entitled to because he had been drinking and because he was Samoan*". She felt that her concerns regarding her husband's deterioration were not taken seriously by medical staff in the Emergency Department.

Mr Brian Gardiner

Background

Mr Gardiner was a 49 year old owner-operator of a taxi from Christchurch. He kept "generally good health" although he suffered from rheumatoid arthritis which required regular medication and monthly injections. Mr Gardiner had been feeling unwell for up to two weeks before his admission to Christchurch Hospital.

Circumstances of Admission

On 23 September 1996 Mr Gardiner was referred to the Christchurch Hospital Emergency Department by his general practitioner. He had been feeling unwell for most of the day and had been experiencing gastric pain and blood in his bowel motions. The general practitioner correctly diagnosed that Mr Gardiner was suffering from a gastrointestinal haemorrhage. The general practitioner arranged for an ambulance and spoke to the acute surgical registrar to inform him of Mr Gardiner's condition. Intravenous saline was administered to Mr Gardiner upon arrival of the ambulance at Mr Gardiner's home.

Mr Gardiner was admitted to the Emergency Department at 1946 hours. At that time, the Emergency Department was in a state of overload. Waiting times to see a doctor were prolonged even for patients in triage categories 2 and 3. On arrival, Mr Gardiner appeared to be stable and, for that reason, he was not examined by a doctor in the Emergency Department. This was in accordance with Christchurch Hospital's policy for referrals from general practitioners.

The surgical registrar who had been advised of Mr Gardiner's condition was unable to see Mr Gardiner when he arrived because he was in theatre, so he delegated responsibility to a surgical house surgeon. The house surgeon was also busy with another patient. When the house surgeon arrived at the Emergency Department at 2100 hours, Mr Gardiner was about to be transferred to the ward. The house surgeon said he would assess Mr Gardiner once he got to the ward.

Mr Gardiner was admitted to the acute surgical ward at 2130 hours, although he had been discharged from the Emergency Department at 2040 hours. The Coroner thought that the likely explanation for the delay was that, although logged out of the Emergency Department at 2040 hours, the physical process of transfer did not occur until some time later.

By the time that Mr Gardiner arrived at the ward, the house surgeon had been called away to attend an acute admission. The registrar was still delayed in theatre and, as a result, Mr Gardiner was seen on the ward by a trainee intern. Due to the intern's inexperience, he failed to recognise the seriousness of Mr

Gardiner's situation. The trainee intern did arrange for blood samples to be sent to the laboratory but there was a considerable delay in obtaining the results because the samples were not immediately collected by an orderly from the ward. The house surgeon ended up taking the samples to the laboratory himself. Mr Gardiner was not examined by a more senior doctor until 2330 hours when he was given a full and appropriate review by the medical team.

Mr Gardiner's blood results were received back on the ward at 0025 hours. However, 35 minutes later Mr Gardiner suffered a cardiac arrest. All attempts to resuscitate him were unsuccessful.

Coroner's Findings

The Coroner concluded that the following were the major factors contributing to Mr Gardiner's death:

(a) the lack of early assessment by a doctor in the Emergency Department and drawing of blood for analysis and cross-match at that time; and

(b) the inability of relatively inexperienced medical staff to recognise the precarious nature of his physiological status.

Nevertheless, the Coroner felt that the evidence fell short of forcing him to conclude that in terms of proper practice on the part of any individual, the death ought not to have occurred. The Coroner was of the opinion that, given the clinical signs (of relative stability) exhibited by Mr Gardiner and the demands on the Emergency Department during the period, the Emergency Department staff acted appropriately in their treatment of Mr Gardiner.

The Coroner found that the cause of Mr Gardiner's death was "*myocardial infarction with very recent extension of infarction secondary to a large gastrointestinal haemorrhage*".

Coroner's Recommendations

The Coroner made the following recommendations:

(a) that protocols for shared responsibility of patients being admitted through the Emergency Department to the Department of Surgery be further defined if this had not already occurred;

(b) that consideration be given to establishing a protocol for the reporting of acute admissions to surgical consultants in the event that registrars are detained unavoidably in theatre;

(c) that the limits of responsibility of trainee interns with respect to acute admissions be reviewed, and that the trainee interns' Programme Manual be redrafted to make it much clearer that all of the work of trainee interns must be supervised by a medical practitioner; and

(d) that the system of transfer of blood samples to the laboratory be reviewed.

Concerns of Patient's family

Mr Gardiner's twin brother, Mr Murray Gardiner, complained that he had had difficulty obtaining an explanation for his brother's death. He had made three or four calls to the ward where Mr Gardiner had been admitted, but could not obtain any information. Mr M Gardiner wrote, with assistance from his Member of Parliament, to Canterbury Health for information. This was not forthcoming for approximately four months.

Mr M Gardiner was also very concerned about the standard of care that his brother had received. Mr M Gardiner stated that "*on the night in question there were insufficient senior medical staff on duty*" and that there was a "*definite systems failure*". According to Mr M Gardiner, he had been told that

"*it was cheaper to put a patient in a ward for the night than to keep them in Accident and Emergency"*.

One of the difficulties Canterbury Health experienced with respect to Mr Gardiner's hospital admission and death related to issues of information privacy. Mr Gardiner was married but had been separated for many years. The next of kin details recorded were those of his wife even though he was in a new relationship. Mr M Gardiner felt legally entitled to the information concerning his brother and when informed by Canterbury Health in January that his twin was one of the four deaths mentioned in the Patients are Dying Report, felt further frustrated when unable to obtain more details from Canterbury Health.

Ms Bridget Garnett

Background

Ms Garnett was a 22 year old sickness beneficiary from Christchurch who had a history of various mental health problems including depression and anorexia nervosa. The Coroner was told that Ms Garnett had previously manifested suicidal tendencies, involving both drug overdoses of varying degrees and minor lacerations to the arms.

Circumstances of Admission

On 13 June 1996 Ms Garnett came to believe that her relationship with her partner was under threat. Ms Garnett was distressed and took an overdose of drugs. She arrived at Christchurch Hospital at 1548 hours, approximately an hour and a half after she took the overdose.

Upon admission, Ms Garnett was co-operative with treatment. When asked by a doctor what medication she had taken, Ms Garnett replied that she had consumed 40 moclobemide tablets and her normal medication. When asked what her normal medications were, Ms Garnett could not recall but stressed to the doctor that she had not taken an overdose.

Ms Garnett was administered 50 grams of activated charcoal though a nasogastric tube within 12 minutes of her admission to the Emergency Department. Her blood pressure, pulse and temperature were all recorded to be normal. Following this procedure, Ms Garnett was transferred to the Medical Day Unit adjacent to the Emergency Department.

Approximately four hours after being admitted to Christchurch Hospital, Ms Garnett's condition began to deteriorate. She was reported to have a very high heart rate, was flushed, sweating, and appeared to be hallucinating. At 2115 hours Ms Garnett suffered a cardiac arrest. Resuscitation attempts were unsuccessful.

Coroner's Findings

The post-mortem revealed that Ms Garnett had ingested lethal quantities of the drugs moclobemide and clomipramine, each being capable of causing death. It was noted by the Coroner that the combination of the two drugs would be "*life-threatening, even in the absence of the lethal quantities of drug present"*. The Coroner formed the opinion that even though the presence of the clomipramine was not known when she presented at the hospital, "*by the time she was admitted to hospital, there was little … which could have been done to save her"*.

The Coroner was satisfied that Ms Garnett had been treated both promptly and appropriately at Christchurch Hospital and that the cause of her death was "*suicide by the ingestion earlier that day of lethal quantities of the prescription drugs Clomipramine and Moclobemide"*. However, even though Ms Garnett was given charcoal promptly, there was a considerable delay until she was seen again by a doctor.

Mrs Nancy Malcolm

Background

Mrs Malcolm was an 80 year old woman from Christchurch. According to the Coroner, she was an "*independent woman who lived on her own*", but kept in close contact with her son and her neighbours. Mrs Malcolm had a history of problems with her health, particularly her breathing. However, with support from her son and her neighbours "*she cared for herself and looked after herself*".

Circumstances of Admission

On 16 June 1996, Mrs Malcolm "*took a turn for the worse*" and called her general practitioner, who promptly referred her to Christchurch Hospital. While the general practitioner's diagnosis was asthma, the medical registrar was advised of Mrs Malcolm's past history of heart failure.

Mrs Malcolm was admitted to the Emergency Department at 0954 hours. Mrs Malcolm was assessed as triage category 4, for which the requirement is that the patient should be seen by a doctor within one hour. She was examined by a medical officer of special scale, an experienced medical practitioner, at 1110 hours. Her condition at that time was described as stable. She was prescribed Ventolin and Atrovent to be administered by nebuliser.

At 1145 hours Mrs Malcolm was placed in the Medical Day Unit, having been assessed by nursing staff and a senior doctor. Her condition was still noted to be stable. She was transferred to Radiology at 1252 hours. The medical registrar assessed Mrs Malcolm at 1330 hours. After this, her condition deteriorated suddenly and she died despite attempts at resuscitation.

Evidence was given to the Coroner that on the day of Mrs Malcolm's admission to Christchurch Hospital a large number of seriously ill patients had presented to the Emergency Department causing prolonged waiting times for patients assessed as falling within triage categories 2 to 5. There were insufficient inpatient hospital beds to accommodate all of the admissions and some patients, including Mrs Malcolm, were admitted to the Medical Day Unit .

Coroner's Findings

The Coroner agreed with the following findings of the Assessor assisting.

(a) Mrs Malcolm's admission to the Emergency Department and her relocation to the receiving ward (the Medical Day Unit) was handled appropriately and she was overseen by both nursing staff and a medical practitioner during that time (although she was not specifically assessed between 1145 and 1330 hours).

(b) The assessment by an experienced medical practitioner, in the absence of the medical registrar, was appropriate.

(c) Given how busy the hospital was on the day, the time taken to obtain the chest x-ray was appropriate.

(d) The timing of Mrs Malcolm's death could not have been predicted and, given that severe myocardial ischaemia was identified at autopsy, it is doubtful whether her death could have been prevented.

The Coroner found that the cause of Mrs Malcolm's death was "*myocardial infarction, associated with underlying ischaemic heart disease and aortic stenosis*".

OTHER DEATHS DEALT WITH BY THE CORONER DURING THE COURSE OF THE INQUIRY

Mr Brian Brown

Background

Mr Brown was a 57 year old man who lived in Christchurch and owned a shop in partnership with his wife.

Circumstances of Admission

On 21 June 1996 Mr Brown was admitted to Christchurch Hospital, having been diagnosed with pneumonia by his general practitioner. Following a course of antibiotics in hospital, Mr Brown was discharged four days later as his condition had improved. He was discharged on the basis that he would be reviewed by his general practitioner after one week, and his family was to report any deterioration. Mr Brown was readmitted to Christchurch Hospital on 9 July 1996. He was diagnosed once again with pneumonia. His condition was worse than that observed upon his admission in June.

The working diagnosis of the medical staff was that Mr Brown's symptoms were attributable to pneumonia. The possibility of pulmonary embolism was considered by the registrar on 11 July but this diagnosis was discounted due to other symptoms that were presenting in Mr Brown. The Coroner's Assessor stated that in relation to the pulmonary embolism "[t]*here were clues to be recognised but perhaps more easily so with hindsight"*. Mr Brown died on 15 July 1996. In the view of the Coroner's Assessor, "*there was ... underlying disease process throughout the two admissions*".

The findings at post-mortem showed the principal cause of death as "*multiple pulmonary emboli and infarcts from pelvic venous thrombosis and from possibly right atrium"*. This differed from the cause of death stated on the medical certificate which recorded "*aspiration pneumonia*" as the direct cause of death.

Coroner's Decision to Initiate Inquest

The Coroner had received notification of Mr Brown's death but had initially declined jurisdiction to initiate an inquest. However, in the light of the allegations contained in the Patients are Dying Report and in an article in *The Press* on 22 January 1997 that suggested inadequacies in the treatment of Mr Brown contributed to his death, the Coroner resolved to open an inquest into the cause of Mr Brown's death.

Coroner's Findings

The Coroner made the following findings.

(a) There was no evidence to support Mrs Brown's accusation that hospital staff who treated Mr Brown lacked the experience to deal with his condition.

(b) Given Mr Brown's underlying disease processes and other evidence put forward at the inquest, it was appropriate that Mr Brown was treated in the Oncology Ward.

(c) The other factors that had concerned Mrs Brown, such as a mix up with beds and Mr Brown's fall, did not have any bearing on the causes and circumstances of death.

(d) Although the medical team had proceeded with an incorrect diagnosis, this was not unreasonable given Mr Brown's symptoms.

(e) There was no evidence to support Mrs Brown's claim that the cause of death was not explained to her.

In relation to Mrs Brown's criticism that her husband had not at any time been referred to a cardiologist, the Coroner's Assessor found that a cardiologist had not been consulted because the doctor in charge believed that she had an explanation for the patient's illness. In the opinion of the Coroner's Assessor "*an illness such as Mr Brown experienced …would warrant consultation with a chest physician and probably with a cardiologist"*. He added further that "*in the practice of Medicine a commitment to early consultation in puzzling clinical situations is a valuable exercise even if the outcome is only to confirm the clinician's own conclusions"*.

The Coroner and the Coroner's Assessor stated that "*pulmonary thromboembolism is still a treacherous disease both to diagnose and to treat. It is by no means certain that had the diagnosis been made early on, treatment would have prevented death"*.

The Coroner had no recommendations or further comments to add other than that the jurisdiction of the Health and Disability Commissioner may extend to some aspects of Mrs Brown's complaints.

Concerns of Patient's Family

Mrs Brown, who was present for much of the time during Mr Brown's July admission, raised a number of concerns at the inquest about the treatment of her husband while he was in hospital. The Coroner summarised these as follows:

> "*On admission to Ward 30, he was drinking "like a fish" desperately trying to bring up thick black tar-like phlegm; there was a mix up with beds; Mrs Brown had to "put him on (her) shoulders and carry him to the toilet"; Mrs Brown had to keep getting him drinks; a female nurse suggested that Mrs Brown* ['s assistance] *was required to keep the oxygen mask on* [Mr Brown]*; there was a large coldsore on the inside of his nose affecting the fitting of the oxygen mask; in the X-ray department his "drip was leaking blood and fluid onto the floor", he had a "mouthful, a fistful of black phlegm"; Mrs Brown accompanied her husband during a lumbar puncture, he was subsequently "screaming with pain"; he had fallen on the floor over a tea break; he was not placed in the correct ward, the staff lacked the experience to deal with his condition; at no time was he referred to the cardiologist; no-one explained the cause of death; she could not understand why the Coroner had not held an inquest at the time*".

As well as raising her concerns at the inquest, Mrs Brown had complained to one of the doctors at Christchurch Hospital about the treatment that her husband had received. She felt that her husband was "*treated poorly … and that they do not have the staff to function properly*". Mrs Brown told the Commissioner that the doctor did not explain her rights under the Code of Rights or about her ability to complain under the Health and Disability Commissioner Act. According to Mrs Brown, the doctor told her that her complaint was "*political and that* the *best people to see about* [the] *complaint were politicians*".

Mrs Brown tried various other ways to get her complaint acknowledged. She contacted her local Member of Parliament and the Patient Advocacy Service. She had an interview at the Patient Advocacy Service and stated that when she was with the patient advocate, she thought that person was the Commissioner.

Mrs Brown advised that she also had difficulty gaining access to her husband's medical records. Originally she was informed that she had no rights to the medical records. On subsequent enquiry, Mrs Brown was advised that she could have a copy of the records but that the person who did the photocopying was away on holiday and that she would have to wait. Mrs Brown eventually gained access to the records but had to pick them up personally from the hospital. Mrs Brown said it was a "*terrible ordeal*" to have to "*again visit the hospital where* [her] *husband had died and where* [she] *had had to carry him around while he was seriously ill*".

Mrs Brenda Watson

Background

Mrs Watson was a 71 year old widow from Christchurch. She had three adult children who all live in the Canterbury region.

Circumstances of Admission

On 4 June 1996 Mrs Watson was admitted to Christchurch Hospital with a number of complaints and background illnesses. Mrs Watson's physical condition gradually deteriorated from the date of her admission until she died on 16 June 1996. At the post-mortem, the cause of death was established as a perforated gastric ulcer with peritonitis.

A chest x-ray had been ordered for Mrs Watson at 1048 hours on 12 June and was taken at approximately 1105 hours that day. The x-ray was seen by a consultant radiologist mid afternoon. The consultant noticed an "*unexpected and untoward finding*" of a large amount of free gas in the peritoneal cavity and reported this to a nurse on duty in Mrs Watson's ward. The Coroner found that this information was not passed on to the doctor. There had been no registrar on duty on 12 June due to sickness. In the Coroner's opinion, if there had been a registrar on duty it is likely that the radiologist would have communicated the unexpected x-ray findings to the registrar. The house surgeon did not see the faxed radiology report until the following morning. By that time Mrs Watson's condition had deteriorated significantly.

When the serious nature of Mrs Watson's condition became apparent, urgent surgery was organised. Initially Mrs Watson gave her consent to an operation and was prepared for theatre. Subsequently she stated that she did not want the operation. A powerful factor in her decision not to undergo surgery was the possibility that if there was perforation of the bowel, surgery would have been more complicated and would have required any obstruction of the bowel to be relieved by a colostomy.

Evidence was presented to the Coroner that indicated that Mrs Watson's chances of successful surgery on 12 June were in the vicinity of 50% but had reduced to 20-30% the following morning. Other evidence was given to suggest that the operative risk would have been the same if the operation had taken place on 12 June.

Concerns of Patient's Family

Mrs Watson's family were concerned about the care that Mrs Watson had received in Christchurch Hospital. The family alleged, among other complaints, that there was a delay in a crucial x-ray report reaching Mrs Watson's physician and that insufficient pain medication on at least two nights sapped Mrs Watson's strength and contributed to her death.

Mrs Watson's family utilised the hospital's internal complaints procedures prior to the inquest. Canterbury Health acknowledged that there were unacceptable delays in taking action on Mrs Watson's x-ray findings. The Patient Care Manager, Christchurch Hospital Services wrote to the Watson family on 14 November 1996 stating "*there has been a lot of ongoing discussion about your mother's case and how we failed to meet many of your mother's and your family's needs when she was in hospital*". As a result of discussions between the hospital and the deceased's family, the hospital resolved to establish the following protocols which had been recommended by a Medical Advisor.

(a) Communication of an unexpected and potentially serious x-ray finding must be doctor to doctor. In the evening the radiologist must contact the duty medical registrar.

(b) The radiologist must document in the written report that he or she has passed the information on to the duty medical registrar.

(c) Ward staff are to document in the notes any information relating to the patient that might be of significance.

(d) Each facsimile received after hours in the ward is to be read by nursing staff and action taken whenever results are obviously abnormal or flagged as abnormal.

(e) Written statements are to be given to patients and families advising of the people responsible for their care.

(f) The wards and resident medical officers are to be advised of the names of general medicine consultants to contact out of working hours.

(g) Laminated signs are to be displayed in medical wards with information as to whom to contact if there are concerns regarding a patient's care.

Coroner's Findings

The Coroner found that the cause of Mrs Watson's death was "*a perforated gastric ulcer with peritonitis*".

In relation to the concerns of the Watson family, the Coroner found that any failure to provide pain medication was not relevant to the circumstances of Mrs Watson's death. The Coroner made no formal recommendations but supported the changes that had been recommended by a Medical Advisor. The Coroner noted that it was the efforts of Mrs Watson's family that had brought about these significant changes in procedures at Christchurch Hospital. The Coroner suggested formalising a protocol on handover between one medical team and its successor to best ensure that significant matters relating to a patient are brought to the attention of the incoming team.

New Protocols

The Commissioner was advised that the protocols recommended by a Medical Advisor had been established at Christchurch Hospital in November 1996. The Medical Advisor advised that among others, the communication issue between the Radiology Department and medical staff had been addressed, that a form had been developed to provide information to patients about who was responsible for their care and that laminated signs had been placed in medical wards to inform patients and family whom to contact if there are any concerns about patient care.

Commissioner's Investigation

In an interview with the Commissioner, the Watson family expressed particular concern that assumptions had been made about their mother because of her age. The Watson family informed the Commissioner that their mother "*water skied at Christmas time, she gardened, she rode a bike, she hardly had a grey hair in her head. For a 71 year old ... she was reasonably fit*" and that without their continual discussions with Canterbury Health, the full details regarding the circumstances of their mother's death would never have been known.

In August 1997 the Watson family continued to be unhappy about the way Canterbury Health had dealt with their complaints. These complaints are dealt with later in this section of the report.

In relation to the protocols adopted after Mrs Watson's death, the Commissioner was advised that "*monitoring of the protocols is obviously a line management function. However, on top of this* [Canterbury Health] *have instructed the Risk Manager and Quality Assurance team to audit the Coroner's findings. However, obviously because of the inquests there has been a focus on these issues by staff*". In March 1998 the Commissioner was advised that two audits of these protocols had now occurred.

Mrs Patricia Humphrey

Background

Mrs Humphrey was a 60 year old woman from Christchurch. She had been diagnosed with cancer of the gullet in 1993 following a period of difficulty swallowing food and fluids. She started on a course of radiotherapy to control the growth of the cancer.

In April 1996 Mrs Humphrey had a "stent" inserted into her gullet at Christchurch Hospital. A stent is a plastic tube which is inserted into the oesophagus to provide a passageway to the stomach for food and fluids. At some stage the stent slipped from its position and descended to Mrs Humphrey's stomach.

Circumstances of Admission

On 19 June 1996 Mrs Humphrey was readmitted to Christchurch Hospital to have another stent inserted. Following this operation, Mrs Humphrey developed abdominal pain and an x-ray revealed subdiaphragmatic air, consistent with a perforated organ. Mrs Humphrey was treated with IV fluid, analgesia and antibiotics. However, Mrs Humphrey's condition did not improve and she developed pneumonia. Mrs Humphrey died on 16 July 1996.

A post-mortem revealed that, among other things, Mrs Humphrey had a perforated stomach. The evidence was unclear as to whether the perforation had been caused by the displaced stent or by the placement of the second stent.

Coroner's Decision to Initiate Inquest

Mrs Humphrey's death was notified to the Coroner. The Coroner initially declined jurisdiction. However, following allegations by Mrs Humphrey's family, the Coroner decided to hold an inquest.

The family of Mrs Humphrey alleged that their mother received suboptimal care while at Christchurch Hospital and that the perforation of Mrs Humphrey's stomach was a major contributor to her death.

Evidence was given at the inquest that Mrs Humphrey's disease was "*beyond surgical treatment*" and that it was unclear as to what extent, if at all, the perforation of the stomach had affected the progression of her "*inevitably fatal*" disease.

Coroner's Findings

The Coroner found no evidence of medical misadventure in the case of Mrs Humphrey and found that the cause of Mrs Humphrey's death was "*aspiration pneumonia associated with inoperable carcinoma of the oesophagus"*.

Commissioner's Investigation

The Commissioner did not investigate the clinical aspects of Mrs Humphrey's treatment prior to 1 July 1996 as they could not amount to a systems failure in breach of the Code. However, the Commissioner did investigate matters relating to the complaints of Mrs Humphrey's family and these are dealt with later in this section of the report.

A review of Mrs Humphrey's file, which was received from the Patient Affairs Manager, showed that enquiries had been made of the medical staff involved in Mrs Humphrey's care. Certain medical staff responded to the Patient Affairs Manager's enquiries, although not all of the issues that Mrs Humphrey's family had raised were addressed. Mrs Humphrey's family confirmed in October 1997 that they still had not received from Canterbury Health the information they had requested.

PATIENTS' COMMENTS ABOUT SERVICES

Patient Feedback about Quality of Care

A number of patients and their family members approached the Commissioner with their comments on the quality of care at Christchurch Hospital. The consistent themes that emerged are set out below.

Emergency Department

At times care in the Emergency Department was less than optimal due to the number of patients being attended to, the lack of resources and perceived inadequate number of staff to monitor patients' needs. Some patients commented that they had waited on trolleys in corridors in the Emergency Department receiving minimal attention and were sent home with inadequate assessments of their ability to cope at home. Examples were given of patients requiring re-referral by general practitioners and having been called back because x-rays had been reviewed and serious injuries subsequently found. Some consumers commented that they had not received clear information about why there were delays and they did not appear to have been expected when referred from after-hours clinics.

Acute Admitting Wards

On occasion, care in the Acute Admitting wards was less than optimal. Patients commented that they did not always get their medication and it was difficult to know who was caring for them because many medical and nursing staff were rushing around. Patients also commented that they were moved from ward to ward and that this was confusing.

Paediatric Service

Examples were given about less than optimal care in the two Paediatric wards. These included lack of support, conflicting information and very busy staff who did not always provide consistent care or assistance. One consumer complained to the Commissioner that she was given inadequate information about her daughter's condition and "*little support to deal with the situation*".

Formal Care Co-ordination

Patients and family members described limited formal care co-ordination. Examples included the lack of a clear plan for patients with chronic disease, lack of a consistent person to ensure that follow-up care or referrals had been arranged or who could remember what had happened previously and the absence of a member of staff to call if problems arose.

Discharge Planning

Comments were received about inconsistent and inadequate discharge planning. Examples included receiving phone calls in the evening from the Hospital to advise that a patient could go home, lack of information about what follow-up care was planned and delay in receiving appointments.

Other Comments

Some consumers commented that cleaning of inpatient wards was not always adequate. One consumer advised the Commissioner that the "*state of showers and toilets were disgusting*".

The comment was made that nursing techniques were not always consistent. One consumer commented to the Commissioner that she found the "*nursing care, supervision and attitude unprofessional*".

The Commissioner was informed that patients who required assistance with sitting up and meals did not always get nursing attention and relatives planned their day to ensure they were present at meal times. There was also comment about the quality of the food, the lack of variety and the fact that food was cold on delivery. A patient complained to the Commissioner that "*one of the meals offered was about a cup of tinned spaghetti with a mound of mashed potato beside it. Hardly a nutritious appetising meal to offer patients struggling to eat because of their medical condition*".

Generally the feedback suggested some sympathy with the nursing and medical staff who were perceived as overworked and as trying to do their best in difficult circumstances. However there was comment about the attitudes of some of the staff who could be off-hand, stressed or lacking an awareness of what needed to be done. One family member complained to the Commissioner that when her mother was in hospital "*... she was not closely monitored as nursing staff seemed unable to accept her condition was serious. She was treated with a total lack of compassion and not helped with many tasks she was unable to perform herself*".

Some patients and families perceived that staff did not always listen to what they were saying and therefore did not always meet their needs. Consumers complained that there was a "*lack of communication and support for caregivers*" and that they were "*treated with disrespect, disregard, and neglect by some of the proffessional* (sic) *people*".

Concerns about the supervision of trainee surgeons are dealt with in the chapter on Supervision, Training and Credentialling.

THE COMPLAINTS PROCEDURE AT CANTERBURY HEALTH

Notification of Rights

Clause 1(3) of the Code of Health and Disability Services Consumers' Rights requires providers to inform consumers of their rights and enable consumers to exercise their rights. In order for consumers to complain effectively they must know what their rights are as consumers of a health service, as well as how to complain.

Complaints Procedure

Since August 1993, Canterbury Health has had a procedure for handling customer complaints. The procedure was set out in a document called "Customer Complaints Handling Procedures". The document provided guidance to all staff about how to receive and handle complaints, and also provided time-frames for the procedure. The document was included in the staff induction handbook.

Southern Regional Health Authority Audit in 1994

In 1994 the Southern Regional Health Authority commenced an audit of the complaints process at Canterbury Health. The objective of the audit was to ensure Canterbury Health had a widely publicised procedure for dealing with complaints. The Southern Regional Health Authority considered "*CHL to be only partially compliant with the requirements because of the need for them to further develop information materials for clients*". Canterbury Health was asked to develop these materials for clients by 30 June 1994. Southern Regional Health Authority informed the Commissioner that the audit requirements were met by Canterbury Health by 3 August 1994.

Advocacy

In addition to the "Customer Complaints Handling Procedures" document, a patient advocacy service was housed at the front entrance of Christchurch Hospital until March 1996. The service was established as a consequence of recommendations made in the Cartwright Report ("The Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into other related matters") and was independently funded by the Ministry of Health. The patient advocates were a constant physical presence in the corridors, wards and dining areas of Christchurch Hospital. The advocates made themselves known and were available to listen to consumers' complaints about services at Canterbury Health and to assist in the resolution of those complaints.

In early March 1996 the advocacy service moved out of the hospital. The move came about as a consequence of the advocacy service being given the task of providing advocacy to all consumers of health and disability services in the Canterbury region.

From 1 July 1996 Canterbury Health was obliged by Right 10 of the Health and Disability Services Consumers' Code of Rights to ensure that it had a system in place that facilitated consumers knowing where and how to complain. The Commissioner visited all Crown Health Enterprises in May and June 1996 to talk with senior staff about these obligations.

Complaints Policy

On 1 January 1997 a formal complaints policy came into force at Canterbury Health. This formal policy had "*evolved through a consultation process throughout 1996*". Canterbury Health recognised in the policy that "*in the past complaints coming into different parts of the organisation have been dealt with in a rather unco-ordinated way*".

Canterbury Health noted that

> "[b]*oth the Information Privacy Code and the Code of Health and Disability Services Consumers' Rights, require health service providers to have in place clear policies and procedures for the recording and management of complaints as they arise. Similarly Canterbury Health's policy of care provides for timely and fair means of handling difficulties or complaints*".

The policy stated that Canterbury Health

> "*will maintain an effective system for receiving, recording, reporting and monitoring of complaints from consumers of health and disability services provided by Canterbury Health, in a manner which is fair to all parties concerned*".

The policy sets out what constitutes a complaint and lists the objectives the policy is designed to achieve. The objectives are to:

(a) "*Impartially investigate all complaints ensuring that the rights of both the complainant and the complainee are respected.*

(b) *Monitor and process the outcome of all complaints.*

(c) *Ensure confidentiality and privacy of the individual is respected at all times in accordance with the requirements of the Privacy Act.*

(d) *Act at all times within the law and with respect for Human Rights, confidentiality and the principles of the Treaty of Waitangi.*

(e) *Respond appropriately and quickly to individuals and groups who have complaints about services provided by Canterbury Health*".

The policy also provides timeframes within which all complaints must be responded to:

(a) *"All complaints will be acknowledged in writing within five working days of receipt, unless resolved to the satisfaction of the consumer within that period.*

(b) *All complaints will be responded to in full within 20 working days. If further time is required for investigation or working through to resolution the consumer should be informed of this prior to the expiry of 20 working days from acknowledgement.*

(c) *Consumers will be given monthly updates if the Health and Disability Code* (sic) *resolution is taking longer than 20 days"*.

The Chief Executive, Mr Webb informed the Commissioner that the

"*Complaints Management Process is intended to be patient focused and is co-ordinated by the Patient Affairs Office, which oversees compliance with response times and has primary responsibility that affected staff have input into the complaints resolution process and that any complaints dealt with by this office comply with* [your] *Code, together with the legal obligations under the Health Information Privacy Code. Complainants are also informed of the service offered by the Patient Advocacy Service and of their right to approach the Health and Disability Commissioner direct*".

The Commissioner followed an individual complaint through the Canterbury Health complaints process. The Patient Affairs Office and the complaints process appeared to be well established and responsive to the needs of complainants. It was apparent that the processes had recently been reviewed and re-established but there are still some gaps in the complaints system.

Individual Consumer Complaints

Several consumers reported to the Commissioner that they did not complain to Canterbury Health because they did not know how to make a complaint. Other consumers advised that they did not complain because they were likely to need the services of Canterbury Health in the future and did not want to be on record as having complained. Some consumers reported that they did not complain because they saw their complaint as being about the system, rather than individual staff, and considered that a complaint to Canterbury Health was not a useful means of changing the system.

The following paragraphs illustrate problems consumers have had with the complaints process at Christchurch Hospital.

(a) On 31 August 1996 a 78 year old woman, Consumer A, was admitted to Christchurch Hospital with a fractured right arm. The injury required surgery. Following surgery a wound infection developed, causing numerous ongoing and distressing problems for the consumer. In April 1997 Consumer A had recovered sufficiently to write a letter of complaint and in this letter asked for specific information about the infection and outlined the events that had followed her discharge. The consumer was particularly concerned that she had not been informed by Canterbury Health about her post surgical care, including appropriate assessment and treatment of the infection. A prompt acknowledgement was sent by Canterbury Health as required by Right 10 of the Code but a full response was not sent until a request to respond

was made by the Commissioner. That response is dated 10 June 1997 and the Consumer was not satisfied with the information provided by Canterbury Health in that letter.

(b) In July 1996 Consumer B was admitted to Christchurch Hospital for the diagnosis and treatment of a respiratory condition. On 24 July 1996 he sent a letter of complaint to Canterbury Health that insufficient information was provided to him by nursing and medical staff about his diagnosis and that personal information was revealed to his parents which he had explicitly stated was not to be disclosed. An acknowledgement letter dated 29 July 1996 stated Canterbury Health would respond when they had investigated the circumstances.

Eight months later, on 19 March 1997, Consumer B met with the Patient Affairs Manager to discuss the complaint. On 21 March 1997 Canterbury Health finally sent a formal response to the complaint letter of 24 July 1996. However, Consumer B advised the Commissioner he was still unhappy with the response from Canterbury Health and that they had not answered all the questions that he had asked.

(c) After the death of her husband in July 1996, Mrs Brown complained to two of the doctors involved in the treatment of her husband about the standard of care that Mr Brown had received. According to Mrs Brown, the doctors responded by indicating to Mrs Brown that the problem was a "*political one*" and she would be "*better off talking to the politicians*". The doctors did not inform Mrs Brown about the Code of Health and Disability Services Consumers' Rights or her right to complain. On the day of Mr Brown's death, Mrs Brown filled in a Canterbury Health form stating that she wished to complain but this action drew no response.

Mrs Brown was not told by Canterbury Health that she could access her husband's medical records. The Patient Advocate Service advised Mrs Brown of her entitlement to the medical records and following this she was given access to the records.

Mrs Brown also contacted a Member of Parliament and a senior medical specialist who assisted Mrs Brown to make her complaint.

(d) The Watson family advised the Commissioner that they became concerned about their mother's treatment during her hospitalisation. In particular, they were concerned that the delay in the reporting of x-rays and insufficient pain medication had contributed to their mother's death. The Watson family advised the Commissioner that they had sought the advice of both the Patient Advocacy Service and the Patient Care Manager. Following Mrs Watson's death, the family also took up their concerns directly with Christchurch Hospital and laid a formal complaint in writing on 24 July 1996. The letter also requested answers to a number of questions that the Watson family felt should be answered.

A meeting was held on 23 September 1997 between the Watson family, members of the medical team responsible for Mrs Watson's care, the Patient Affairs Manager and the Patient Care Manager to discuss the family's concerns. The Watson family advised the Commissioner that at this meeting the family stressed that Mrs Watson's condition had been deteriorating for a considerable time in the hospital before her death and that the family had found it "*very difficult to get any assistance from the nursing staff or to get doctors to come*". The Watson family felt that at this meeting "*the discussion went around several times without resolution*". The family was also concerned that the Medical Advisor who had received the complaint was unaware of the delays in the reporting of the x-rays. The family was therefore sceptical about the depth of the enquiry.

According to the Watson family, the Patient Affairs Manager was to follow up on the meeting and advise them of what progress had been made regarding the Watsons' concerns about nursing.

Mr Watson stated that he tried to contact the Patient Affairs Manager seven weeks after the meeting, but he could not get through. Mr Watson left a message to have his call returned, but the Patient Affairs Manager never responded. The Watsons' tried to contact the Patient Affairs Manager again five weeks later. Finally, in January 1997, the Watsons managed to contact the Patient Affairs Manager. The Patient Affairs Manager informed them that a reply had been mailed to them on 14 November 1996. The Watson family had not received this information and it was finally received by them in April 1997.

The Watson family advised the Commissioner in August 1997 that they remained unhappy about the way that Canterbury Health dealt with their concerns and complaints about the care of their mother. At that time they still felt that their complaint had not been resolved.

In March 1998 Canterbury Health advised that they believed the Watson family were now happy with the resolution of their complaint.

(e) The family of Mrs Humphrey complained to Christchurch Hospital about the care that their mother received while in hospital. Mrs Humphrey's daughter complained in person both to the doctor involved and to the Patient Affairs Manager prior to her mother's death, and in writing following her mother's death.

Prior to Mrs Humphrey's death, the family approached the doctor involved and asked him to respond to a list of 25 questions that the family had about their mother's care. The family advised the Commissioner that only three of the 25 questions were answered and that the answers were not satisfactory. Further, the family did not receive responses to their questions directly, rather the three answers were left in Mrs Humphrey's bedside drawer.

The family then approached the Patient Affairs Office with a number of concerns to be raised with the medical team. According to the Patient Affairs Manager, a meeting was arranged but it happened to be on the very day that Mrs Humphrey died. The Patient Affairs Manager reported that he had met with the family coincidentally following Mrs Humphrey's death and advised them to contact him again once "*they felt they were in a position emotionally to deal with their issues*".

Mrs Humphrey's daughter advised the Commissioner that she had delivered a complaint to the Patient Affairs Office on 16 October 1996. The complaint was written on the Christchurch Hospital Customer Response Form and a letter was attached. The complaint related to complications that arose during an operation performed on Mrs Humphrey, unanswered questions of the family relating to those complications and inadequate nursing and medical care.

The Patient Affairs Manager acknowledged the receipt of the family's complaint on 25 October 1996. A copy of the autopsy report was sent to the family with that letter. The letter from the Patient Affairs Office indicated that a full response would be forthcoming following enquiries with the medical and nursing staff concerned.

On 28 January 1997 the family of Mrs Humphrey wrote to the Patient Affairs Manager to advise that they had contacted the Health and Disability Commissioner regarding their complaint as they still had not had a response from Christchurch Hospital. This letter was acknowledged on 4 February 1997 and extended an offer to the family to "*initiate an investigation through our internal complaints system*".

Mrs Humphrey's daughter replied on 10 February 1997 that she was puzzled by the Patient Affairs Manager's letter. She pointed out that she had complained to Christchurch Hospital on a number of occasions, requesting responses to the ten issues she had outlined in her complaint of 16 October 1996. Mrs Humphrey's family advised the Commissioner in October 1997 that

they remained unhappy that nine months after their initial complaint was acknowledged, they had yet to have their queries answered by Christchurch Hospital.

Complaints to Southern Regional Health Authority

In June 1997, following a request by the Commissioner, Southern Regional Health Authority reviewed Canterbury Health's complaints records from 1995 and 1996. From a total of 27 complaints received over the two year period, Southern Regional Health Authority stated that only two related to "quality issues", defined as the appropriateness of services and/or equipment provided. The remainder concerned access to services, defined as the availability of services and whether or not the available services were provided in a timely fashion. One of the complaints regarding quality is post 1 July 1996 and has been referred to the Health and Disability Commissioner.

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MANAGEMENT AND COMMUNICATION ISSUES

Organisational Structures Prior to 1995 Restructure

There was a major focus on removing administrative layers when Canterbury Health assumed the management of Christchurch Hospital from the Canterbury Area Health Board.

From 1 July 1993 until the 1995 restructure, the organisational structure was very flat. The General Manager Christchurch Hospital Services had 64 people reporting to him and Canterbury Health's medical staff had line responsibility for clinical departments excluding wards. The 25 Clinical Directors were encouraged to undertake management responsibilities in addition to their clinical work. However only a small part of their working week was allocated to management duties.

Nursing staff assumed professional responsibility independently from clinicians and were strongly protective of this independence. Each of the 29 wards had a Unit Nurse Manager reporting to the General Manager Christchurch Hospital Services.

Additionally there were 10 administrators (with a business background), known as Service Facilitators, whose responsibilities included collecting and analysing information and advising the Clinical Directors, while at the same time briefing the General Manager Christchurch Hospital Services, on financial and operational aspects of the department for which they were responsible.

The Chief Executive, Mr Frame, formed the view that this structure did not deliver the gains in efficiency and effectiveness hoped for and that budgetary management was not devolved effectively. The number of direct reports to the General Manager Christchurch Hospital Services was considered to be unsustainable. Clinicians themselves were aware of the problems and philosophical difficulties involved in taking responsibility for financial management. A senior physician, in a submission on the restructuring proposal, stated:

> "*There are a number of conflicts of interest between the needs of management who perceive budgetary restraint as the important goal, compared to medical Clinical Directors who are focused more on clinical care delivery and are less motivated by financial matters. Further, it has been stated publicly by senior management of Canterbury Health that some Clinical Directors are not 'co-operative' with management and in some cases this may have reflected their philosophical disagreement with the thrust of the health reforms*".

The original structure adopted by Canterbury Health was not effective. A range of views were given for this.

The General Manager was not able to function effectively because he had far too great a span of control with 64 direct reports (25 Clinical Directors, 29 Unit Nurse Managers and 10 Service Facilitators).

No clear framework for decision-making was established until 1995 with the drafting of the business plan. Canterbury Health did not communicate medium or long term goals or objectives to staff which would provide them with a basis on which to make sound operational decisions.

Policy development and operational planning was undertaken by the senior management team with little input from clinicians or other staff. This was evidenced by minutes of the Medical and Surgical Policy Group meetings at which operational issues were discussed but no decisions or actions were recorded and at which the intentions or views of management were rarely expressed. The minutes of these meetings record the opinion of Clinical Directors that they could help Canterbury Health more if they were included in the running of the organisation.

Management did not set up appropriate delegations or control and accountability mechanisms to ensure that service objectives were being met. Prior to 1996 Canterbury Health did not have adequate information systems in place for this to occur. Clinical Directors did not have job descriptions and there were no performance targets or performance appraisals. Clinical Directors themselves expressed their dissatisfaction at the lack of clear directions and responsibilities and the lack of opportunity to take fiscal responsibility. Despite the stated goal of management to devolve financial responsibility, this did not in fact happen in the three years that this structure was in place.

Minutes of Medical Advisors' Breakfast Meetings point to the failure of management to deal with dysfunctional clinical inter-relationships, medical audit and incident reporting. Canterbury Health had little control over its clinician employees, nor did it demonstrate the ability to harness their talents and clinical experience to achieve the organisation's objectives.

Of the original structure, a Medical Advisor commented:

"*The medical staff and CDs* [Clinical Directors] *were not required to be accountable. There were not well organised administrative meetings where CDs had to give an account of their department or explain why they had or had not done something .... Some CDs did relatively little in an administrative way. There was not a good system to make sure CDs implemented CHE policy or the policy for the group that was running the hospital. .... One could not get things implemented. Even if the Medical Advisors had had executive authority there was no structure to get things done*".

1995 Restructuring Proposals

Faced with a directive by the shareholders to improve organisational efficiency, a restructure was undertaken in 1995/96. The key features of this organisational restructure were:

Service Managers were appointed with responsibility for departmental operational management and doctor driven costs.

Clinical Directors and Medical Directors were responsible for medical care and reported to the Service Managers. Clinical Directors (but not Medical Directors) had line management responsibility for their department.

Six Patient Care Managers were appointed to replace existing Unit Nurse Managers. Patient Care Managers were to be accountable for the development of a nursing infrastructure, nursing quality systems, professional standards and ward and support services.

The aim of the restructure included:

(a) providing the General Manager Christchurch Hospital Services with a workable line management structure;

(b) providing line nursing leadership;

(c) ensuring professional and budgetary accountability;

(d) ensuring line accountability for quality assurance; and

(e) providing the framework for implementation of the case management model.

In general, the minutes of Divisional Team Meetings indicate this structure functioned better than the previous structure in terms of better management systems and processes, more formal communication, better accountability and documented action points. The minutes indicate better decision-making, management disciplines and efforts by members of senior management to encourage clinical involvement in operational matters including financial issues. Despite this, many of the clinicians interviewed felt that their input was not valued by management. The following difficulties emerged with the structure.

Although these were senior management positions with substantial budgets and staff numbers, the Patient Care Managers and some of the Service Managers had limited management experience.

The Service Managers and Patient Care Managers did not necessarily manage the same clusters which fragmented the management team to some degree.

Having Clinical and Medical Directors report to Service Managers was inappropriate given the relatively low level of experience and seniority of Service Managers. In some areas effective working relationships developed as partnerships despite the reporting structure intended. It is clear that the Service Managers had little or no control over the clinical staff and in some cases Clinical Directors refused to report to or co-operate with the Service Managers.

The span of control problem was simply shifted from the General Manager Christchurch Hospital Services to the Patient Care Managers and Service Managers. Inefficiency was caused by an inadequate number of Service Managers relative to the workload; excessive spans of control; and failure to resource the positions properly, particularly in terms of human resources and clerical support. Service Managers had between 50 and 200 staff reporting to them with no effective supporting, supervisory or delegation structure. They had no secretarial support although some Clinical Directors lent the services of their own secretaries. One Human Resources Advisor was assigned to the Hospital Services Division, which had 1800 staff. The frustrations of Service Managers appear to have resulted in significant staff turnover and this meant that workloads were increased as responsibilities were delegated to existing staff.

While operational management was devolved to Service Managers and Patient Care Managers, and a meeting structure developed to share information and co-ordinate policy across Christchurch Hospital, development of co-ordinated policy and effective relationships between clusters did not occur.

The General Manager Christchurch Hospital Services continued to maintain a direct relationship with the Clinical and Medical Directors, creating an avenue for clinicians to undermine the Service Managers if they were inclined to do so.

Essential support services were in a separate division under a different General Manager, adding complexity to resolution of systems issues between core and support services, and creating a barrier to the shared values and objectives that are essential to good co-ordination of service.

The Role of Duty Managers

Most major acute hospitals have a duty management system, some covering 24 hours, while others have 16 hour coverage. The role is usually included in management decision making and has authority to act on a wide range of issues in the absence of the general managers. The role has large resource co-ordination and public relations components. It is responsible for projecting an image of harmonious management.

Christchurch Hospital has had an after-hours management presence for decades. Previously the role was "nursing supervisor" and, since 1991, Duty Manager. In the past there were two or three nursing supervisors on afternoon and night duty to provide assistance and guidance to different parts of the Hospital. From 1991 there has been only one Duty Manager on a shift for the entire hospital. As the Hospital became busier and more complex, particularly when additional speciality departments transferred to the Christchurch Hospital site, the ability of one person to manage the needs of the whole Hospital was tested.

The Duty Manager traditionally worked closely with the Unit Nurse Managers. They found the Clinical Nurse Facilitators installed in their place more difficult to communicate with than the Unit Nurse Managers and, at the time of the 1995 re-structuring, the Duty Managers felt the loss of experienced colleagues acutely. The Duty Manager's role had also been under ongoing review from the beginning of 1995, adding further stress to the role.

The after-hours management of the Hospital was said by Duty Managers to have become more difficult as new Patient Care Managers and Clinical Nurse Facilitators learned about the requirements of managing a 24 hour service, the use of casual nurses increased and the availability of beds in which to place acute admissions became more difficult.

Duty Managers: Developments in 1995/1996

In August 1995 Canterbury Health decided to remove the daytime Duty Manager and replace the role with a Bed Manager (a role managed by the Admitting Department). During the day Patient Care Managers rotated the responsibility of holding the Duty Manager locator and attending cardiac arrest emergencies. While the Bed Manager received a hand-over about availability of beds from the night duty manager, there was often no hand-over by the Patient Care Managers to the Duty Manager in the afternoon and there was no-one to whom the night Duty Manager could hand-over clinical and staffing issues that required attention during the day. This meant there was a gap in the update on day to day Hospital and ward issues. In addition, some staff thought Patient Care Managers had little understanding of what was happening in those parts of the hospital outside their own "cluster" which made it difficult for them to perform a hospital-wide role.

From July 1996 the afternoon Duty Manager commenced duty at 1530 hours. The Duty Manager would assume that the afternoon staffing had been reviewed by Patient Care Managers, but found that at times the skill mix for the afternoon was inadequate. Little could be done to remedy this inadequate skill mix as there were no more permanent casual pool staff to share around in the middle of a duty.

The Bed Manager would advise the Duty Manager at 1600 hours of the availability of beds. The Duty Manager was then required to assess the needs of the Hospital and to decide whether the Medical Day Unit should remain open or not. To keep it open required additional staff which the Duty Manager then had to find.

The Duty Manager was also required to review the night staffing and would personally contact casual staff by telephone to meet clinical unit needs for the next shift. The booking and placement of casual staff for the night shift could take many hours and was interspersed with calls for decisions about available beds for acute admissions, ward staff requesting an escort for a patient going to x-ray, requests for equipment or supplies and requests to find junior medical staff cover when medical staff were off sick.

Duty Managers: Developments in 1997

Early in 1997 the Acting Director of Nursing had reservations about the Duty Manager handing the Hospital over to the Bed Manager in the mornings before the Patient Care Managers arrived. She considered there was a risk because the Bed Manager was not employed as a nurse and the role of duty management is wide ranging and requires more than finding staff and beds. For example, it also involves attending cardiac arrests, providing guidance in the use of unfamiliar equipment and attempting to ensure that staff have adequate equipment.

A Duty Manager was therefore reinstated in May 1997 to cover the morning duty and the Bed Manager role ceased, though there was dissatisfaction amongst some staff about the loss of the Bed Manager role.

Some Patient Care Managers and nursing staff were critical of the Duty Managers and have communicated this to various managers.

Perspective of Patient Care Managers and Pressures on Duty Managers

The span of responsibility of Patient Care Managers and the disestablishment of a centralised quality assurance role, causing the loss of an organisational overview of nursing quality, were both matters raised by the New Zealand Nurses Organisation to Canterbury Health in 1996 as areas of concern. Because of the high number of new appointees to the Patient Care Managers role, these nurses were on a steep learning curve and were only able to offer a limited amount of leadership support.

Patient Care Managers considered that a Duty Manager should be available to assist staff if called. Concern was expressed about the Duty Manager's inability to debrief staff after cardiac arrests and the Duty Managers expressed concern at not being able to support orderlies working in the mortuary, due to a lack of time.

Duty Managers acknowledged that there were occasions during winter 1996 when they informed ward nurses that there were no casual staff to replace staff who were sick. When nurses stated that they would write an incident form about the situation, the Duty Managers advised the Commissioner they supported this action. There was nothing the Duty Managers perceived they could do to rectify the problem.

The Duty Managers believed they did not receive the management support and coaching essential for the effective management of an acute hospital. They met with management on occasions to explain the pressure they were under. Service Managers also advised the General Manager Christchurch Hospital Services that Duty Managers were being overwhelmed. As the Duty Manager role was not represented formally on the organisational structure, Duty Managers perceived they were forgotten, particularly as they often did not receive information about

changes or developments, were not included in discussions about workload and were not always included in planning for changes.

A number of people identified that the duty management arrangements were inadequate. They proposed the appointment of a clinical person who was able to work hospital-wide to provide clinical support and guidance for the staff.

During the winter of 1996 a second Duty Manager was temporarily rostered on the afternoon shift when it became clear that the Duty Managers were struggling with the demands and pressures of their positions.

The 1997 Restructure

Canterbury Health has recently completed its third restructure, which is intended to place clinicians back in positions of responsibility in the organisation's structure, to provide overall leadership to the nursing workforce by creating a Director of Nursing position and to encourage the General Manager Christchurch Hospital Services to redirect some of his energies away from financial planning into health planning.

To enable the General Manager Christchurch Hospital Services to focus on health planning, an Operations Manager position has been created to take responsibility for operational and financial management and the co-ordination and direction of the Service Managers whose role is now to support the Clinical Directors. Clinical Directors and Service Managers are expected to form a partnership with joint responsibility for planning and resource management.

The structure is strongly reflective of clinicians' wishes for each department to report individually to the General Manager Christchurch Hospital Services, who now has 26 individual departmental directors reporting to him.

The Chief Executive, Mr Webb, described the aim of the new structure as being to 'file down' and focus the non-Clinical Directors' side of the organisation and to give the General Manager Christchurch Hospital Services more time with the Clinical Directors to focus on clinical planning, policy and co-ordination. This is consistent with Mr Webb's aim of achieving a balance in management focus between financial planning and health planning.

Clinical Input

The former Chief Executive, Mr Frame, considered that, until late 1994, he had encouraged initiatives from clinical staff to improve productivity and costs. This approach was not considered to be sufficiently aggressive by the Crown Company Monitoring Advisory Unit whose observer, Mr Hartevelt, said "*there was insufficient tension between management and clinical staff*" at Canterbury Health. Mr Frame believed it was not possible for management to continue with the consensus style it had adopted up until 1995 and effect the restructuring contemplated in the 1995/98 business plan. He stated:

> "*Within the timing constraints of the 1995/96 Business Plan, I do not believe that the restructuring could have been planned any other way. To have adopted a more consensus approach would have taken significantly more time*".

In the words of the Chairman, Dr Layton:

> *"The Chief Executive did not wish to be thwarted by 'paralysis through analysis' ".*

Mr Frame stated that he derived clinical input for the 1995 restructuring proposal from those in the management team with clinical and nursing backgrounds. He further commented that he received feedback informally from some clinicians. This feedback influenced the formation of the restructuring proposals. Mr Frame acknowledged that towards the end of 1995 his relationship with some clinical staff became more strained as a consequence of the pressure placed on him by the Board to effect the restructuring.

Dr Coughlan considered that clinical staff were not involved in the 1995/96 business plan because it was a "*very difficult business plan to achieve*". Mr Frame stated that clinicians were not involved in preparing the 1995 restructuring proposals because he was "*aware of the pressure that went on clinicians when they were associated with something that may .... have attracted some disagreement*" and *"...* [A]*ll clinical input came through the consultation process"*.

Mr Frame advised the Commissioner that he respected Dr Coughlan's views on clinical issues and that he relied on Dr Coughlan to accurately relay the views of a wider group of clinicians. The Chairman of the Board also confirmed that he placed reliance on Dr Coughlan's clinical experience. However the Deputy Chairman emphasised that he did not rely on Dr Coughlan and that he had reminded the Chief Executive from time to time that Medical Advisors and Clinical Directors should be his clinical advisors. Dr Coughlan stated that members of the Board and the Chief Executive "*did not rely on me to speak on clinical issues that I felt uncomfortable speaking about*".

Dr Coughlan explained that it was the policy of the Board that clinicians' concerns should first be raised with the relevant General Manager at Christchurch Hospital. If they were not addressed by that General Manager then they should be raised with the Chief Executive. If the Chief Executive did not deal with the issues, the next step was to refer the matter to the Board. However, the Board emphasised in the minutes of its meeting of 20 December 1995 that it was prepared to consider specific safety issues directly. According to the Chairman of the Board, Christchurch Hospitals' Medical Staff Association provided a general criticism of the management and would not produce specific safety issues. The Association stated that it did not supply these for fear of staff reprisals.

The Board relied on the Chief Executive relaying to it matters discussed with the Medical Advisors. The Board also relied heavily on the advice of the Deputy Chairman, Professor O'Donnell, on clinical matters. He was the sole medical practitioner on the Board. Professor O'Donnell considered that the major reason for his appointment to the Board was his ability to contribute a medical perspective and comment on clinical matters. Mrs Pip Wyber, a non-practising nurse, was appointed to the Board on 18 May 1996.

Since August 1996 there have been several presentations to the Board by Clinical Directors and Medical Advisors to discuss various clinical issues. Professor O'Donnell stated that he was keen to have clinicians attend Board meetings and considered that from mid-1996 this objective had been achieved.

Involvement of Clinical Staff in Planning and Policy Development

The Clinical Directors interviewed were resentful of management's failure to involve clinical staff in high level policy and planning. The Medical Advisors' advice appears to have been limited largely to operational issues while in matters of organisational policy and planning they were seldom consulted. The most obvious example was the failure to consult with the Medical Advisors on the 1995 restructuring proposal and failure to invite the Medical Advisors to the March Board meeting to discuss the 95/98 business plan.

Both Service Managers and Clinical Directors considered that until late 1996 they had not participated in policy making at a senior level. The frustrations of clinicians in this respect was summed up by a senior doctor:

> "*I used to go to the medical policy group meetings and I stopped part way through because nothing that was discussed of any substance seemed to be consummated. Secondly, the minutes were often totally inaccurate. So I could see no sense in wasting time with those meetings. They were of no relevance. They seemed to be held because somebody said they had to be held. That's the way I saw it*".

Dr Coughlan disagreed with this view, stating that the minutes for each meeting were confirmed as a true and accurate record. He advised the Commissioner that both Service Managers and Clinical Directors were considerably involved and cited Cardiothoracic and Surgery services as examples.

Following the 1995 restructure, Divisional meetings were held to discuss and implement policy and operational issues. These were attended by management and senior clinical staff. About 15 Clinical Directors regularly attended these meetings and participated actively in decision-making, while others rarely attended. A review of the minutes of the Divisional Meetings in 1996 showed a marked improvement in the involvement by clinical staff in operational planning from that recorded in 1995.

Dr Coughlan advised the Commissioner that he considered that clinical staff must be involved with the whole business planning process for it to be successfully implemented. He stated that clinical staff would be heavily involved in the planning for and implementation of the 1997/98 business plan.

In 1997 clinicians were formally involved in negotiations with the Southern Regional Health Authority. In earlier years clinical involvement was in respect to developing specifications and other clinical issues.

Leadership by the Board and Senior Management

Some senior clinical staff and managers were very critical of the lack of leadership shown by the Board and senior management of Canterbury Health. The former Chairman was held in high regard in 1994 as evidenced by letters and a petition from clinical and nursing staff following his resignation. However his comments at the 5 December 1995 meeting were central to the staff's later lack of faith in his leadership. Dr Layton responded to the Commissioner that some senior clinicians pursued an active campaign to discredit him and the Deputy Chairman in 1995/96. Some clinicians believed the Deputy Chair was unable to stand up to the former Chairman in representing clinical issues. Professor O'Donnell advised the Commissioner he

was active in an appropriate governance role and that it was inappropriate for him to be involved in management, though he facilitated when requested by the Chief Executive.

The former Chief Executive was initially popular and considered effective. Until 1995 he had a lot of support from senior clinicians and the Chairman and Executive of the Christchurch Hospitals' Medical Staff Association. According to a number of clinicians his management style changed in 1995 when he came under pressure from the Crown Company Monitoring Advisory Unit and the Chairman of the Board. The degree of pressure on management is illustrated in the following excerpt from a confidential memorandum from the Chairman of the Board to the Crown Company Monitoring Advisory Unit observer, Mr Hartevelt on 15 March 1995. This memorandum was sent prior to a Board meeting with management at which management's attempts to meet the requirements of the Crown Company Monitoring Advisory Unit were to be discussed.

"*The objective is for us to let management get their plan on the table in as complete a form as possible before we start to scrutinise it critically.*

I suggest we then start going through the various components of management's plan slowly, and systematically .... Only if they are not getting to a truly viable plan will we seize more initiative over what will and will not be done.

I suspect management will be anticipating a fairly "robust" approach from me, and probably from you also. The above tactic will not only surprise them, but make them feel more in charge than they do at present, and so reinforce John Perham's [a Board member's] *message to Ian* [the Chief Executive] *that if he produces workable solutions the Board will not have to seize the initiative to make the decisions that have to be made. It will also increase the chances of successful implementation, and leave it less likely for management to attempt to split the Board prior to Wednesday, when, if the plan is not viable, this will be apparent, and the Board will be very together to ensure a viable plan is produced forthwith.*"(sic)

While the General Manager Christchurch Hospital Services was considered to be agreeable by many staff interviewed, he was also considered to be indecisive and lacking in vision and leadership and the Hospital Services Division was considered to lack strategic direction and strong and consistent leadership. Minutes of meetings indicate these lacked a well structured format and effective chairmanship to ensure decisions were reached. Working groups were established and discussed issues widely but did not resolve them. In general there was an absence of timely decisive action to resolve problems. Dr Coughlan advised the Commissioner that he provided vision and leadership but some people did not always agree and attacked him personally, particularly in relation to the resistance to critical pathways.

The General Manager, Diagnostic and Support Services was also criticised by clinicians for his leadership style and a lack of timely decision making.

Managers were undoubtedly under pressure from above to reduce costs and from below to make additional resources available, which is arguably a no-win situation.

Leadership by Clinicians

Clinical Directors gave differing evidence on leadership, management and their own roles. Most considered that clinical leadership was being provided by Clinical Directors. Others

acknowledged Clinical Directors' inability to influence the practice of their colleagues. Others stated that communication between Clinical Directors and both junior and senior medical staff was poor.

Some Clinical Directors took the view at meetings that management decision-making was not their responsibility and that the organisation's financial problems were the Board's problem. Attendance at Hospital Services' monthly Divisional Meeting was generally poor despite the fact that, according to Canterbury Health, clinicians were encouraged to attend and participate. One Clinical Director commented that Clinical Directors were viewed with distrust by some of their colleagues because aspects of their work were considered to be management. They were seen as having been "*captured somehow, by management*".

There is clear evidence that while some departments established excellent decision-making partnerships between Service Managers and Clinical Directors, in other areas the Clinical Directors would not participate in decision-making despite attempts by the Service Managers to encourage this.

Reasons offered by clinicians for their limited leadership roles included:

> "[After the restructure] *the organisation has drifted. Staff have become disillusioned and their energies have been put into fighting the administration, or to a lesser degree, among themselves...*".
>
> "*There had been a 'them and us' attitude, with corporate management versus clinicians*".
>
> "*Morale was low, therefore people tended to deal only with issues that directly affected them. Systems issues are set aside for someone else to deal with*".

While some clinicians continued to work together with management to move the organisation forward, others withdrew their support and co-operation. This significantly affected the ability of management to perform its role effectively.

There was also evidence to indicate that Clinical Directors were prepared to take management responsibility only if they considered conditions were right. Some Clinical Directors refused to sign job descriptions because these did not precisely define responsibilities, nor guarantee good information by which to manage. One Clinical Director indicated that he would be prepared to manage a budget, provided that prices and volumes were set in a realistic way. A Service Manager stated:

> " *... although many clinicians feel they have not been included in this* [the contracting] *process, when offered the opportunity this year, some were not prepared to look at the constraints of the health dollar and believed they should be given unlimited capacity and more staff without looking at ways that additional revenue can be sourced in order to support additional staff*".

Management of Change by Canterbury Health

Background to the 1995 Restructuring Proposals

In August 1995 Canterbury Health released proposals for an ambitious programme of change to the organisation. The objective was to set in place a new model for service delivery based on patient-centred care and to achieve a projected surplus by 30 June

1997. The Proposals involved major change within a short time-frame and are described in detail in the General Environment section of this report.

Change management is recognised as complex and risky for an organisation and certain characteristics of the health sector increases these risks. Some of the matters to be considered in implementing a change process at Canterbury Health are summarised below.

(i) The "culture" of the health sector and values of health professionals.

(ii) A highly qualified, skilled and articulate workforce in the health sector who are well paid and strongly unionised.

(iii) Strong ideological opposition among many in the health sector to the commercial thrust of the health reforms in the public sector, thought by Canterbury Health to be very strong in the Canterbury region.

(iv) The challenge of achieving a balance between individual, professional and organisational goals, and loyalty from senior staff given the number of part time clinicians with other business interests.

(v) The difficulties experienced by Canterbury Health in managing its senior professional staff.

(vi) The general obligation on providers in the health sector to ensure that change is carried out in a manner which does not prejudice the continued safe and effective provision of services.

The 1995 Restructuring Proposals

Underlying the 1995 restructuring proposals was the intention of introducing a new "patient centred" service delivery model. The core elements of this model were:

(i) care plans which provide a guideline to the range and timing of the services to be provided to individual patients;

(ii) case management which involves the appointment of a person or team to co-ordinate the patient's progress through the care plan;

(iii) clinical protocols to provide a guideline for best practice in developing the care plan; and

(iv) clinical audit and exception reporting as a basis for reviewing cases which vary significantly from the care plan.

This new model was expected to deliver improved outcomes and consistency of outcomes, less duplication of services applied to patients, less waiting time for patients during their stay and generally more cost effective healthcare. The model required a re-organised management structure which would deliver the flexibility, efficiency and accountability required to enable the model to work most effectively.

The restructure also sought to overcome a number of deficiencies that had been identified in the existing organisational structure and processes. These deficiencies included:

too large a span of control for the General Manager Christchurch Hospital Services;

absence of clear accountabilities and responsibilities;

little inter-ward co-operation and co-ordination;

absence of a consistent model of nursing practice throughout Canterbury Health;

absence of nursing management above ward level; and

confusion between the role and responsibilities of the Professional Nursing Unit and line management in relation to professional and quality issues.

The Environment of Change

Mr Frame described Christchurch Hospital as a bastion of ideological resistance to the health reforms.

A clinician described the hospital as a "*traditional, close knit community. People in health feel they belong to health. Christchurch Hospital belongs to the people of Christchurch. It has been there for 100 years and will be there for another 100*".

Dr Coughlan indicated that "*a culture change is required in the organisation to implement change in which many staff still do not accept that the CHE should only do what they are paid to do*".

It was stated that the turnover of professional staff at Canterbury Health is relatively low, therefore long standing relationships had built up between clinicians and nurse managers over the years. The restructure plan threatened to destroy these relationships.

The introduction of clear accountabilities through line management, together with changes in traditional working relationships and processes for delivery of care required a major culture shift at Canterbury Health.

Lack of Consultation Prior to Publication of the Proposals

Staff at Canterbury Health did not have a clear understanding of the direction of the organisation nor the benefits that change would bring. The March 1995 business plan was developed by management without formal clinical input and was not shared with staff for fear of disturbing and alienating them.

Canterbury Health staff felt aggrieved by the lack of consultation prior to the release of the Proposals for Change. Although the management team made reference to taskforces, forums and the Patient Management think tank meetings as the source of ideas, minutes of these meetings do not support a direct link between the meetings and the restructuring. Management did not involve staff in any meaningful way in the development of the Proposals, nor did staff have any idea of the direction in which the organisation was heading, though most were aware of the need to reduce the deficit.

The Proposals for Change came as a complete surprise to senior nurses at Christchurch Hospital, who had not previously been asked to comment about the direction or impact of the proposed changes. The proposed changes had a profound impact on these nurses personally

and also on the clinical care teams within which they worked. The lack of opportunity to comment in the early stages of planning concerned many of the people interviewed.

The New Zealand Nurses Organisation offered assistance to Canterbury Health two weeks before the Proposals for Change were released and this offer was rejected.

Consultation after Publication of the Proposals

The clear message from staff at all levels was that the proposed changes were not clearly explained. In particular, the changes were presented as concepts, with little detail on how the proposed changes would be implemented. The fact that the Proposals did not make clear what the restructure team meant by "case management" was acknowledged by the General Manager Christchurch Hospital Services, who in August 1996 (one year after the Proposals for Change had been distributed) produced a document with a further covering explanation that was simpler and more definitive than those released in the original proposals.

Nurses reported that all wards and departments put considerable effort into the submissions about the Proposals that were presented to the managers in September 1995. The perception of those interviewed was that little notice was taken of what the staff had to say.

However, management provided to the Commissioner a detailed analysis of the submissions on the restructure proposals, together with minutes of meetings and responses to concerns expressed in the submissions.

The November Restructuring Plan

While the post-consultation document still did not contain a detailed description of "case management", it did indicate that there had been some genuine efforts to address concerns raised during the consultation process. In particular, there was recognition that case management could not be universally applied across the hospital. Other changes from the Proposals for Change were that Clinical Nurse Facilitators were to be introduced as an interim measure to address concerns expressed in the submissions at the loss of Unit Nurse Managers, and the span of control of Patient Care Managers was moderated slightly.

These changes did not satisfy staff. The restructure plan was released despite a groundswell of opposition by clinician staff.

Implementation of Restructuring

Role of General Manager, Special Projects

Delivering change requires leadership. Canterbury Health's original intention was that the restructuring would be scoped using internationally recognised health sector change management experts and that these experts would also be on the restructuring steering group. This intention was not realised because of expenditure constraints.

The job description for the General Manager, Special Projects stated that one of the specific tasks assigned to the role was to:

> *"Project manage the implementation of the Business Plan including all proposed initiatives, and any additional initiatives that may arise ... In doing*

so, to work through existing line management structures with the assistance of other management staff allocated to the Project".

This included management and initiation of all "Planned Efficiency Gain" projects which included the implementation of the restructuring.

Mr Frame described the job as project-based to facilitate some of the special projects arising from the business plan. However, the responsibilities of the General Manager, Special Projects were not clear to other managers. The General Manager, Special Services saw the role in terms of consultancy rather than project management. Projects were managed by the line managers with the General Manager, Special Projects assisting in negotiated roles and responsibilities as directed by the Chief Executive or where requested by line management.

The sharing of information and views between the General Manager, Special Projects and the General Manager Christchurch Hospital Services was limited. Each considered that leadership and responsibility for change rested with the other and no one co-ordinated the process.

Service Managers and Clinical Directors

The Service Manager positions created in 1995 were identified as being senior management roles with significant staffing and budgetary responsibilities and therefore requiring appropriate support infrastructure. Service Managers were given responsibility and authority for medical staff. The difficulty of recruiting sufficiently senior and experienced people was one of the risks identified by the Board. Most of the appointees were relatively young. A number had limited line management experience and others were new to the health sector.

As a result of reversing the status of Clinical Directors in the management hierarchy with the appointment of Service Managers, Service Managers faced a very powerful group of individuals within the organisation, some of whom felt personally slighted by their relegation from the senior management team. This created difficulties for some Service Managers in establishing close working relationships, in delegating effectively and in calling on clinical support in order to make their roles manageable.

Impact of Management of Restructuring on Nursing

The implementation of the restructuring was managed in what was regarded as an unfeeling manner. Staff whose positions were dis-established were in most instances not given re-deployment options but required to find alternative employment for themselves without formal assistance from Human Resource staff. The way in which those not appointed to a Clinical Nurse Facilitator or Patient Care Manager position were handled had a severe impact on those concerned and left a "don't speak out" legacy for those remaining.

Many of the Charge Nurse positions were replaced with new staff in the Clinical Nurse Facilitator roles. Some Patient Care Managers were also new to their leadership roles. The absence of assistance and orientation for new people commencing leadership roles also had an impact.

Restructuring: Effect on other Initiatives

Canterbury Health's intention to introduce the case management model of care appears to have put on hold initiatives to address systems problems identified by mechanisms such as the Patient Management think tank and post-think tank meetings, and the Radiology and Pathology Taskforces. In the third quarter of 1995 these forums identified important systems issues and the means of addressing these. The Commissioner was unable to ascertain why these forums ceased to function. Although the General Manager Christchurch Hospital Services advised the Commissioner that the issues identified were primarily addressed by the structural changes made in 1996, very few of their recommendations were implemented until the restructure was complete.

Morale

Although there was some conflict in the evidence about the morale at Christchurch Hospital in early 1997, the following comment represents the majority view expressed by staff:

> "*There is a depressed mood in the hospital. Morale is low and it has been since the restructuring document came out. There is not the sense of belonging and collegiality that there used to be. There is not the feeling that people want to come to work and the buzz that used to exist in the institution is no longer there. There are embers, but they need a great blow of wind.*"

Mr Frame commented:

> "*Morale always falls when people feel they are faced with insurmountable challenges and there is no doubt that occurred within Canterbury Health during 1995 and 1996. The fall in morale was primarily caused by external forces that, on the one hand, placed unrealistic expectations on performance and, on the other hand, did not recognise the need to create an appropriate environment in which to achieve that performance. It may interest the Commissioner to know that the morale of the Board and executive was low during the same period and probably for the same reasons".*

Canterbury Health advises that a survey of morale today would produce considerably different results. Mr Webb considers that the trust between the management of Canterbury Health and senior medical staff has improved considerably since August 1996, although he considers that it is still not "*as good as it needs to be*".

Changes in Governance and Management

During the period under investigation there were some changes which should be noted:

Dr B. Layton	Resigned as Chairman of the Board on 15 January 1997.
Prof. T. O'Donnell	Deputy Chairman, acted as Chairman from 3 February 1997 until 4 June 1997.
Mr S. Bradley	Appointed Chairman of the Board on 15 June 1997.
Mr I. Frame	Resigned as Chief Executive on 6 May 1996 and departed on 2 August 1996.

Mr T. Sew Hoy	Acting Chief Executive from 5 August 1996 until 18 November 1996.
Mr R. Webb	Appointed Chief Executive on 18 November 1996.
Dr J. Coughlan	Resigned as General Manager Christchurch Hospital Services on 27 February 1998.

QUALITY ASSURANCE AND RISK MANAGEMENT

Quality Strategies and Activities Within Canterbury Health

One of the key requirements for a Crown Health Enterprise is to use processes and indicators to monitor the quality of its performance. Canterbury Health has undertaken a range of activities over time to measure its performance. The processes and indicators used by Canterbury Health are examined in this chapter.

Quality Planning

A three page quality plan outlining Canterbury Health's vision and mission was finalised to comply with a desk audit of 70 health providers conducted by independent quality system auditors for Southern Regional Health Authority in June 1995. The review was carried out in two parts:

(a) an assessment of the minimum requirements of the quality plan, as specified by Southern Regional Health Authority in the purchase agreement; and

(b) a more comprehensive assessment of the quality plan, against defined desirable attributes intended to enhance the application of the plan.

Canterbury Health was one of a small number of providers which met 100% of the minimum requirements of its purchase agreement. However, the quality plan as a whole was assessed as meeting only 41% of the desirable attributes, which was below the target set for partial compliance with the standards set.

Canterbury Health's quality plan was given a full compliance assessment in respect of designation of responsibility for quality strategies and/or activities, because the plan stated that all employees were responsible for quality. Yet the quality plan did not describe how employees were to be informed of the contents of the plan which they were expected to implement. Other deficiencies of Canterbury Health's quality plan included the absence of a detailed plan and time-frames for implementation and the absence of reference to peer review or clinical protocols.

The plan was presented to the Board of Canterbury Health in August 1995. The minutes of that meeting record no formal comment on the plan. No evidence was shown to the Commissioner that Canterbury Health developed an implementation plan in respect of the quality plan for Christchurch Hospital or its other Divisions.

Performance Monitoring

The Performance Monitoring Unit of Canterbury Health was established on 1 July 1993. Its role was to assemble data and report on indicators and statistics to enable the Chief Executive to report to external agencies such as the Crown Company Monitoring Advisory Unit, the Ministry of Health, the Southern Regional Health Authority and the Board.

Canterbury Health identified and compiled a number of clinical indicators. Monitoring clinical indicators is viewed by the Crown Company Monitoring Advisory Unit as "*a process of assessing performance and taking action to achieve desired results. Its purpose is to make sure that actual performance is consistent with planned performance*".

The clinical indicators monitored by the Performance Monitoring Unit were:

(a) patient falls per 1,000 inpatient days;

(b) IV and medication errors per 1,000 inpatient day equivalents;

(c) hospital acquired blood stream infections per 1,000 inpatients;

(d) unplanned re-admissions as a percentage of total admissions;

(e) unplanned returns to theatre as a percentage of surgical procedures;

(f) unplanned admissions after day surgery as a percentage of day surgery procedures; and

(g) autopsies per 100 deaths.

At the time the restructuring proposals were circulated in August 1995, the Manager of the Performance Monitoring Unit indicated her concern to the General Manager, Special Projects about the potential for safety problems. The Manager's submission stated:

> "*... the restructuring proposals would take out the Professional Nursing Unit and not only will there be no one quality co-ordinator for Hospital services but the Professional Nursing Unit will also be gone. It appears that the unit will be faced with having to collect quality information and work with eight Service Managers, or whoever they delegate, rather than one main person in the Professional Nursing Unit*".

The Chief Executive, the Board, the General Managers and the Patient Care Managers at Christchurch Hospital were aware that there had been a rise in some clinical indicators in winter 1996 from a report by the Performance Monitoring Unit on operating performance. Dr Layton noted that only some indicators were showing deterioration, while others were showing improvement. A report was requisitioned from the Performance Monitoring Unit which was scrutinised by two directors with clinical training and the Board was briefed. The Board asked management to bring forward proposals to bolster the management of nursing at Canterbury Health. This was done and the plan actioned.

Since the 1995/96 restructure of Canterbury Health, the Performance Monitoring Unit has worked with the Patient Care Managers to ensure that they understood how to monitor trends, what the numbers and ratios meant, what the targets were and the trends to date for a particular year. A Performance Monitoring Unit analyst has met with Patient Care Managers to ensure that they understand the importance of quality systems and the "feedback loop" for the

implementation of improvements. The Patient Care Managers provide information about their service to the Unit. This information is then compared against Canterbury Health targets and, where necessary, the particular service is asked for an explanation.

The Commissioner was informed that although the Performance Monitoring Unit has a reporting function only, it has developed a process of asking unit level managers for explanations about changes in trends and what actions are being undertaken to address negative variance. Some indicators, such as customer satisfaction indicators, have been monitored directly by the Unit. The Performance Monitoring Unit report for the Chief Executive sets out details of negative variance, any explanation that may have been given for such variance, and any action that management have taken to rectify problems.

The Manager of the Performance Monitoring Unit considered that the data collected was as reliable and consistent as possible given the absence of satisfactory computerised information systems. However, the Manager confirmed the reluctance amongst staff to report errors. Canterbury Health has provided the Commissioner with no information on when these clinical indicators were last audited to determine their validity.

The Commissioner was advised that quality improvement had a low profile in Christchurch Hospital. There was no evidence that managers used the data from the Performance Monitoring Unit to identify and rectify errors.

Mortality Review Committee

The Mortality Review Committee was set up in 1993 under the auspices of Christchurch Hospitals' Medical Staff Association. It was established following the commencement of the Coroner's investigation into deaths relating to the surgeon, Mr Ramstead. One of the three original Medical Advisors was on the Mortality Review Committee to ensure a link between the Committee and the Medical Advisors. There is no longer a Medical Advisor on the Committee. The Committee has jurisdiction over both Crown Health Enterprises in Christchurch which together provide financial support for the Committee.

The objectives of the Mortality Review Committee were described by the Chairman of the Committee as:

(a) "*Formal correlation between clinical notes and autopsy findings;*

(b) *Audit of accuracy of death certification;*

(c) *Audit of the reporting of deaths to the Coroner; and*

(d) *Audit of compliance with Standing Orders relating to deaths*".

The Committee convenes formal meetings every four to six weeks and discusses cases that have been referred to the Committee. It meets with the Coroner formally approximately once every two to three months, although it liaises with the Coroner informally on a daily basis.

For each death in Christchurch Hospital, the clinical notes are reviewed by one of the clinical members of the Mortality Review Committee. A "Notification to the Coroner" form is completed in every case, but this form is only faxed to the Coroner where notification is necessary under the Coroners Act 1988.

The Mortality Review Committee's function is distinct from the morbidity and mortality peer reviews undertaken by clinicians in particular services. It is agreed by the Committee and the Christchurch Hospitals' Medical Staff Association that the Committee's role does not include reviewing treatment outcomes or standards of care by clinical teams.

The minutes of the Mortality Review Committee are not provided to management. There is an understanding at Canterbury Health that the Clinical Director responsible for the department where the death occurred or a Medical Advisor, if consulted, will report to the General Manager Christchurch Hospital Services any significant issues that arise in the Committee.

The Mortality Review Committee provides data and advice to Canterbury Health and Healthlink South management as requested.

A significant impediment to the Board receiving direct reports from the Mortality Review Committee and the Morbidity and Mortality peer reviews undertaken at departmental level, is clinicians' fear that any report may prejudice them in the event of a subsequent inquiry or litigation.

Infection Control

Infection control activities are co-ordinated by the Infection Control Committee. The Commissioner was advised that there is an active infection control programme in the Hospital, with staff education on key issues, maintenance of resource manuals for reference, monitoring of hospital acquired infections and liaison with clinical staff regarding techniques and care delivery.

The Infection Control Committee decides on priorities, makes recommendations and develops policies which apply across the Hospital. Efforts are made by the infection control nurses to improve standards of care and practice through presentation of research on contemporary practice. Education sessions are provided for staff at orientation and when introducing new procedures or updating people.

The Infection Control Committee has attempted to progress policy on the issue of re-use of single use items. Internationally it is considered that a number of items can be safely re-used, but the re-use of single-use items has obvious implications for patient safety if protocols relating to their preparation for re-use are not strictly adhered to. A sub-committee was set up to look into the matter in 1995, but the recommendation it gave to the General Manager, Diagnostic and Support Services was apparently not accepted and the sub-committee was disestablished shortly after. The Infection Control Committee developed a position on the issue in 1996 and sought assistance with costings. The costings were unable to be completed due to unanswered clinical questions.

Re-Use of Single Use Items

Reuse of single use items was drawn to the attention of management in July 1997 by the Commissioner. Management responded by issuing an interim policy directing that "*no single-use items should be reused until there is a written protocol in place that has been approved by this committee*".

The current Chief Executive advised the Commissioner that Canterbury Health had no hospital-wide policy with regard to the re-use of single use items in 1996. Some departments had written protocols for the re-use of particular items, but a substantial number of the items that were

being re-used were not the subject of any formal re-use policy. In this respect the Commissioner was advised that Canterbury Health may not differ from a number of other Crown Health Enterprises.

Professional Nursing Unit

The Professional Nursing Unit was responsible for overseeing the professional leadership and quality of nurses' standards of practice until early 1996 when it was disestablished as part of the restructuring of the nursing service. Responsibility for the quality of care and performance of nurses and the development and monitoring of standards of practice was then transferred to the Patient Care Managers.

Occupational Health and Safety

There do not appear to be any policies outlining how Occupational Safety and Health is integrated at ward and unit level or how managers might access services from the staff educators. Staff considered that the Occupational Safety and Health Co-ordinator could take a more pro-active approach. The Commissioner was also advised that there have been occasions when Occupational Safety and Health forms have gone missing and staff have not received follow-up.

There is an awareness of the health risks of glutaraldehyde use. In the Gastroenterology Unit there is up-to-date machinery, protective equipment and staff training. However, there are said to be continuing problems in some of the theatre areas, where trays of glutaraldehyde stand in the corner of the theatre and the fumes are said to cause problems for some staff.

Portable x-rays have been used in the resuscitation areas of Christchurch Hospital for some time. In November 1996 the National Radiation Laboratory informed Radiology's Medical Director of the need for radiation barriers in the Emergency Department. Radiation protection work for Resuscitation Rooms one and two was completed in February 1997. The Commissioner was advised that Resuscitation Room three would be leadlined by mid July 1997.

Where possible patients are transferred to the Radiology Department for x-rays where better imaging equipment is available. The decision to use portable equipment is made by a doctor based on clinical indications. In January 1998 Canterbury Health confirmed that there were 6 resuscitation rooms, all of which are leadlined.

Clinical Committees and their Authority

A number of committees exist as clinical advisory groups but have no formal decision-making authority. It appears that all hospital-wide committees report to the relevant General Manager, but this is not clear from the committees' terms of reference. The former Chief Executive stated he received copies of Infection Control and Radiation Safety Committee minutes and was advised if there were particular issues causing concern. It was also not clear what process committees should follow to have their recommendations supported or implemented. Some committees, such as the Infection Control and CPR (Cardiopulmonary Resuscitation) Committees, review hospital-wide issues and make recommendations about practices and products. However, often there is reported to be a delay or inaction in implementing their decisions (for example, the delay in implementing a single use items policy). According to the Minutes of Medical Advisors Breakfast Meeting in July 1996 the

Medical Advisors were going to review all standing committees and set up a database indicating how these committees reported back to line management. This did not appear to have been actioned.

Incident Reporting - Audit in 1994

Southern Regional Health Authority undertook an audit in 1994 to determine whether Canterbury Health had implemented a formal incident reporting process, including policy guidelines, definitions of an incident, a monitoring process and a corrective action process. The Authority concluded that the material provided by Canterbury Health fell short of a comprehensive and credible policy. Canterbury Health's process consisted of nursing incident reports only, rather than all incidents hospital-wide and accompanying documentation to the incident reports was undated.

Canterbury Health was found not to be in compliance with the standards required in its contract with the Regional Health Authority in respect of a formal incident reporting process. Canterbury Health agreed to develop a hospital-wide policy by 20 September 1994.

Southern Regional Health Authority undertook no follow-up action to determine whether the policy was implemented.

The need for a comprehensive incident reporting process was identified at a Medical Policy Group meeting and the General Manager Christchurch Hospital Services wrote to the Medical Advisors on 22 June 1994 requesting consideration of the matter. The Medical Advisors sought advice from the Professional Nursing Unit, Healthlink South and Christchurch Hospitals' Medical Staff Association and then held further discussions among themselves. They considered that "*a central system across all departments may be desirable*" and wrote to the Clinical Directors on 1 September 1994 to inform them of this and to seek "*brief details of any system you have in your unit for reporting medical incidents to you as a Clinical Director*".

Incident Reporting - 1995

Canterbury Health attempted to set up a comprehensive incident reporting procedure across the Hospital in 1995. A combined Nursing/Medical Incident Form was developed by the Medical Advisors and sent to the Chair of Christchurch Hospitals' Medical Staff Association, Clinical Directors, General Managers and various others on 1 February 1995 and again on 1 March 1995 seeking comment on the draft form.

On 14 August 1995 the final combined Nursing/Medical Incident Form was sent out by the Medical Advisors and the Professional Advisor Nursing and Midwifery Services to Clinical Directors, Heads of Department, Unit Nurse Managers, all clinicians and General Managers. The procedure for incident reporting was clearly set out, but it was not accompanied by a procedure for review or audit of incidents.

Incident Reporting - 1996

Despite the above effort, there was no comprehensive incident reporting system in operation at Christchurch Hospital in 1996. The system for incident reporting was not widely adopted by medical staff. Many of the medical staff reported to the Commissioner that they believed that

incident reporting (by means of incident report forms) was a nursing activity and very few incident report forms were received from medical staff.

However, it was apparent that there were some departmental types of incident reporting in operation, for example, in the Emergency Department. While these were not hospital-wide, they did address some of the problems that were occurring. In some areas, incident reporting was used proactively as an audit tool to improve the quality of services.

On 7 August 1996 the Medical Advisors wrote again to Clinical Directors and Medical Directors outlining the incident reporting procedures:

> "*In the year since the introduction of this system, very few medical incidents have been reported. In order for this important audit process to be successful, please ensure all medical staff, senior and junior, in your department report all incidents deemed by them to be of significance*".

Despite this reminder, there was a relatively poor response from medical staff.

Reporting and Follow-up of Incident Reports

Incidents were reported using standard forms, memoranda, letters, reports, cardiac arrest report forms and in Morbidity and Mortality peer review meetings. The actual number of incidents is thought to be under-reported. The word "incident" appears to be interpreted as something that has happened that is an outcome for the patient. Thus, where a potential incident is averted it is not always classified as an incident and therefore not recorded.

The Commissioner was informed of several potential incidents that had been averted by skilled clinical practice. The Commissioner was also told that staff had felt frustrated and "put down" by management when in some cases they completed an incident form about an incident which almost happened and were given the impression by management that the form should not have been completed.

Some professional staff perceived that little was done when incidents were reported, or if something was done, the response was punitive. It was noted by the Commissioner in a review of the correspondence relating to one particular incident in which the response was perceived by staff as punitive, that in fact a constructive and quality focused response was given by management.

After the Christchurch Hospital restructuring in early 1996, the number of incidents reported reduced quite markedly. Consequently, the Performance Monitoring Unit undertook a major education process with the Patient Care Managers to ensure that they knew what was expected regarding the processing of incidents and what the information meant. Incident reporting improved to such an extent after this that the Board asked for an explanation of the trends.

As a result of the restructuring of Christchurch Hospital in early 1996, the person who had previously collated and analysed the incident reports was removed from her position as Quality Assurance Co-ordinator in the Professional Nursing Unit. All incidents and accidents were then dealt with by the Patient Care Managers who passed information on to an Information Officer in order for the data to be reported to the Performance Monitoring Unit.

The Performance Monitoring Unit then collated the numbers and types of incidents for reporting to Christchurch Hospital management.

Clinicians' fear of prejudicing themselves in a later inquiry or litigation meant that management has had great difficulty in getting clinicians to report formally to management on incidents and clinical audits or to complete incident reports. The former Chief Executive reached an agreement with the Medical Advisors that he or the General Manager Christchurch Hospital Services would be notified of any breaches of clinical practice that were serious and could lead to litigation or presented a risk to patient safety.

The Commissioner has sighted no evidence to indicate that there were regular reviews and professional analysis of aggregated incident data at either a divisional or hospital-wide level until 1997 when the Christchurch Hospital Incident Review Committee was established.

Quality Reviews - the Emergency Department

Since June 1996, the Emergency Department has used its own incident report forms which are read and actioned daily. They are then discussed on a weekly basis at the Emergency Department Management Meeting at which the Emergency Department's Clinical Director, Service Manager, Clinical Nurse Specialist and any other specialist on duty meet weekly to discuss incidents and any other issues that have arisen. Since appointment in 1997, the Quality Assurance Co-ordinator now attends these meetings and brings significant issues to the attention of the new Christchurch Hospital Incident Review Committee.

Since the introduction of a computerised triage system in the Emergency Department in mid 1995, waiting times in triage categories are produced automatically. These results are examined each time that a triage category one or category two case exceeds the recommended waiting time.

Regular cluster meetings are held with the Intensive Care Unit and the Department of Anaesthesia which are attended by the three Clinical Directors, a finance person, the General Manager Christchurch Hospital Services and the Service Managers.

Each month an audit or morbidity review is undertaken of a subject chosen at random. Morbidity and Mortality meetings are held every second month and at these meetings triage categories and protocols are often discussed.

Audits of deaths have been carried out by the Emergency Department since May 1996. Three of the deaths noted in the Patients are Dying Report were brought to the attention of the Medical Advisors and subsequently to the General Manager as a result of these audits.

Product Evaluation

A Product Nurse is employed to review new products entering the Hospital, review products being used, consider where standardisation may apply, and address inappropriate product use.

Responsibility for Quality Assurance

Canterbury Health considered that a primary responsibility of line management and the professional staff was to ensure appropriate quality assurance processes were in place and appropriate clinical standards met. The Board regarded Clinical Directors as having a professional

responsibility to manage the medical and quality related issues in their service and relied on their proper performance of this role to ensure that quality issues were addressed.

The General Manager Christchurch Hospital Services relied on Clinical Directors and Service Managers to keep him informed of any problems and had formal weekly meetings with Patient Care Managers and Service Managers. He met fortnightly with the Medical Advisors together with the Chief Executive, and the Chairman and Deputy Chairman of Christchurch Hospitals' Medical Staff Association. He also met monthly with Clinical Directors, nursing staff and management in the various areas grouped together in the organisational structure as "clusters".

Until 1997 there was no central quality committee and quality co-ordinator.

Crown Company Monitoring Advisory Unit Performance Indicators

On the establishment of the Crown Health Enterprises, the Crown Company Monitoring Advisory Unit (CCMAU) put in place measures and processes, described as "quality measures", by which the clinical and operational performance of all Crown Health Enterprises could be measured and compared.

There were a limited number of Crown Company Monitoring Advisory Unit quality measures, called clinical indicators, that related to patient care. The original list included patient falls, medication errors, unplanned readmission to hospital, blood stream infections, surgical site infections and unplanned return to the operating theatre.

In February 1996 the Crown Company Monitoring Advisory Unit advised all Crown Health Enterprises that they no longer required monitoring of Crown Company Monitoring Advisory Unit clinical indicators (with the exception of blood stream infections and surgical site infections). Crown Company Monitoring Advisory Unit advised that due to wide variations in the collection and interpretation of the data, the results could not be used to compare the performance of one Crown Health Enterprise against another.

Canterbury Health continued to collect the Crown Company Monitoring Advisory Unit performance indicators for internal use and intended to add several other measures of quality and efficiency related to discharge, clinical pathways, and time from admission to theatre. However, Canterbury Health never appeared to develop measures for monitoring the categories of clinical audit and quality indexing as outlined in Canterbury Health's quality plan.

The Crown Company Monitoring Advisory Unit advised the Commissioner in September 1997 that

> "*...CCMAU does not consider it has a role to monitor clinical performance. ... this is the role of the Ministry of Health, which licenses CHE hospitals)* (sic) *and the THA (as purchaser of services)"*. Further, they advised that *"... CCMAU does not consider that a CHE board could rely on these clinical performance indicators. Boards are expected to have their own measures in place to manage them*".

The General Manager Christchurch Hospital Services, was critical of some of the measures used by the Crown Company Monitoring Advisory Unit to measure the relative operational efficiencies of the Crown Health Enterprises. For example "average length of stay" is used as a measure of operational efficiency. He considered this inappropriate as it did not allow for

the varying complexity of day surgery performed by the different hospitals. This in turn meant that there was no provision for variations in recuperation time allowed following different surgical procedures. The Crown Company Monitoring Advisory Unit advised that the "average length of stay" measure was changed in March 1996 to include data based on both day surgery and inpatient surgery and that both of these measures are case mix weighted to reflect complexities.

Further, the former Chief Executive considered that the information available was inadequate to accurately determine the relative efficiencies of each of the Crown Health Enterprises. Consequently, in his view Treasury and the Crown Company Monitoring Advisory Unit had formed a view as to what savings should be put into Canterbury Health's 1995 business plan on the basis of inadequate information about Canterbury Health's efficiencies compared with standard best practice. However, the Board minutes for the period from August 1995 to February 1997 inclusive do not contain any references to the Chief Executive noting the inadequacy of the Crown Company Monitoring Advisory Unit efficiency criteria. Nor is there criticism by any Board member of these measures. The Chair of the Board, Dr Layton, reported that the Board considered that the Crown Company Monitoring Advisory Unit indicators were adequate and fair "*as far as they went*" but that they were not the only indicators relied on.

Autopsies

The Board placed emphasis on Canterbury Health's autopsy rate as one of the quality indicators reviewed. Dr Layton advised that autopsies were seen as "*the medical equivalent of quality assurance processes*". Both Dr Layton and Professor O'Donnell considered that reporting the autopsy results back to clinical staff would enable clinicians to monitor the quality of diagnosis and the appropriateness of treatment. Dr Layton stated that "*if you have an autopsy, you find out whether the diagnosis is right, whether the treatment was appropriate, timely and so forth, and then you have a feedback loop that goes back into the clinicians who are doing this"*. This would facilitate continuous clinical improvement.

As the Southern Regional Health Authority did not specifically purchase autopsies, the cost of purchasing autopsies was part of the overheads of Canterbury Health.

Canterbury Health decided that the autopsy rate should be above 20% of all deaths in Christchurch Hospital and achieved this. At each Board meeting, the Directors were informed of the numbers of autopsies performed as a percentage of deaths at Canterbury Health's hospitals. They did not receive the information obtained as a result of the autopsies about the quality of diagnosis and the appropriateness of treatment.

The Commissioner was advised that until about a decade ago autopsies were one of the main quality assurance tools. However, with the increasing sophistication of organ imaging techniques such as Computerised Tomography (CT) and Magnetic Resonance Imaging (MRI) scans and other technological advances (such as fibre optic endoscopy which allows the direct viewing of internal organs) there has been a progressive improvement in diagnostic accuracy, and it is generally considered that the value of autopsies has decreased, given that they cost about a thousand dollars each, and raise ethical problems. The clinical autopsy rate (that is, excluding Coroner's cases) at Auckland Hospital in 1986 and 1996 illustrates the decline in the autopsy rate in New Zealand over the last decade. In 1986 the rate was 31.4% of deaths (283 clinical autopsies). In 1996 the rate was 5.5% (50 clinical autopsies).

Reporting to the Board of Canterbury Health

The Chief Executive reported to the Board on matters arising from his meetings with the Medical Advisors, General Managers, Service Managers and Patient Care Managers. In addition, at each Board meeting the Chief Executive would report on correspondence or conversations that he had had with the Executive of Christchurch Hospitals' Medical Staff Association. The Board emphasised the importance of being provided with data covering systems and processes important in the delivery of care, and was generally satisfied with the adequacy and extent of reports received by it from the Chief Executive and senior management. In particular, the Chairman of the Board stated that he was satisfied that the standard of information he received from the Chief Executive was of sufficient quality to make appropriate decisions on strategic and operational initiatives and to manage the risks associated with these decisions. Dr Layton commented:

> "*I think it would be hard to find a CHE Board in the country that had such a focus on risk management, such a focus on those quality indicators, tied with the Chief Executive salary, had review processes, had internal audit of its own charter, had a proper process in terms of that, had legal and risk reports at every Board meeting, had the Performance Monitoring Unit separate from other bodies and so forth*".

Targets for all performance indicators were set out in the business plan. The Chief Executive's enterprise performance bonus was partly determined by performance relative to these performance indicators. Since the Chief Executive's bonus controlled the bonus levels of all General Managers, the bonuses of the entire senior management team were partly tied to performance on these quality indicators.

The Board minutes of August 1996 identified that a report was presented by the Performance Monitoring Unit which raised concerns about the quality and safety of care in Christchurch Hospital. The Chief Executive pointed out that the data presented by the Performance Monitoring Unit needed to be kept in perspective and that a considerable amount of work was being undertaken to rectify the situation. A Board member advised the Commissioner of being satisfied issues were being dealt with after an explanation by the Chief Executive and General Manager Christchurch Hospital Services of the actions taken to deal with the Performance Monitoring Unit's concerns. However, the Commissioner was unable to identify that any reviews of systems took place, that staff education issues were addressed or monitoring enhanced.

Significant internal memoranda to the General Manager Christchurch Hospital Services addressing concerns by senior clinical staff appear not to have been presented to the Chief Executive or Board for their information or to provide further collaboration of the Performance Monitoring Unit's concerns. The General Manager Christchurch Hospital Services advised the Commissioner that it was not necessary to refer some of these concerns as a number of them were incorporated into the restructuring in 1995/96.

The New Chief Executive Reviews Quality Assurance, Early 1997

In January 1997 Canterbury Health began a number of initiatives to review and improve quality assurance. The General Manager, Special Projects reviewed quality assurance activities and incident reporting processes in January 1997 for the new Chief Executive. This "Snapshot" report, although completed within very tight time constraints, involved interviews

with various Service Managers, Patient Care Managers, Staff Educators, staff of the Performance Monitoring Unit, the Company Secretary, the Medical Advisors and the General Manager, Diagnostic and Support Services and the review of certain documents, including the Canterbury Health Quality Plan, correspondence with the Ministry of Health and the Medical Advisors' Report on the Patients are Dying Report. Conclusions reached by this report follow.

(a) "*There appears to be no explicit or implicit, planned or systematic* (sic) *divisional or hospital wide Quality Assurance Programme at Christchurch Hospital at present.*

(b) *The quality related processes and procedures in place appear to be reactive rather than proactive, with wide variation in implementation between departments and professions.*

(c) *There appears to be differences between the expressed processes and procedures and the reality of individuals' and departments' experiences of these processes and procedures.*

(d) *The interpretation and implementation of quality assurance and quality development appears to be completely devolved to third tier line managers in the Christchurch Hospital Services division.*

(e) *Inter and intra divisional communication, co-ordination and integration activities related to quality appear to be ineffective or absent.*

(f) *Differing perceptions of the roles of Patient Affairs Manager and the Performance Monitoring Unit appears to be creating possible gaps in incident monitoring.*

(g) *Formal and explicit processes to audit compliance with guidelines and standards appear to be lacking, as are processes and procedures to monitor the ongoing appropriateness and updating of those standards and guidelines.*

(h) *The lack of an interim acting Nurse Advisor, or formal temporary re-allocation of some of that position's professional responsibilities since August 1996 appears to have created a gap in the analysis and synthesis of nursing incident information and in the processes required to update standards*".

A Quality Assurance Committee was established by the new Chief Executive in February 1997. The committee's overall objective is to "*plan, implement and evaluate a quality management system for the division, with a focus on continual quality improvement*". Its stated short term goal was to develop a quality strategy by:

(a) reviewing and documenting current quality systems;

(b) assessing quality systems available in New Zealand and making a recommendation to the Chief Executive;

(c) determining the resources and support necessary to introduce and sustain a quality system; and

(d) drafting a quality plan for submission to the Chief Executive and Board.

The minutes of three of these meetings held during February and March 1997 indicate that the following matters were discussed.

Incident reports for the period July 1996 to January 1997 were reviewed. The review outlined several key issues that needed to be addressed to prevent incident recurrence. These key issues constituted critical system and process discrepancies that might compromise patient safety. The report concluded that the following "*would seem timely and prudent in the immediate future*:

Provision of appropriately skilled staff for 'special' and 'escort' responsibilities. (now being addressed by CEO, see also [(iii)] *below)*

Systems for timely and appropriate clinician interventions for patients throughout services, particularly during evenings, nights and weekends.

Permanent bank of appropriate nursing resources to manage acuity variances. (now being addressed by CEO).

Revue (sic) *of Emergency Department resources.*

Clarification of bed management for timely/appropriate admissions process.

Review of documentation processes throughout all stages of care delivery.

Implementation of effective OSH assessment/education programmes.

Clarification of Duty Manager role/responsibilities/resources.

Commence general education programmes on policy and procedures, documentation, consent and patient safety.

Incident Reporting responsibilities and process. (now being addressed by QA Co-ordinator)".

A review of the reporting process with a memorandum to all clinical staff on the need for and processes of incident reporting.

Confirmation that Morbidity and Mortality reviews (medical peer review and audit) were not occurring across Canterbury Health or being well managed and agreement that this needed to be definitively addressed.

Development of a Quality Planning Steering Group to enable a "*proactive approach to Quality Improvement*". The Quality Assurance Co-ordinator indicated that the Christchurch Hospital Quality Assurance/Quality Improvement Campus Committee would develop divisional plans once Canterbury Health's quality plan was updated.

Quality Assurance Co-ordinator and Quality Planning Steering Group

In February 1997 a Quality Assurance Co-ordinator was appointed. The Co-ordinator, who is accountable to the Director of Nursing, monitors incidents and complaints and is a member of both the Quality Assurance Committee and the Quality Planning Steering Group which was established in March 1997 to oversee all quality assurance and quality improvement initiatives. This group also comprises a Medical Advisor, the Director of Nursing, the General Manager Christchurch Hospital Services, the Risk Manager, and the Quality Control Manager of the Diagnostic and Support Division of Christchurch Hospital. The Steering Group reports to the new Clinical Policy and Planning Committee described elsewhere in this Report. The Board receives monthly reports from the Quality Assurance Co-ordinator.

Incident forms are sent by Clinical Nurse Facilitators to the Patient Care Managers or Service Managers who now forwards them to the Quality Assurance Co-ordinator.

Incident Review Committee

An Incident Review Committee was established in March/April 1997 to review incident reports referred to the Quality Assurance Co-ordinator. These weekly meetings are attended by the Quality Assurance Co-ordinator, the Risk Manager, the Medical Advisors and the Company Solicitor. The Committee's aim is to provide a formal mechanism for the review of incidents at a senior level. Incidents to be reviewed by the Committee include:

"*Incidents which exhibit clinical practice failures*

All incidents which result in significant patient injury, e.g. a fracture following a fall

Incidents that are an example of an emerging trend, where further action may need to be taken than that already initiated.

Incidents which have characteristics of "risk" for the Organisation

Incidents which may become complaints

Systems failures

All incidents primarily involving Medical Staff (at the request of the Medical Advisors)

Any incident about which the QA Coordinator has a concern"

Reports prepared by the Committee and suggestions for improvement are submitted to the General Manager Christchurch Hospital Services and to others where appropriate.

Risk Management

Canterbury Health appointed a Risk Manager in early 1997. Most Crown Health Enterprises of a similar size and complexity have had a Risk Manager for at least two years.

A Risk Management Committee comprising a range of clinical staff was formed in March 1997.

A risk management policy has been drafted, and a range of priorities identified. The policy identifies that risk management should be devolved to the managers of each division and be the responsibility of line managers. The Commissioner was advised that risk management does not as yet have a high profile at a ward and unit level. The link between the Risk Management Committee and the Quality Assurance Committee has been established. The Risk Manager attends Quality Assurance Committee meetings and the Quality Assurance Co-ordinator is a member of the Risk Management Committee.

Dr Layton advised that responsibility for risk management was commenced from 1993 and a Risk Management Committee existed from that year. However, no evidence of clinical input to risk management was apparent.

Risk Management - Cardiac Arrest

Some concern was expressed by a clinical nurse facilitator, a duty manager and a nurse that front-line clinical staff were not compelled to undergo annual training in cardiac arrest management and there was no policy addressing this issue. This was thought to impact at times on the effective management of cardiac arrests. Canterbury Health informed the Commissioner that it has a cardiac arrest policy which states that all trainee interns and first year house surgeons undergo formal CPR training provided by the Department of Anaesthesia and that medical registrars have training in advanced life support and head the cardiac arrest team. Registrars undergoing surgical training are required by their College to attend an EMST (Early Management of Severe Trauma) course which is an advanced trauma care course.

Nursing staff trained to teach others in the technique of Cardiopulmonary Resuscitation (CPR) have been identified in most settings but management have not clarified their expectation that clinical staff will co-operate with the trainers.

There is no consistent practice of orientating medical staff to the Hospital and this has been reported as an issue in the use of emergency equipment.

The Duty Manager traditionally attended all cardiac arrests and other emergencies. In 1996 Patient Care Managers carried the duty manager locator during the day and the Commissioner was advised that there were occasions when the Manager on duty did not attend a cardiac arrest because of meetings. This was a particular problem when emergencies occurred in an area such as Radiology and Physiotherapy, where there was not always a nurse present and nursing skill was required to assist and co-ordinate the resuscitation event.

The Chairperson of the CPR Committee advised that the incidence of arrests and analysis of the outcomes was studied intermittently on a formal basis by that Committee. The CPR trainer reviewed all forms that were received and discussed issues with the chairperson of the Committee as required. The CPR Committee meets six monthly and reviews the arrest management sheets for trends and issues. It was not clear what has been done by Canterbury Health with this information in relation to changes in policy, practice and equipment, although the CPR trainer provided a number of reports and recommendations for approval by the General Manager Christchurch Hospital Services to whom the CPR Committee is accountable.

Canterbury Health advised that the Director of Nursing has ensured that by the end of 1997 the majority of nursing staff had attended a CPR update. All CPR instructors received update sessions. The status of CPR training for nursing staff is monitored by monthly competency updates.

Risk Management - Security

Canterbury Health has employed a security contractor to respond to violence or threats of violence towards staff and patients. Security personnel are present in the Emergency Department at night and are readily available on call at other times. The Hospital is developing a policy to address patient restraint practices. Some staff have felt threatened by visitors to gang member patients and have raised their concerns with their managers. Some staff considered that management have not acted on their concerns.

Risk Management - Disaster Planning

Staff identified that while there were some instructions about what should happen in particular units in the event of a disaster, the overall plan was out of date. The person given the task of updating the hospital-wide plan, information processes and staff preparedness had to fit this into their pre-existing role at Christchurch Hospital, as authority was not given to appoint a new member of staff to undertake this task.

The Hospital has demonstrated its ability to cope with multiple emergencies on a few occasions (for example, the Rolleston Train Crash and the Christchurch Girls High science experiment) but there is some concern about what would happen if the Emergency Department was inundated with patients. While there have been disaster response practices within the Emergency Department, general ward staff education and practice in disaster response procedures was said by some staff to need updating.

In the event of a major interruption to Christchurch Hospital's services, Canterbury Health considered that tents could be acquired from the Army so that patients could be re-located to Hagley Park. However, doubt was expressed as to whether such tents were still available locally.

Christchurch Hospital is an essential component in the Regional Disaster Response Plan. The Christchurch Hospital Disaster Response Plan was revised in 1994 for the Emergency Department, following the Rolleston train disaster. The newly formed Disaster Steering Committee determined in 1997 that the revised draft response plan required co-ordination with other departments in the Hospital and ratification. The Commissioner has been shown no evidence of the completion of such co-ordination or ratification. The General Manager Christchurch Hospital Services has delegated responsibility for the Disaster Response Plan to the Disaster Steering Committee.

The Southern Regional Health Authority recently convened a meeting of all agencies that would be involved in a regional disaster response. Some of these agencies are now approaching Christchurch Hospital to ask how the Hospital would manage certain aspects of the response. The Commissioner has been advised that these issues have not been worked through as yet.

Canterbury Health advised that in the event of a regional emergency and immobilisation of the hospital, Civil Defence is in control of mobilisation of the army hospital. The Civil Defence "response cascade" is located in key points of the Hospital and is triggered by Civil Defence.

Concern was expressed by a clinician in September 1996 that the Emergency Department had inadequate facilities to cope with a mass casualty incident. At that time the Emergency Department could only deal with two serious victims of trauma at once, and a third with difficulty by using a poorly resourced third resuscitation room.

In January 1998 Canterbury Health advised the Commissioner that in October and November 1997 new internal and external disaster plans were ratified and included in the Policy and Procedure Manuals. In December 1997 these new plans received encouraging feedback from St John Ambulance who wrote to the Southern Regional Health Authority commending the work.

A 1996 Regional Trauma report *(Regional Trauma Service Project, Stage Two: Hospital Services)*, produced by the Southern Regional Health Authority and the Accident Rehabilitation and Compensation Insurance Corporation, also raised concerns about Christchurch Hospital's

ability to provide an advanced trauma service. Canterbury Health supports the initiatives suggested in this report, but noted that the project was not funded by the Health Funding Authority.

In January 1998 Canterbury Health advised that a dedicated trauma team had been in place at Christchurch Hospital since late 1997.

Policies, Standards and Guidelines

Canterbury Health is currently developing comprehensive policies and procedures to assure quality and manage risk. While there are existing policies and procedures for a number of activities, these are in different formats throughout the organisation and there has been no central index or control process. A draft index was produced for the Commissioner along with copies of some of the existing policies and procedures. The Commissioner was advised that there were not necessarily policies written for all of the headings listed on the index pages.

A new project was established in May 1997, under the guidance of the Risk Manager, to find and index hospital standards, policies and procedures for all services. Decisions are also being made as to the formatting of policies and procedures so that work can commence on updating all existing information.

In most areas the Commissioner was advised that there are guidelines for nurses. Some of these have been updated in the past year. These are not multidisciplinary guidelines and are generally specific to one speciality setting. The Hospital has published an updated handbook "Management Guidelines for Common Medical Conditions" to provide guidelines for medical staff. These guidelines have now been made available nationally. Canterbury Health also has guidelines for junior staff in particular services e.g. Orthopaedics. A number of staff commented that while hospital managers might say there are policies on a number of issues, the staff at ward level do not necessarily know what those policies are.

Many of the policies, standards and procedures sighted by the Commissioner did not have dates of issue or dates for review. The person authorising the document was not always identified and the documents were not indexed or coded. The words 'standard', 'policy' and 'procedure' were used interchangeably, which was confusing.

In January 1998 Canterbury Health showed the Commissioner a copy of the introductory volume of a Policy and Procedures Manual dated 30 November 1997.

STAFFING AND CONTINGENCY PLANNING

Issues Raised in 1994/1995

Concerns were raised by clinicians and the Medical Advisors during 1994/95 about under-staffing and the ability of Christchurch Hospital to deal with demand during winter. For example, the Medical Advisors wrote to the former Chief Executive, Mr Frame, in May 1995 stating "*Proper care and communication can be achieved with normal levels of activity. Our point is that frequently, levels of activity are above normal*".

Mr Frame advised the Commissioner "*John Coughlan and I were both very concerned about the fact that we were going into the 1996 winter without having addressed issues that had arisen*

during 1994 and 1995". Mr Frame described having raised these concerns with the Board when it was formulating Canterbury Health's business plan for 1996. Mr Frame stated the Board had decided that there was to be no provision in the business plan for any increase in demand, as both the Southern Regional Health Authority and the Crown Company Monitoring Advisory Unit had determined that growth in demand was driven by growth in supply and therefore that there would be no increase in resources. (The economic theory is that because the demand for free goods is unlimited, you have to regulate supply to control demand.)

The 1995 Post "Think Tank" Meetings

The post "think tank" group (described earlier in this report) met in September and October 1995 and made a number of observations in relation to acute medical patients. Attached to the minutes of the second meeting, and described as a summary of both meetings, was the following series of observations and recommendations:

Pre-admission

that space be made available in Outpatient clinics for the acute medical registrar and general practitioners to refer patients semi-urgently;

that improved outpatient investigation facilities be made available to avoid unnecessary admissions;

that a cell phone might be useful for the duty medical registrar;

Admitting process

that more equipment be purchased for the "holding" ward (two monitors, two pulse oximeters and an ECG machine);

that closer links with Health Care of the Elderly be developed;

to avoid delays, that x-ray support be improved by employing more radiology staff, porters and escorts during evenings and weekends;

that more equipment be purchased for admitting wards, particularly ECG machines;

Inpatients

that investigative duplication be avoided (it was assumed that the Patient Management System would improve this);

that formal discharge planning be undertaken by the medical team, nursing, allied health departments and Health Care of the Elderly (this recommendation was implemented);

that specialists focus on post-acute ward rounds and discharge planning to speed up the discharge process;

that doctor/nurse integration be improved for the efficient management of each facet of a patient's care;

that the IV community service be used more so that patients' stays could be shortened by giving them IV antibiotics at home;

Discharge Process

that discharge plans assist the discharge process, especially at the weekend;

that consultations and investigations on inpatients be carried out more quickly;

that there is daily communication between registrars and consultants; and

that a relief registrar should help in General Medicine (this recommendation was implemented).

According to the Patients are Dying Report only two ((c)(ii) and (d)(iv) above) of the recommendations made were implemented by Canterbury Health. It should be noted that (d)(i) is an observation rather than a recommendation and is related to the formal discharge planning process that was previously described by Christchurch Hospitals' Medical Staff Association as having been implemented.

When the comment was made at a Medical Advisors Breakfast Meeting in December 1996 that issues regarding the location of patients were to be addressed in the Resource Review Project, the Chairman of Christchurch Hospitals' Medical Staff Association commented that "*these issues had been discussed previously in the 'think tank' and these need to be incorporated into solutions"*. The Chief Executive then asked for the think tank minutes to be forwarded to the Emergency Department's Clinical Director and Service Manager for inclusion in the February 1997 board papers.

Dr Coughlan considered that the issues raised by the post think tank group were primarily addressed by the structural changes made in 1996 and that many of the issues were clinical matters, not management matters.

Nurse Staffing and Skill

Having an adequate number of nursing staff who are sufficiently skilled to cope with the clinical needs of consumers and their families is a central component in providing health services of an appropriate standard. The pressure of increased patient numbers and acute care needs in winter has been perceived to be a problem by nursing staff at Christchurch Hospital for many years; staff also believed there was a reduction in nursing staff numbers over the period from 1995 to mid 1996.

Canterbury Health has not been able to provide information about nursing staff turnover by service. The information available suggests that nurse numbers and turnover were not being analysed prior to the Ministry of Health's request for clarification of the position in September 1996. Nursing staff numbers at Auckland Healthcare were used in some of the comparisons sent to the Ministry, but the information did not compare "like with like".

Nurse Staffing Numbers

According to the formula used nationally to calculate nurse hours per patient day, the general medical and surgical wards at Christchurch Hospital were staffed to the national average of 4.5 nurse hours per patient day at the time the Commissioner's Nursing Investigator was gathering information. However, this formula needs adjustment for speciality units such as Coronary Care, Emergency Department, Oncology and Paediatrics and there is evidence to suggest that nursing staff numbers in these areas was lower in the period under investigation than is required to meet demand. Emotional support is not something that can be anticipated. A nurse must be free to work with a patient at the right time and staffing was not thought to allow for this.

The Cardiology service also reported that they had inadequate numbers of experienced specialist nurses to cope with patient escorts to Dunedin or the replacement of specialist nurses in the Coronary Care Unit when sickness depleted core staffing.

Recruitment for the Emergency Observation Area was said by a number of Clinical Nurse Facilitators and nurses interviewed to have depleted the wards of experienced nurses and to have seriously impacted on their own ward staffing.

Winter 1996

For some staff, the winter of 1996 was not as bad as that of earlier years. However for many the winter of 1996 was thought to have created more significant problems than previously.

Patient numbers were higher (8%) which meant that the number of people to be placed in a bed was potentially higher.

Many of the managers were new to their roles and were managing the winter pressures for the first time.

Those staff in the Clinical Nurse Facilitator and Patient Care Manager roles had only just been appointed when winter impacted earlier than expected. There had been inadequate time for planning.

There was already an over-dependence on casual nurses to supplement ward staff numbers, which meant that during winter the skill mix became critical when experienced ward nurses were off sick and more casual staff were recruited.

Morale was low due to the upheaval of the past few months.

Staff sickness was high, due to seasonal factors and also due to stress.

Acute admitting wards were not adequately resourced, either in terms of equipment or staff, and the casual staff employed on temporary contracts to staff these wards had not been fully oriented to the wards and protocols.

There is evidence that each year there was a review of the issues arising from the previous winter. However, some nursing and management staff interviewed felt that contingency planning was not as systematic and extensive as it should have been. Others were concerned that those directly involved in managing the winter influx of patients were not involved in planning for it.

There was still some anxiety about Canterbury Health's preparations for winter 1997 amongst nursing staff interviewed in May 1997. For example, some staff were concerned that experienced appointees to Paediatrics would not wait indefinitely for formal approval of their appointment, and, for those who were prepared to wait, there would only be minimal time for orientation prior to the winter peak.

Skill Mix of Nursing Staff

The skill mix of the nursing staff was a matter of concern to the medical and nursing staff. A number of house surgeons advised they could not always rely on nurses to let them know when patients were not well and therefore often needed to check on patients more frequently than otherwise would have been necessary. Some house surgeons made this point to Canterbury Health. Casual nurses were said to be over-cautious at times because they did not know the accepted practice.

Many staff indicated that there was a high and increasing use of casual staff at Christchurch Hospital over the past few years. Available casual staff were seen as less experienced and skill mix problems were compounded as a result.

There were reportedly few casual nurses used in the early 1990s (one or two employed in the Hospital on a shift). This had increased quite significantly since 1994 to two or three per ward each shift. In 1995 Unit Nurse Managers were encouraged to use casual nurses rather than part-time staff, to reduce the accrual of annual leave.

The casual staff usage figures in 1996 showed an average number of 52.3 buy-in shifts per day (agency nurses). The total average buy-in shifts for each month at Christchurch Hospital equalled 1585.86 placements. In comparison, Auckland Healthcare's total buy-in usage for a similar month for four hospitals, plus mental health patient use, respite use and general community nursing and respite services, was 2000 placements.

The term "casual nurse" at Christchurch Hospital was applied to various different categories of nurses which masked their different skills, as the table below indicates.

• **permanent pool nurse**	(also known as resource team nurse)	These are experienced specialised nurses who have worked in Christchurch Hospital for a number of years, know how the various wards work and can co-ordinate a ward after-hours.
• **hospital casual nurse**	(also known as bank or bureau nurse)	These are nurses who generally have some years post-graduate experience, although new graduates were employed for the "bank".
• **bureau nurse**	(also known as private agency nurse)	These are nurses employed by a private agency. They may have minimal recent relevant acute care clinical experience because they generally work in private hospitals and rest homes, although some of them are very experienced and enjoy the flexibility and unpredictability of agency work.

Casual staff were generally used when there were vacancies on the roster due to sickness, injury, absence, study days or leave. They were also used when staffing numbers were inadequate to cope with changing patient needs. Casual nurses generally were sent to wards where the patient load was high and the needs of the patients were complex.

The Commissioner was advised that at Christchurch Hospital during 1995 and 1996, the casual pool was used as a mechanism to employ graduate nurses in the absence of a formal graduate programme. New graduates found the role of a casual nurse difficult. The role of casual nurse requires experience, confidence and a wide range of skills that new graduate staff do not yet have. The Commissioner was informed that since January 1997 new graduates are no longer employed casually at Christchurch Hospital.

According to some casual nurses, they have not always received structured support and guidance and the role can be stressful and difficult. Casual nurses may be sent to different wards each shift. They usually do not know the patients or the medical teams and may not know the systems and procedures of the ward or the location of equipment. Some wards provided a hand-over and a mini-orientation. Some wards were welcoming and collaborative.

However, this was not a universal phenomenon and there were wards where casual nurses refused to work.

The Gastrointestinal Investigative Unit has trained some casual staff who form a back-up for the unit staff in the event of illness or increased workload. In the Gastrointestinal Investigative Unit staff were not placed "on call" until they had worked in the unit for six months and, for the first few months, the Clinical Nurse Specialist closely supervised new staff until they were confident. The Emergency Department and Intensive Care Unit also had a pool of casual nurses with appropriate experience that was separate to the general casual pool.

A report was prepared in June 1995 at the request of the General Manager Christchurch Hospital Services following questions regarding the safety of patients with the then existing staffing numbers and schedules. This revealed that the majority of nurses on the casual pool had over two years' experience. However, a former staff member estimated that about 20% of the casual pool did 50-60% of the casual shifts and that the more experienced nurses (62% of the casual pool were registered nurses with over three years experience at 1 October 1996) might work 20% of the shifts. Another staff member advised the Commissioner that graduate nurses tended to seek forty hours work each week on the casual pool, while experienced nurses sought work on a more intermittent basis because of family commitments and therefore it was the most inexperienced casual nurses who did the majority of the casual work.

Canterbury Health presented the following information about nursing experience in the casual nursing pool in its 1 October 1996 report to the Director General of Health.

Staff Level	**Number of Pool Staff**	**Percentage**
Enrolled Nurses	15	13%
New Graduates (Registered Nurses (RNs))	6	5%
NP1 Equivalent (1st Year Nurse Practitioner)	19	16%
RNs with 2-3 years' experience	9	8%
RNs with more than 3 years' experience	69	58%
TOTAL	**(118)**	**100%**

The following figures were provided for its permanent staff.

Level One Beginning Practitioners	3.80%
Level Two Competent 1-2 years' experience	19.50%
Level Three 3-4 years' Experience	30.70%
Level Four Experts or Specialists greater than 5 years' experience	46.00%

On the basis that 76.70% of Canterbury Health's permanent staff had greater than three years' experience, that 70% of the casual pool had over two years' experience and that 73% of the

nursing workforce (including casual pool) were intravenous certified, Canterbury Health concluded that the current skill mix was appropriate.

The reviewers of the October 1996 report to the Director General of Health made 17 recommendations. One of the recommendations about the use of casual staff was:

> "*That the proportion of casual shifts worked to shifts worked by permanent staff be monitored, ensuring that casual staff form no more than 30% of the staff in an area on any one shift*".

In response, Canterbury Health referred to a system in place at 17 October 1996 that enabled the ratio of casual shifts worked to shifts worked by permanent staff to be monitored. The acting Chief Executive said that every endeavour was made to have less than 30% of a shift staffed by casual nurses.

The figures presented to the Ministry of Health in October 1996 did not provide adequate analysis of the following features of the casual workforce:

the number on each ward;

the number of casual staff appointed on temporary contracts to staff the acute admitting wards;

the experience of the casual nurses who worked the majority of the casual shifts (many new graduate nurses on the casual pool worked nearly full time); and

the number of new graduate casual nurses used as a percentage of the total buy-in shifts.

In addition, the information presented to the Ministry of Health did not consider the risk to the Hospital of using inexperienced nurses on the casual pool where they received little supervision or support. Casual nurses did not receive a standard orientation to the hospital, ward or particular service to which they were assigned. They did not always have experience of working in complex situations with limited support and there was no requirement for them to be on the intravenous register. Finally, the report did not appear to show an appreciation of the added pressure on permanent staff required to supervise, when up to 50% of the staff on duty were casual staff, some of whom were new graduate nurses.

The following instances of the use of casual nurses were given by staff. Casual nurses were:

> used in winter 1996 to "open" a ward (Ward 17) where beds were urgently required to cope with patient volumes and had to hunt for equipment and resources as well as receive patients who were acutely ill;
>
> asked to care for acutely ill patients overnight on stretchers in the Medical Day Unit when no other beds could be found;
>
> asked to go to more than one ward on a duty, which is not unusual in hospitals nationally but is disruptive to continuity of patient care;
>
> employed as the primary staff on the acute admitting wards, caring for some of the sickest patients in the hospital without backup and guidance; and
>
> left to supervise and observe patients with conditions that might deteriorate, despite the fact that these nurses might not be properly trained to recognise or interpret the signs of deterioration.

Staff Planning

There appeared to have been little formal workforce planning and analysis by Canterbury Health, except in some departments where low staff numbers had been identified as a problem. Some departments attempted to judge the adequacy of staffing by benchmarking staff numbers with other centres. Poor staff planning had caused concern in a number of wards in Christchurch Hospital. An example given was the Bone Marrow Transplant Service which informed the General Manager in 1996 of the impossibility of providing a seven day a week Apheresis service with only one nurse. On one occasion a Nephrology patient needing a plasma exchange after a kidney transplant had to wait until the Apheresis nurse returned the next day.

Professional Development Programme

In 1996, following the restructure, Clinical Nurse Facilitators and Patient Care Managers initially had difficulty identifying the individual capabilities of their staff. The absence of a formal professional development programme meant that there was no easy way of differentiating between the level and particular area of skills possessed by each staff member and ensuring that there was a balanced skill mix on each shift.

The nursing service had begun work on a professional development programme but this was stopped in 1995, to the regret of some staff.

Medical Staff

There were various levels of medical staff employed at Christchurch Hospital, as the table below indicates.

• **Medical Student (4th year, 5th year)**		• 4th and 5th year medical students in the "clinical years" of the undergraduate course for MB ChB • Covered by the Medical Schools - no registration status with the Medical Council
• **Trainee Intern**	Also known as • 6th year medical student	• 6th year medical student (final year of study before gaining MB ChB.) • Covered by the Medical Schools - no registration status with the Medical Council
• **House Surgeon (1st year)**	Also known as • Intern • Class 1 Probationer • 7th year • Resident Medical Officer • Junior House Officer	• Have attained MB ChB (or equivalent) and qualified to practise medicine • Hold probationary registration with the Medical Council of New Zealand • May practise as a medical practitioner only under supervision in the employ of, or in association with, an approved person. • Normally granted general registration after one year
• **House Surgeon (2nd year)**	Also known as • 8th year • Resident Medical Officer • Senior House Officer	• Have attained MB ChB (or equivalent) and qualified to practise medicine • Obtained general registration with the Medical Council of New Zealand
• **Registrar**		• Follows two years as a house surgeon • Most registrars are in training programmes with a relevant College to become specialists to

		obtain vocational registration • Usually in 3rd to 7th year post-graduation
• **Medical Officer Special Scale**	Also known as • MOSS	• Have got some skill in a branch of medicine but may not have completed a registrar training programme
• **Specialist**	Also known as • Consultant • Senior Medical Officer	• Normally will have completed five years of post-graduate training in the speciality • Normally will have attained membership or fellowship of a specialist College • May also be vocationally registered with the Medical Council of New Zealand

The New Zealand Resident Doctors Association (RDA) outlined their concerns to the Commissioner about Resident Medical Officer understaffing throughout the hospital which "*leads to a compromise in patient safety due to ... overwork… increased stress levels and a decrease in the time that can be spent assessing and treating patients, which all inevitably increase the risk of misdiagnosis and mismanagement*".

The employment contract for Resident Medical Officers provided that not more than 16 hours may be worked in any one day. The RDA stated that Resident Medical Officers were faced with the option of leaving patients unattended and going home, or struggling on and doing their best. The RDA submitted that the number of patients each Resident Medical Officer was required to attend to in the Department of Surgery at Christchurch Hospital was well above the national average. The RDA provided statistics which compared Christchurch Hospital with Auckland and Middlemore Hospitals. These hospitals were chosen because they offer the same range of services as those offered at Christchurch Hospital. In Christchurch, there were four general surgical house officers and five registrars. Auckland had a complement of seven house officers and eight registrars and Middlemore had six of each operating the roster.

The RDA asserted that the issue of insufficient staff at Christchurch Hospital was first raised with Canterbury Health at negotiations on 21 May 1996 and on numerous subsequent occasions. According to the Association, management's standard response was to state that this was a "funding issue". The Association believed that patient safety at Christchurch Hospital became a concern to management once the Commissioner's investigation was announced and that the appointment of an extra house surgeon was prompted only by the announcement of the investigation.

One Clinical Director considered that the skill mix of the medical and surgical teams who were on acute admitting rosters was often not appropriate as there was undue reliance on the trainee intern to undertake the work of a house surgeon. Clinicians generally considered that there was also insufficient support of clinical decision making for house surgeons in the general surgical service, and for others who required surgical advice, when the registrar and consultant surgeon were engaged in theatre.

The Commissioner was advised that there were insufficient qualified junior medical staff to ensure that when the Hospital was busy patients would be seen and assessed in a timely manner, and that there was an undue reliance on trainee interns and medical students to "help out" Resident Medical Officers. The RDA provided an example from 1996 where a trainee intern was required to perform pre-admission procedures on a surgical patient. Follow up of

the laboratory tests resulted in the patient being incorrectly diagnosed and then subsequently undergoing an unnecessary procedure.

Emergency Department

High Volumes

Christchurch Hospital's Emergency Department had traditionally had higher volumes than that of other Crown Health Enterprises. The following reasons were suggested by Canterbury Health for this.

Christchurch Hospital has the only Emergency Department in Christchurch. General practitioners who do not provide services at night refer their patients to the Emergency Department.

There are also few after-hours medical centres in Christchurch in comparison with other cities in New Zealand. Therefore, a lot of the work done by general practitioners in other centres is performed by the Emergency Department.

Due to the difficulties of effecting an urgent outpatient referral, general practitioners refer patients to the Emergency Department.

Staffing Numbers

The Australasian College for Emergency Medicine has laid down guidelines for the medical staffing of Emergency Departments. The guidelines state:

> *"When considering the requirements for the medical staff establishment of the Emergency Department a ratio of one doctor : patient : hour for non ambulatory patients and one doctor : patient : half hour for ambulatory patients should permit quality care, adequate supervision and proper fulfilments of the "gate-keeping" role of the department.*" (sic)

In May 1996 the College's formula was presented to Christchurch Hospital management. Concerns were raised with management about the Hospital's ability to cope with patient numbers in June 1995 and May 1996. A senior clinician suggested that Christchurch Hospital should be closer to the one hour figure than the half hour figure but used three-quarters of an hour to calculate Christchurch Hospital's needs, given that:

(i) Christchurch Hospital Emergency Department has a high level of acuity, in that it has a higher proportion of patients needing admission than other Emergency Departments;

(ii) Christchurch Hospital Emergency Department has a high proportion of general practitioner referrals, and a low proportion of inappropriate "General Practice type" patients, and virtually no follow-up patients;

(iii) there is no easy way of measuring ambulatory patients (it does not equate to how patients arrived, their triage code or how many were admitted); and

(iv) it is recognised that "ambulatory" does not accurately determine how much doctor time is required.

Using this calculation, on the basis of a probable yearly attendance of 65,000 patients, the clinician calculated that Christchurch Hospital's Emergency Department needed 27.75 doctors. At that time the Department had 18 doctors (not including the Clinical Director but including all regular casual labour), which meant that it needed 9.75 more. The Department had 19.65 doctors in April 1997 which still left a significant shortfall.

The current minimum nursing staff level established by the Australasian College is one full time equivalent per 1000 attendances per annum. The figure for nurses in the Christchurch Hospital Emergency Department in August 1996 however, was one full time equivalent per 1529 attendances per annum. After the 1997 increase in nursing staff this figure changed to 1007 attendances per annum.

While this figure represents an improvement, there are other factors that need to be considered. For example, 13 of the extra 22 nurses were allocated to the Emergency Observation Area and may not be available for Emergency Department use. If these nurses are subtracted from the total of full time equivalent nurses, there is one full time equivalent per 1,262 attendances per annum. This figure represents almost 60% more patients per nurse than the minimum Australasian College standard. The nursing staff are also required to act as escorts for patients moving to x-ray or to the wards.

Insufficient clerical staff and the difficulty in communicating in writing with management or collating and presenting information for planning also added to the stress on clinical staff.

The Emergency Department has had difficulties filling vacancies for medical staff. Canterbury Health management considered that this might have been because salaries are significantly higher in Australia and there are few Fellows of the Australasian College for Emergency Medicine available. Canterbury Health advised that there was a contingency plan in place to advertise for Medical Officers of Special Scale (doctors who have not qualified as a Fellow of the Australasian College for Emergency Medicine) for the winter 1997 workload.

The Effect of Understaffing

Waiting times - Christchurch Hospital has an Emergency Overload Disaster Plan, the first level of which is reached when there are 18 or more unseen patients (one computer screen full), at least six of whom have exceeded their triage category. Reaching this first level was said to have been a frequent phenomenon in the Emergency Department since the winter of 1996 and sometimes it happened twice a day.

Reduced Experience for Staff Training Purposes - If more staff were available, other work could be undertaken in the Emergency Department and this would enable patients to be seen more quickly and allow Emergency Department staff to acquire greater expertise in dealing with specialised complaints (e.g. those of children and cardiology patients) when they arise during night shifts.

Thrombolytic therapy - Thrombolytic therapy is not given in the Emergency Department because it requires too much space, monitoring and staff time. On the basis of research, it is preferable for this treatment to be provided in the Emergency Department. Christchurch Hospital has no written policy on "door to needle" times. At a Pharmacy Taskforce meeting in June 1995, attended by the General Manager Christchurch Hospital Services, it was suggested that there was a need to develop appropriate thrombolysis protocols and to monitor compliance with them. However, neither the Cardiology nor Emergency Departments have any such

records. The Clinical Nurse Facilitator in the Coronary Care Unit has recently started recording the times. Dr Coughlan noted this was a clinical protocol for clinicians to draft.

Proper Assessment - Doctors in the Emergency Department commented that when the department is busy they are forced to treat patients differently. They could not "*make proper assessments*". They had to do things more rapidly and could not wait for results because patients were queuing up.

Paperwork Not Done - When the Emergency Department was in a state of overload the paperwork had to be left. Registrars were of the opinion that there was a need for a more efficient x-ray reporting system. The system relied on a registrar examining an x-ray and writing a provisional report. However, because of a lack of time this may not happen. Where x-rays are taken out of hours, the "day-registrar" was supposed to go through the forms and match the tentative diagnosis with the radiology reports to ensure appropriate treatment was given. A radiologist finding a discrepancy was supposed to call a senior doctor so that the appropriate feedback can be given. However, sometimes the registrars did not fill in the provisional reports and radiologists did not report discrepancies.

Winter load

To cope with its lack of resources during the winter of 1996 the Emergency Department developed a plan to reduce waiting times. This emphasised the need to:

(i) concentrate on "core business";

(ii) involve other services immediately after triage for specific groups (e.g. transfers from other hospitals, failed discharges and post-operative problems); and

(iii) discourage full "work-ups" in the Emergency Department.

Core Business was defined as:

triaging all patients;

providing emergency care and stabilisation for seriously ill patients;

prioritising treatment for those patients who have not yet been seen by any doctor; and

referring general practitioners' referrals on early.

According to the Clinical Director's memorandum of 26 June 1996 to all Clinical and Medical Directors, "work-ups" in the Emergency Department would now be limited to those required:

(i) for patient safety;

(ii) for patient comfort; and

(iii) to determine patient disposition.

Both clinical and nursing staff advised the Commissioner that during the winters of 1995 and 1996 the Emergency Department relied very heavily on the goodwill of its staff. Numerous staff commented that they were overworked, and worked in the Department without pay rather than leave patients without adequate care. During 1996 there was only one house surgeon and one registrar on night duty in the Emergency Department.

During the winter of 1997 more beds were available for Christchurch Hospital Emergency Department patients at Burwood Hospital and better arrangements for the elderly existed with Healthlink South. However, some winter resources for the department, particularly medical officers, that staff thought had been allocated to the Emergency Department, had not arrived by the end of May 1997.

Notification to Management

Staffing levels were described in staff correspondence with management as being "dangerously low", particularly during the weekends. As early as July 1994 the General Manager Christchurch Hospital Services was notified by the Clinical Director of the Emergency Department that the Department was not providing a safe service because of insufficient staff and this was brought to the attention of management on other occasions by clinicians.

Dr Layton asserted that this matter was never brought to the Board's attention.

Skill mix

The Emergency Department was not allowed to hire extra permanent staff in winter 1996. At times the department depended heavily on casual workers, although one view was that casual staff could be unreliable, less easily audited, and less trainable.

In April 1997 the complement of senior and junior medical staff at Christchurch Hospital was far below the ratio of 1 doctor : 1 patient : 1 hour recommended by the Australasian College for Emergency Medicine. This indicator is not a strict guideline and few hospitals in Australasia meet it. One of the factors that appears to have led to the death of Mr Fonoti was that he was not assessed by any doctor more senior than a house surgeon until the registrar saw him on the ward. By this time his condition had already deteriorated to a serious level.

Warnings about skill mix were given to Christchurch Hospital management from as early as 1993. The Minister of Health and the Ministry of Health were also informed of specific concerns about skill mix in relation to patient safety.

Acute General Medical Services

(a) Available Beds

Early in 1996 it was apparent that acute general medical admissions were rising steadily each year, yet the total available medical beds were reduced to 100, increasing to 120 in the winter months. At one stage in 1996 management was informed that the number of acute general medical patients rose to 220.

Until 1997 Christchurch Hospital used two acute admitting wards rather than a home ward system. This meant that all acute admissions went to two wards, unless these were full, no matter what the diagnosis, except Paediatrics, Cardiology and Oncology.

In winter 1996 the total number of beds for general medical patients was inadequate in the two designated acute admitting wards and the other medical wards, leading to congestion in the Medical Day Unit. This led to an overflow of medical patients into non-medical wards all over the Hospital, despite the temporary opening and closing of

supplementary wards. At times in winter 1996 medical teams had patients in up to 15 wards.

(b) Medical Day Unit

The Medical Day Unit was adjacent to, but not directly staffed or supervised by, the Emergency Department. It consisted of two open areas, each capable of holding up to four "trolleys" and two separate single rooms. These were staffed for day time observation only, had minimal equipment, and experienced physical crowding. Due to the shortage of beds in the ward area, this unit often had to be kept open overnight with hastily recruited casual staff. Radiology support was by portable x-ray only if the patient could not go to x-ray. Admission to the Intensive Care Unit was not easily obtainable due to its limited number of beds, which meant that, at times, very ill patients had to be held in the Medical Day Unit.

(c) Registrar and House Surgeon Cover

The shortage of registrar cover in 1995 was acknowledged by the appointment of two further registrars in 1996, a further Cardiology registrar and, more recently, an additional night registrar. The duties of one of the medical house surgeons continue to be particularly stressful (the "duty one" medical house surgeon). There are now two night house surgeons who continue to be kept very busy.

(d) Standards of Care

Virtually all staff interviewed felt that the conditions under which they were working in winter 1996 compromised standards of care and patient safety on many occasions. The only exceptions were the Clinical Nurse Facilitators of the medical wards who felt that standards of care on their wards were reasonably satisfactory.

The situation in winter 1996 was compounded by the difficulty of matching up laboratory and radiology reports with patient location, "*all of which contributed to the near impossibility of providing an adequate consistency and continuity of care*" (junior hospital staff).

All general medical physicians wrote to the General Manager Christchurch Hospital Services on 19 July 1996 regarding compromises to patient standards and safety due to the high number of winter medical admissions. The Chief Executive informed the Board of this in August 1996 and on the recommendation of management, the Board commissioned a Resource Review.

Department of Surgery

General Position

The Clinical Director of Surgery stated that in 1996 "*the department had been running on a shoestring. There were not enough junior staff. There were also not enough beds, elective or acute operating hours and senior staff. Last year the Department of Surgery could hardly function properly*". Medical staff in the Department of Surgery perceived several major difficulties.

Lack of Supervision

Because of inadequate staff numbers, when the surgical registrar was in theatre assisting a surgeon on duty days, he/she was not available to liaise with the Emergency Department, the wards or other specialists within the hospital, or to supervise house surgeons.

The single biggest concern for the house surgeons and other speciality registrars interviewed was the non-availability of surgical registrars for advice and assistance because they were so often tied up in theatre. Junior house surgeons were therefore having to make decisions and to attend to problems that required more senior input.

It was also observed that when registrars were operating, house surgeons did not have consistent access to adequate surgical supervision. House surgeons in the Department of Surgery notified management at least twice that there were times they were unable to guarantee the safety of patients under their care. The house surgeons outlined two main reasons for their concerns:

(i) that the patient workload for each run was too much for a single house surgeon; and

(ii) that trainee interns and fourth year medical students were performing a significant portion of the workload and were largely unsupervised.

Inexperienced Nurses

It was stated that there was a lack of experienced nurses available to assist and run the theatres. During the winter of 1996, when so many staff were off sick, casual nurses were called in. As noted above, many of these were inexperienced nurses, in some cases straight from polytechnic.

Bed Numbers

Lack of beds appeared to clinicians to be a problem for the Department of Surgery in 1996. However, the General Manager Christchurch Hospital Services advised the Commissioner in July 1997 that "*I believe that there is an adequate number of surgical beds at the present time*". He did note however, that "[d]*uring last Winter* [1996] *we had to cancel some elective surgery because of lack of surgical beds. However, this is not an uncommon event in other hospitals and whilst doing this we were still able to meet our contractual obligations*".

The Lack of Administrative Assistance

According to the senior surgeons, "*unless notes were hand-written, some surgeons would still be waiting for their notes after they had met the patients they had operated on in Outpatients twice. Letters and notes were waiting three to four weeks to be typed*".

The surgical secretaries appeared to be overloaded with work and despite working overtime each day and even working on statutory holidays, they had not been able to keep up. Surgeons and secretaries stated that the support staff situation had become progressively worse. The Service Manager responsible for surgery acknowledged that secretarial workload had increased since January 1997 and that it had been untenable since March 1997. She stated that using casual or temporary staff was not

necessarily a solution. At the time of interview, the Service Manager was waiting on budget approval for another secretary.

It is clear that Canterbury Health was aware of the administrative situation in the department. The General Manager Christchurch Hospital Services stated that "[t]*he department is working at maximum capacity at present. The workload is extremely high, however the department is due to be reorganised with the appointment of 2 more senior staff members and hence clerical workload distribution will be further addressed. There are efficiency process issues that also need to be addressed*".

Canterbury Health advised that the lack of administrative assistance in the Department of Surgery was addressed with the appointment of one additional full time secretary in September 1997 and reconfiguration of workload.

Management's Perspectives of Winter 1996

In management's view, the following factors either caused or exacerbated the problems that occurred at Christchurch Hospital during winter 1996.

The volume of patients in winter 1996 was far greater than in previous years. This was due, in part, to an influenza epidemic. In particular, in June 1996 there were 869 medical admissions compared to 541 for the same month in 1995. This level of admissions was unprecedented for Christchurch Hospital and at no time was the increase predicted.

The abnormally high demand experienced by Christchurch Hospital was also experienced by hospitals in Hamilton, Palmerston North, Rotorua and Auckland. Hospitals in these centres also reported having difficulties coping with the high demand.

The influenza virus depleted the numbers of staff available to treat patients. Staff absence due to sickness was 75% above average in June 1996.

The winter problems were also compounded by the refusal of the Southern Regional Health Authority in 1996 to buy additional beds for Health Care of the Elderly at The Princess Margaret Hospital. In the previous year, the Southern Regional Health Authority had bought these extra beds. The unavailability of these extra beds meant that elderly patients who had been admitted to Christchurch Hospital could not be transferred for assessment and continuing care at The Princess Margaret Hospital. These patients were therefore placed in Christchurch Hospital and their slow discharge blocked beds. Canterbury Health and Healthlink South both made repeated requests to the Regional Health Authority and the Minister for Crown Health Enterprises for these beds to be provided.

Management Responses to Winter 1996

Canterbury Health undertook the following actions in response to the problems that arose as a consequence of the large numbers of admissions in winter 1996.

The Board met with the Clinical Directors of General Medicine and Intensive Care on 7 August 1996 to discuss the large numbers of acute medical admissions. As a consequence of this discussion, the Board resolved: "*that the General Manager, Hospital Services* [Christchurch Hospital] *arrange for Healthlink South to take any additional patient overflow this winter at Canterbury Health's expense and if a satisfactory price could not be obtained from Healthlink South, he is to consider other options for these patients in conjunction with Dr Beard, for example, the possible use of Burwood, Southern Cross and St Georges Hospitals*".

The Board resolved on 7 August 1996 that it would "*organise a group to study how to deal with winter peaks and the growth in acute cases at Christchurch Hospital*".

Nursing staff numbers were increased by 6.85% from July 1995 to July 1996.

15 full time equivalent nurses were appointed for the six month winter period.

A 30 bed ward was opened to increase Christchurch Hospital's total capacity during winter to 604 beds.

Canterbury Health requested nurses to work extra shifts of up to 12 hours when necessary.

Deferrable elective surgery was postponed. Only 10% of surgery done at Christchurch Hospital is deferrable. This measure, therefore, did not free up many beds.

Intensive Care Unit patients were transferred to other centres where appropriate.

Volunteers were used, where appropriate, to assist with non-nursing tasks.

A crèche was established so that the Hospital could continue to employ staff who had children at home during the school holidays.

Approval was given by the Board in August 1996 to extend the Intensive Care Unit by a further three beds.

Preparations for Winter 1997

There was a formal process of evaluation to prepare for the 1997 winter. A series of meetings was held for relevant people to give their views on planning for the winter and problems that arose in winter 1996 were discussed in meetings in July and August of 1996. The Resource Review Report was prepared following 55 meetings with interested parties in the months of September and October 1996. The report which followed in October took a macro view of Canterbury Health's resource planning requirement, describing the resource problem facing Canterbury Health, canvassing the factors contributing to the resource problem, summarising opportunities and options for improving resource use, and recommending an action plan to address the resource requirements in the near to medium term. The key recommendation of the report was the proposal to establish a "DESIGNCARE" project plan to look at projects such as identifying services that must remain on the Christchurch Hospital site, identifying alternative provision sites and opportunities, reviewing a number of issues such as primary care/tertiary care, Emergency Department resources and processes, and inpatient management processes.

As a consequence of the various meetings, discussions and the Resource Review Report, the following actions were taken.

The Emergency Observation Area in the Emergency Department was redeveloped. There are apparently plans to further redevelop this area and provide an additional 25-30 beds.

A decision was made to install a 15 bed "step down unit" at Burwood Hospital for respiratory patients. In addition, compared to winter 1996, there are now an additional 15 beds available at The Princess Margaret Hospital and another three in the Intensive Care Unit at Christchurch Hospital.

In addition to the measures set out above, and those referred to below in relation to specific areas, the following actions were undertaken to provide for winter demand:

a bed manager was employed to ensure the efficient use of general medical beds and prompt transfer of patients to The Princess Margaret Hospital and the respiratory unit at Burwood Hospital;

a 0.5 full time equivalent geriatrician was employed to review older patients more promptly and to increase the speed of discharge where reasonable;

approval was given to appoint a further cardiology registrar;

a nursing "bank" was established for Christchurch Hospital for the co-ordination of casual staff usage. While wards can still "pre-book" casual nurses where vacancies are anticipated, the bank is supposed to guarantee additional staff to cope with the seasonal peak. The bank is also supposed to allow for additional flexibility. There is close monitoring of casual staff usage and an attempt to keep the number below 30% on any one ward on a duty. However nurses said that there seemed to be fewer nurses employed on the speciality bank than they understood had originally been planned and that the bank appeared to be the former "pool" under a different name. About 20 permanent staff were in the nursing bank. In addition, a further 20-30 nurses were offered between four and six months temporary employment over winter 1997.

1997 Changes in Relation to the Emergency Department Staffing

The following changes were made to the staffing in the Emergency Department in 1997:

(a) 22 more nurses were appointed, but 13 are employed in the Emergency Observation Area;

(b) an increase of one full time equivalent emergency medicine specialist; and

(c) a second night medical registrar was rostered to work in the Emergency Department on Thursday, Friday and Saturday evenings. The Commissioner was advised that although the number of registrars has increased, the hours of registrars were cut back to keep the Emergency Department registrars at the appropriate salary level.

Both nursing and clinical staff stated the employment of extra staff in 1997 improved the situation in the Emergency Department, but they considered that more medical staff and nurses were necessary and that the Emergency Observation Area was still unsafe due to a lack of staff. The Emergency Department was planning the introduction of a "triage first" nurse who would assess patients prior to them booking in with the receptionist and who would be responsible only for triage. Although the number of beds in the Emergency Observation Area increased from 12 to 18, all Emergency Department admissions stay in the Emergency Observation Area between 2100 hours and morning. This means that nine extra nurses are available for the Emergency Department, equating to one third of an extra nurse per shift.

According to some staff, because the Emergency Department has been given more resources, the expectations of the Department have increased, for example, there is now an expectation that the department should be able to provide nursing escorts.

1997 Changes in relation to General Medical Services

The Medical Day Unit was closed in April 1997 and the space redeveloped. The area is now called the Emergency Observation Area and is managed by the Emergency Department. The area is now staffed 24 hours a day by nurses oriented to Emergency Department protocols and expectations and provides 18 beds.

The two acute assessment wards have been re-designated as "home wards" and there are now five home wards designated for General Medicine. (Ward 24 is now a medical service home ward and Ward 17 a surgical service home ward.) A ward was opened for winter 1997 as a medical overflow ward, which allows for 100-150 medical beds, depending on the season (Ward 23).

Patients requiring admission from the Emergency Observation Area are now admitted to the ward of the medical team scheduled to take acute admissions - the "home ward". Fewer "outlying" patients spread around multiple medical and surgical wards reduces the confusion among staff and reduces the risk of staff being insufficiently skilled to meet the specialist needs of their patients.

1997 Changes in Relation to the Department of Surgery

The following changes were proposed or put in place in 1997 for the Department of Surgery.

Two surgical consultants were appointed in 1997, although the Commissioner was informed by the Clinical Director of Surgery that the department was having problems recruiting to these positions.

Approval was given for the appointment of a further registrar and two house surgeons. Canterbury Health advised that by December 1997 a general surgical registrar and general surgical house surgeon were appointed and the paediatric surgical workload has now been removed from general surgery with the appointment of a second paediatric surgeon.

A new system is being introduced whereby the duty surgical consultant is divested of other commitments and is on site on the duty day so as to be more available for Resident Medical Officers and nursing staff as well as to provide care for acute patients by being available 24 hours per day.

The "home ward" system has been reinstated.

The Emergency Observation Area should ease pressure on Surgery as patients will be able to be assessed more thoroughly in the Emergency Department.

Funding for 1997 Changes

The funding for these initiatives has not come from the Health Funding Authority. The Commissioner was advised that Canterbury Health will operate at a greater deficit in 1997 to pay for these measures.

SUPERVISION, TRAINING AND CREDENTIALLING

Junior Doctors

Teaching and research was part of the mission of Christchurch Hospital in the view of many of its senior clinicians. When the Medical School came to Christchurch Hospital in 1973 there was considered to be "*a huge leap in standards*". It was argued that possessing a good teaching service and high quality research means better standards of health for New Zealand in the long term.

This view is backed up by the Australian Medical Council Accreditation Committee, which made the following comment:

> "*… high standards of patient service in a large hospital depend on the hospital staff who deliver that care having an active involvement in continuous quality improvement, evaluation of outcomes, maintenance of professional standards and advancement of knowledge. There is no better guarantee of quality or of maintenance of standards than staff involvement in teaching*". (August 1994)

The loss of some senior nurses through restructuring was thought by clinicians to have had an effect on the teaching of junior medical staff, because of the role these senior nurses played in teaching junior doctors. The restructuring was also viewed by clinicians as having caused a drop in morale, which also adversely affected teaching and research. A number of senior teaching staff who ceased working at Canterbury Health in 1995/96 pointed to the lack of morale in the Hospital as a relevant factor in their decision.

The degree of supervision of junior doctors by consultants in the various clinical services was reported to be variable. Processes for supervision and appropriately graded responsibility varied from being very structured in departments such as the Coronary Care Unit, Emergency Department, Intensive Care Unit, Gastroenterology, and Radiology units, to being only semi-structured in other specialist units.

Following discussions with junior medical staff, it appears that the formal "supervision" of interns by the official intern supervisors of the Medical Council of New Zealand did not work well in 1996. Some interns did not know who their official supervisors were. The situation was reported to have improved in 1997.

Registrars stated that it was not possible for them to do justice to students or more junior staff because of insufficient time. Evidence was given that registrars who were not yet senior enough to be performing unsupervised procedures were being required to do so at times.

Emergency Department: Supervision and Training

Supervision and training in an Emergency Department must be carried out according to the guidelines laid down by the Australasian College for Emergency Medicine. The College provides accreditation to Emergency Departments which offer satisfactory experience and training for trainee registrars. A trainee must spend a minimum period of time in an accredited department before being eligible to sit the Fellowship examination. If the College surveyors do not consider that a department is providing sufficient teaching, supervision or appropriate experience, this accreditation may not be granted or may be withdrawn. One of the implications of the Christchurch Hospital department's policy of only doing "core business" and transferring work from the Emergency Department to the inpatient teams is that the experience available to trainees in the Emergency Department is less than is normally available in other centres. For example, registrars stated that their practical paediatric experience in the department was negligible and that they did not see orthopaedic patients during the day.

The General Manager Christchurch Hospital Services received a letter from the College in September 1996 warning that the Emergency Department had fallen significantly below contemporary standards in that:

the number of medical specialists was insufficient;

the number of registrars was insufficient;

the number of nurses was insufficient; and

there were serious deficiencies in its facilities and resources.

The contribution of the Emergency Department is very important to the undergraduate curriculum. However, because of the pressure of work, consultants and registrars have had little time for supervision and training. Registrars commented that some procedures, for example resuscitation, need to be taught through involvement. They added that at Christchurch Hospital there was no time to stand and watch a procedure because registrars were required to see the next patient.

During interviews in early 1997, concern was expressed by registrars about the poor pass rate of the Primary Examination of the Australasian College for Emergency Medicine at Christchurch Hospital. They noted that this could have adverse consequences for the Hospital. If registrars do not have the time for study, Canterbury Health has a lesser chance of attracting registrars to train as Fellows of the Australasian College for Emergency Medicine, which in turn increases Christchurch Hospital's understaffing problems.

In 1997 the Emergency Department staff organised weekly education sessions and staff attendance is monitored. Two "registrar level" casual doctors are brought into the Emergency Department while teaching meetings take place and a consultant is on call. By the end of 1997, four of the five Christchurch candidates passed the Part I examination.

Surgical Supervision and Training

The Royal Australasian College of Surgeons has established guidelines for supervision of surgeons. The policy does not define the level of supervision by the actual year of training. The Royal Australasian College of Surgeons considers that each trainee must be assessed individually as to the appropriate level of supervision required. This is due to varying levels of pre-training experience.

The College considers that, regardless of the time of day, the level of supervision always needs to match the experience and clinical skills of the trainee. The appropriate level of supervision depends on circumstances such as the experience of the trainee, the surgical speciality, the complexity of the operation and the availability of back-up support staff and experienced surgeons. However, surgeons must ensure at all times that trainees are not undertaking, at any level of supervision, activities that are beyond their capabilities.

The College has no authority to monitor supervision standards. This is the responsibility of hospitals and the heads of their surgical units. The College states that it is in the interests of hospitals to meet the training standards set by the College because hospitals need to attract registrars.

The College has no written policy on the ratio of trainee surgeons to supervisors. However, a prospective supervising surgeon is advised to consider such factors as a trainee's experience and level of necessary supervision, and it is stated that it is imperative that there are enough surgeons available to supervise trainees whenever this is necessary.

Evidence presented during the investigation indicated that at times there had been inadequate supervision for registrars in training in the Department of Surgery. In addition, there have been occasions when house surgeons have had to make decisions and attend to problems

which required more senior input and expertise, but supervision was unavailable because the registrar and consultant were in theatre.

One particular case involved a urological surgical registrar in training who was new to Christchurch Hospital and was rostered to perform the list of another surgeon who was ill. The registrar had operated solo on previous occasions but had not yet performed this particular operation solo at Christchurch Hospital. The consultants in his departments thought it was reasonable for him to perform the list solo. During the operation the registrar experienced difficulties. The anaesthetist left the theatre to enlist surgical backup. In the absence of the anaesthetist, the registrar continued with the procedure and permanent harm was caused to the patient. Evidence was given that although the surgeon who was nominally responsible for the supervision of registrars was himself tied up in theatre, a senior surgeon in the discipline concerned could have been available to assist within four to seven minutes. However, because the registrar was new to Christchurch Hospital, he was not aware that this back-up was available. The Commissioner was informed that residents were told about the consultant cover but at that time the system was not formalised in writing.

Although this incident occurred before 1 July 1996, the Commissioner was given little evidence to show that much had changed regarding supervision orientation and training of surgical staff. For example, in the Department of Urology procedures have been established to regulate the degree of experience necessary before a procedure may be performed solo by a registrar, and each registrar has to perform a certain number of supervised procedures before being "signed off" by one of the senior Urologists. However, it is unclear whether this policy is implemented in practice or is effective, as it has not been audited.

Credentialling of Surgical Staff

In 1992 a report by the Royal Australasian College of Surgeons, entitled Assessment of Surgical Standards in Hospitals, emphasised the need for hospitals to have a credentialling committee to define the clinical responsibilities of appointees, including continuing responsibility and withdrawal of responsibilities. Such a committee would be responsible for credentialling surgeons and for withdrawing this status for a variety of reasons, including lack of competence.

There is no credentialling committee at Christchurch Hospital. Surgeons stated that in the past, credentialling committees have not been set up as management reserved the right to state who is and who is not employed. However, the current Chief Executive of Canterbury Health has approached the Chair of Surgery to look at the establishment of such a committee.

The Assessment of Surgical Standards in Hospitals report considered credentialling to be an important tool for ensuring safety, as it would ensure that no surgery is undertaken by people not credentialled to do it. With a credentialling committee, hospitals taking part in the training of registrars would be able to restrict the solo operating of registrars until a credentialling committee is satisfied that they are competent to proceed. The process is similar for more experienced surgeons who move into specialised fields. The credentialling process ensures there is adequate training in new and innovative techniques before they are practised.

Nurse Training and Continuing Education

Since 1994 the number of staff training courses has declined for a number of reasons including:

the demands on medical and allied health staff, which have impacted on their availability as presenters; and

the decreased opportunity for nurses to be released from the wards because of increased patient acuity.

Prior to 1995, the Professional Nursing Unit employed staff to co-ordinate in-house speciality nursing practice modules. These staff also assumed responsibility for teaching and competence assessments regarding administration of intravenous medications, infusions and cannulation skills as requested by the General Manager Christchurch Hospital Services "*to reduce the medical staff workload*". Cardiopulmonary Resuscitation (CPR) training was also offered to all staff.

In the 1995 restructuring, staff educators were disestablished from their positions and then reinstated in a Staff Development Unit under the management of the Human Resource Manager. Since February 1996, service staff development programmes aimed at a speciality practice area have relied on management initiatives through an internal consultancy model with these staff educators. This method of staff education only delivered a limited amount of training for a small number of staff and the educators were only required to offer the particular training requested.

Since 1996 each Patient Care Manager has been responsible for encouraging speciality in-service education sessions. Some have addressed the area of staff education more pro-actively than others. For example, in Coronary Care, Orthopaedic Trauma, and Emergency Department Triage and Recovery Room, nurses report fairly structured and regular in-service sessions. Nurses attend the weekly education sessions in the Emergency Department. Staff are paid to attend these meetings. The Radiology Department also runs a weekly teaching session for all Emergency Department staff. All areas have established a preceptorship programme to assist new nurses to be orientated to the ward or unit setting.

There were several reports of education being inadequate. The new line managers were not compelled to use the in-house education service. Although nursing staff have attended orientation and CPR training there was no compulsion for casual nursing staff to update their skills. Intravenous Medication Administration teaching continued but attendance was said to be variable. Casual nurses were not required to attend these sessions. In addition, casual staff were not paid to attend orientation or training sessions and might miss out on teaching sessions because they are not in one place on a permanent basis. Staff expressed frustration at the lack of education opportunities or support to attend courses at the local polytechnic.

Clinical staff were reliant on their manager allocating time for their attendance at teaching sessions. Nurses were therefore required to negotiate attendance with Clinical Nurse Specialists who had difficulty organising time off. Canterbury Health expected staff to attend training sessions and update skills, such as CPR, while at the same time managing a full patient workload.

In the view of the limited number of staff educators, there was a lack of strategic planning for staff education and development. The trainers attempted to provide a framework for development of clinical education but they did not have their proposals approved. Reports and recommendations about different programmes were presented to the senior management team for approval but often no feedback was received. A timetable of staff training was presented to the Commissioner that focused on orientation and core clinical risk issues,

including medication administration and cardiac arrest management. These topics were prioritised by the educators themselves.

At the time of interview the acting Director of Nursing had started to plan an education framework for the nursing staff. Two of the Education Department staff had left the department over the last few years. No replacements were found and the remaining educators considered that they were unable to continue without additional staff and a clear direction.

The educators recorded information about updates needed and completed, for example, in Intravenous Therapy or CPR, and worked with the individual staff, through the Patient Care Managers if necessary. The CPR Committee had recently drafted a policy stating that all clinical staff must attend CPR bystander training. This had yet to be approved by management or the new Policy and Planning Committee.

Employee Assistance Programme

The Employee Assistance Programme was introduced in 1997 to provide additional support for staff. During the 1995/96 restructure, support had been provided through the Human Resource Manager.

The Employee Assistance Programme was advertised in December 1996 and January 1997 through a series of manager and staff briefings, brochures, posters, individual stickers and newspaper articles. The service receives referrals from managers, peers and also accepts self-referrals. An employee's first three sessions with a counsellor are paid for by Canterbury Health although additional financial input may be negotiated on an individual basis. Staff advised that the Employee Assistance Programme had been of particular value as staff have dealt with the stress of Coroner's hearings, the media interest in Canterbury Health and the Health and Disability Commissioner's Investigation.

Some staff reported that the promotion of this service was variable and that there were staff who did not know about it.

Medical Council Accreditation

The Australian Medical Council Accreditation Committee, in its 1994 report on the Faculty of Medicine at the University of Otago of which Christchurch Hospital is a part, noted that research of the highest international standard was being produced at the Faculty of Medicine at the University of Otago. However it also highlighted "*a number of factors, some of which are in a stage of incomplete resolution and some of which have already progressed to a stage where urgent action is required to reverse dangerous trends affecting medical education and threatening to have major effects on the overall function of the Faculty and the quality of its graduates and research*".

The unresolved nature of the relationships between the Medical School at its three sites and the Regional Health Authorities and the Crown Health Enterprises was an area of particular concern. The Accreditation Committee suggested that the University needed to take action to ensure "*a common commitment within the CHEs to teaching and advancement of knowledge*" so that individual negotiation did not fragment the medical educational system. The report suggested that it was essential for the successful continuation of the clinical

schools that salaries and conditions of service for Crown Health Enterprise and University clinical staff do not vary between Crown Health Enterprises or between clinical schools.

The Committee was heartened by the Crown Health Enterprises assurance of their commitment to work together with the Universities. However "*the exclusion of the University from the business planning procedure, the continued insistence on breaking down activities for contractual and funding purposes, and the different approaches taken by different CHEs are causes for continuing concern*".

The Accreditation Committee noted that, due to the geographically separate nature of the clinical schools, there is a requirement for considerable effort by the administration and the individual clinical schools to recreate a sense of faculty-wide purpose and planning, so that the Christchurch and Wellington Schools do not feel isolated and separate. It saw a need for a simplified and more effective management and committee structure to allow faculty-wide strategies in policy and research support and development. The Accreditation Committee stated:

> "*The pre-clinical years belong just as much to the Christchurch and Wellington Schools as to Otago and renaming the clinical component of the Otago School as the Dunedin School may be an important symbol of this*".

The funding system was reportedly causing considerable confusion, "*stifling initiative, depressing morale and preventing curricular reform*". The University reportedly recognised this and was in the process of rectifying it.

Another major area of concern related to the need to provide effective staff development and support. The Accreditation Committee said:

> "*In some areas, unbalanced teaching or clinical loads and decreasing teaching staff numbers have led to overwhelming stress and fall in morale throughout the system. Although the University has a formal system of staff support and appraisal, it is not clear that this is working effectively, or that action is being taken to address problem areas. Individual effort and commitment are not being recognised and rewarded*".

Another area which was said to require attention was the development of a more formal system for recognising the contribution of teaching by non-university staff. It was said that a more flexible and extensive range of academic titles, with the higher grades requiring appropriate academic standards, would be a symbolic gesture to improve this situation.

There were also concerns with staff recruitment and it was said that although uncertainty about contracts affects this in clinical areas, the problem is exacerbated by a lack of flexibility in allowing setting up grants to attract research oriented staff. Concern was expressed over the implications arising from the diminishing availability of research funds. This was said to have a major effect on the morale and strength of departments.

In conclusion, the Accreditation Committee found that the University of Otago Medical Faculty was at a crucial stage in its history. It said:

> "*Firm action is required to ensure its future strength and its preservation as a medical school of international standing*".

The Australian Medical Council resolved that the Faculty of Medicine at the University of Otago be accredited for a period of five years in the first instance. Accreditation was subject to conditions, including that:

urgent discussions are held with the relevant Regional Health Authorities and Crown Health Enterprises to resolve the uncertainties and problems identified in the Accreditation Committee's report and that satisfactory progress towards resolution can be demonstrated within 12 months;

a process of review of the management and the organisational structure of the facility be instituted;

a process of review of the existing staff development and support systems be instituted to improve their effectiveness and appropriateness for staff needs;

In comparison, the Australian Medical Council Accreditation Committee recommended that the University of Auckland be granted accreditation for a period of 10 years from 1 January 1996. There were no conditions on this accreditation.

The Accreditation Committee made the following comments about the School of Medicine, University of Auckland:

> "*Excellence in Health Care can only be achieved where teaching, research, service and management are all valued and nurtured. This is the case in Auckland. The School's responses to its challenges over the last three years have been clear-sighted and characterised by excellent short and long term strategic and operational planning. The collaborations between the School, the Hospitals, the CHEs, the RHA and the Community have been an outstanding success. The result is a model for New Zealand and for other centres internationally, including Australia. Innovations in the area of communication with community self-help groups and fund-raising organisations are to be applauded*".

FACILITIES AND EQUIPMENT

Layout

The Hospital facilities are spread out and this limits interaction between some wards and units. The layout makes the work of doctors, orderlies and allied health staff more difficult when patients are placed all over the Hospital as outliers. Staff spend considerable time walking to each patient.

The geographic separation of the Radiology Department from the Emergency Department is a problem for emergency cases who require x-rays or CT scans. The layout is also a problem with cardiac arrests. There are parts of the Hospital that staff do not know and, if an emergency occurs, the emergency team can take some time to find the patient.

Some departments find they have both a lack of space and a lack of equipment. The Paediatric Department was reported to have inadequate space for children and their families.

State of Equipment

Some nursing staff said that beds were poorly maintained and that some were unsuitable for the administration of CPR. However there appeared to be an adequate system for bed

maintenance. The Board had approved the purchase of 25 new beds for Christchurch Hospital as there were a number of beds that had been maintained but were wearing out, and there were more being requested. Key staff had been included in the review and approval of suitable beds.

A clinician described an occasion when the equipment he was using failed. He said that in such circumstances "*you do your best with equipment which is less than optimal and you get minor complications … not life threatening, but important*".

Where Service Managers have been aware of equipment that was not functioning properly or about to break down, Service Managers stated that approval for a replacement has been prompt. However clinicians have found that equipment replacement is often delayed. For example, some patient equipment was said to need replacement as it was old-fashioned, caused skin tears through rough cladding, or was past repair. Once Cardiology moved to Christchurch Hospital in May 1994 the Emergency Department received all acute admissions with chest pains. However, there was only one Electrocardiogram machine and due to its age and high use it was often away for repair.

Lack of Equipment

Concern relating to lack of appropriate equipment was apparent in many of the interviews undertaken. On the other hand, some areas in the Hospital such as the Intensive Care Unit (ICU) and the operating theatres, did not appear to have an urgent problem with lack of equipment.

Many of the items medical staff considered essential to providing an adequate standard of care were lacking. For example, in the Department of General Surgery there was a desperate need for a flexible choledochoscope, an essential item for the management of common bile duct stones. Surgeons stated that due to lack of equipment it may even be unethical for them to treat certain patients. There is a degree of frustration at the lack of special monitors in the Emergency Department and in the Coronary Care Unit. A capnograph monitor was one example given of essential safety monitoring equipment without which care and safety was said to be compromised.

Since the renovations in April 1997, the Emergency Department has been allocated equipment for the Emergency Observation Area and six resuscitation rooms, and the physical changes to the Emergency Department are reportedly excellent. The new Emergency Department resuscitation rooms contain better equipment than the previous rooms. While the layout of the new Emergency Department area was thought to be adequate, clinicians believed some further items of equipment were still required in early 1997. This need was addressed by mid 1997.

Nursing staff have had difficulty with the lack of a system for the retrieval and storage of infusion pumps. Two studies have been done to track where infusion pumps are when they are not in the "pump pool" room. These suggested that there were adequate numbers of pumps but that people might be using them when they did not need to, or were holding them instead of returning the pumps to the store room. However, considerable time was spent looking for and retrieving pumps and the experience of the ward staff was that there were not enough of them. Problems finding pumps were said to create the potential for delay in some patients receiving optimal treatment for pain and infusions in acute situations.

There were reported to be inadequate numbers of spenko mattresses, sphygmomanometers, upgraded portable suction machines, and an assortment of other items.

The supply of basic monitoring equipment has been a major frustration for staff and was a safety problem in winter 1996 when Ward 23 opened earlier than anticipated. Difficulties also arose in 1995 when Ward 17 was opened unexpectedly and there were not enough beds or equipment.

The Patient Care Managers have replaced a lot of basic equipment since their appointment in 1996.

Standardisation of Equipment

Some departments have bought their own infusion pumps (CCU and ICU) which cannot be used by other parts of the Hospital where staff have not been trained in their use. Clinical incidents have arisen as a result of the lack of consistency among infusion pumps. Standardisation of the pumps has been recommended by the Product Nurse Specialist and the Pain Management Clinical Nurse Specialist. Staff have also been frustrated by the lack of consistency of defibrillators. Some medical staff attending cardiac arrests were reportedly not aware of Christchurch-specific practices or how to use the different types of defibrillators located on different wards. There were reported situations of multiple defibrillators being brought to a cardiac arrest situation because each was thought to be broken when in fact the problem was technique when using the older machines.

The Chairman of the CPR Committee advised that defibrillators are updated to current Lifepak models when required and in advance of them failing. There is a deliberate policy of progressively standardising all defibrillators, but the expense of updating all defibrillators at once cannot be justified, particularly when they are in good working order. As part of this policy, the five oldest Lifepaks were replaced in December 1997.

Replacement of Equipment

Many clinicians stated that there was little or no provision for capital replacement of essential equipment. It appeared that capital equipment needs were recorded in each department and then forwarded to a central "pool". The process involved all Clinical Directors reviewing lists of equipment and then rating the importance of the items. "*The items that get the most ticks are purchased*". It was reported that some of the Clinical Directors had little idea of the need for equipment in other areas of the Hospital and therefore many essential equipment needs were overlooked.

Clinicians believed the procedure for obtaining new or replacement items of capital equipment was rather convoluted. There were long delays, sometimes of several years, to replace equipment which is malfunctioning or broken. The delay in obtaining equipment was so great that when approval was given for the purchase of the item, the particular model or machine had sometimes been superseded. This resulted in further delay in the purchase of the item as the whole matter was re-examined.

The need for equipment replacement was brought to the attention of management on several occasions.

Nursing staff had enjoyed differing levels of success in attempting to purchase new equipment for their wards. The process of applying for capital expenditure replacement items was described

as a "lottery". Although capital expenditure requests were forwarded to Patient Care Managers, staff did not always receive feedback about their application.

Service Managers indicated that equipment replacement was adequate to provide care of an acceptable standard, and that equipment was replaced as need indicates.

Some, but by no means all, departments had a three year capital replacement plan. In 1997 a five year projection on capital expenditure was done to differentiate replacement from discretionary expenditure.

During 1996/97 Canterbury Health spent or approved double its previous year's expenditure on clinical related plant and equipment. Approved expenditure was approximately $8 million. Hospital Services Division was allocated $2.175 million in the budget. $4.479 million of equipment was requested by service areas. During 1996/97 Hospital Services Division had $6.1 million of equipment approved. A significant proportion of this additional capital expenditure approved was for upgrading the Intensive Care Unit and Emergency Department.

Budgeted depreciation for 1996/97 was $5.4 million. The business plan confirms that Canterbury Health intended to allocate capital expenditure worth $8.25 million to maintain the book value of clinical plant and equipment and earmarked catch up expenditure of $1.6 million in 1996/97, $2 million in 1997/98, and $3 million in 1998/99. It seems that within the constraints of its budgets, Canterbury Health was committed to progressively upgrading its equipment and was making progress in this regard.

Service Managers maintain that the range and standard of equipment is adequate. However, some of the equipment is 'tired' and there are often insufficient number of items during periods of peak demand.

PATIENT LOCATION, TRACKING AND CONTINUITY OF CARE

Acute Admitting Ward and Home Ward Systems

An acute admitting ward system operated at Christchurch Hospital from 1992. Under this system, acute patients were assessed in the Emergency Department and then moved to one of the wards designated to receive acute patients. Patients were then transferred from the acute admitting wards to the appropriate specialist ward. The theoretical advantages of this system, as it operated at Christchurch Hospital, were:

(a) there was one place to see all patients who were admitted acutely;

(b) only the two acute admitting wards were disturbed at night; and

(c) the wards were relatively close to the Radiology and Emergency Departments.

The disadvantages of an acute admitting ward system were:

the disruption for patients who were admitted to an acute admitting ward and then transferred to another ward within 24 hours;

that nurses caring for very sick patients in the acute admitting wards lost contact with those patients when they were transferred to a specialist ward; and

that nurses in the acute admitting wards had to be capable of caring for a wide range of medical and surgical patients.

A senior clinician commented that "*When the acute admitting wards were established there were good theoretical reasons behind the development, but it "never happened", largely because there were not enough beds*". In 1997 Christchurch Hospital adopted a system where patients who are initially assessed in the Emergency Department may be transferred either to the Emergency Observation Area or directly to a "home" ward under the medical team scheduled to admit acute patients at that time.

Dispersal of Patients

Numerous examples were given by nurses and clinicians of disruption in the continuity of care being received by consumers at Christchurch Hospital in winter 1996. There were times when the dispersal of patients to inappropriate locations compromised patient safety. Examples included:

an asthmatic patient on a ventolin infusion being cared for in a busy Orthopaedic ward by Orthopaedic nurses who had little experience of managing asthmatic patients;

a casual nurse being required to look after two semi-conscious overdose patients in the Medical Day Unit;

Mr Fonoti, a patient with a head injury, being admitted to a Urology ward due to a bed shortage on the surgical ward; and

(d) a Cardiology patient being placed in an Oncology ward, where the beds were not set up for cardiac arrests. As the bed was not constructed so as to be suitable for an arrest, it was not possible to intubate the patient. Additionally the defibrillator did not work and there was no oxygen at hand.

Medical teams reported having patients in multiple wards. Examples were given where some doctors were having to visit up to 15 wards to check on patients. A number of house surgeons commented that the distance between each ward meant precious time was wasted travelling between patients. A senior clinician stated that in winter 1996 "*Patients often did not get the best care with the team running back and forward between sick patients*".

During the winter of 1996 there was an overflow of patients from the General Medical wards. When the General Medical wards were full, acute patients could not be moved out of the acute admitting wards to their home wards which led to a backlog of patients in the Medical Day Unit and Surgical Day Unit. Acutely ill medical and surgical patients were therefore placed as "outliers" in beds all over the Hospital, wherever a bed could be found. This was still the case at the time of interviews with the Commissioner's Investigators. Even after the restructuring of acute admitting to home wards for winter 1997, the Commissioner was told that the equivalent of a whole ward of Cardiology patients were not in the Cardiology ward.

In May 1997 there was still a widespread concern, especially among the physicians and surgeons who are involved in acute admitting, about the way in which patients may be placed all over the Hospital, often in inappropriate wards. Staff generally believed that "outliers" create a safety issue for a number of reasons:

(a) The staff in speciality wards are not familiar with the disease processes or the medications of other medical areas.

(b) They may not pick up on changes in a patient's condition sufficiently early and so outliers often experience delays in receiving treatment because nurses are unfamiliar with treatment protocols and because of the extra time spent obtaining and relocating equipment.

(c) There is also a concern that "*when the patients are not under your nose there is a risk that they will be forgotten*".

In October 1997 the Chief Executive received an account of the implementation of the home based ward system over the winter period which showed a dramatic improvement on the 1996 winter.

Tracking Patients

Clinicians advised that on occasions patients were "lost" by the medical team who was supposed to be caring for them, for periods of up to 2 or 3 days. House surgeons could spend up to one hour every day tracking down patients and "*making sure we had got everybody*".

Patient admissions (classified by doctor) were entered on a computer list and continually updated. However there was some confusion amongst Resident Medical Officers (RMOs) as to whether this list, which ward clerks printed each morning, was continuously updated and whether they could get access to an updated list during the day. According to Canterbury Health, ward clerks in any area and a number of the nursing staff could access this updated list. Staff need training on the computer system before they are given a password which enables them to access their own patient list. Management advised that this training has been offered to Senior Medical Officers (SMOs) but that increased access to this aspect of the computer network for medical staff is not envisaged at this stage.

Continuity of Care

In the winter of 1996 patients frequently moved wards. Consequently, laboratory results and radiology reports often went to the wrong place.

Cardiology patients were generally placed directly in the Coronary Care Unit or Ward 12. If Ward 12 was full, then patients assessed as more stable were transferred out of Ward 12 to allow space for patients with more acute cardiac care needs. At times, up to four patients could be transferred out of Ward 12 during a shift and placed in wards where staff had little training and experience in managing patients with cardiac problems.

Nurses on the various other wards would not have had knowledge of the specific preferred treatment protocols for the patients outlying in their wards. In addition, when multiple teams visit multiple wards, sometimes at the same time, it was impossible for the Clinical Nurse Facilitator to attend the ward rounds with all of the teams to give or receive information about the patients. Canterbury Health advised that a "*return to a Home Ward based system* [in 1997] *has also led to a reduced number of overflowed patients and a limited distribution of inpatients. Instead of patients of a particular team being in several different wards, they are concentrated in one or two areas. Cardiology is the exception to the rule here.*

> *Cardiology presently have their patients in 12 different wards. Although Wards 25 and 30 have lessened this spread, it is still a big problem*".

The high number of outlying patients have hindered discharge planning. It has become more difficult for allied health staff to "follow" the medical teams and ensure that patients receive appropriate assessment and follow up. This also impacted on patients, admitted pre-operatively or for day procedures, who must wait in a dayroom until a bed becomes available. This means that patients may have to get changed in a bathroom down the corridor, and leave their clothes in the Clinical Nurse Facilitator's office. The Commissioner was told of an elderly man receiving "bowel prep" who had to rush down a corridor to get to the nearest toilet and an 80 year old patient who, having had to wait until 2030 hours until a bed was available, became upset and exhausted.

Medical Day Unit

The Medical Day Unit had the following uses.

The Emergency Department used the Medical Day Unit for patients who required observation and/or who were waiting to be assessed by another doctor. These patients were not admitted and continued to be the responsibility of the Emergency Department.

The Medical Day Unit was used during the day to care for medical outpatients requiring assessment during procedures such as blood transfusions and chemotherapy treatments.

The Medical Day Unit was used as a "de facto" admitting ward. The Emergency Department staff would hand-over some patients who were being admitted to Medical, Surgical and Cardiology staff but because there was an "access block" in moving the patients they were sometimes admitted to the Medical Day Unit.

Outside the day time period the decision to keep the Unit open was typically made by Duty Managers and occasionally this occurred without the Emergency Department's knowledge. If there were no beds available in the Hospital and there were patients in the Medical Day Unit at the end of the day requiring care, the Duty Manager determined which staff might be available to care for patients in the Unit overnight. Casual staff were hastily recruited for this purpose.

There were only four beds available in the Medical Day Unit. Other patients had to remain on trolleys. Patients could lie on these trolleys for over 24 hours.

> With regard to the use of the Medical Day Unit (MDU) for acute admissions during the day, a senior clinician said:
>
> > "*Patients were admitted to the MDU during the day because there was nowhere else for them to go. They could not be transferred to other in-patient beds because there were not any other available beds. There was major disruption of the normal operation of the Medical Day Unit where patients who required transfusion on a day* (sic) *basis, patients having bronchoscopy etc., were supposed to be cared for*".
>
> At times, the Medical Day Unit was overcrowded. This gave rise to an inappropriate mix of cases in the Medical Day Unit. Acute psychiatric or overdose patients were placed with patients suffering from a range of other medical and surgical conditions. This situation created the potential for cross-infection.

On the basis of information supplied by clinicians and nurses, around the time of Mrs Malcolm's death in the Medical Day Unit there were occasions on which there was no senior nurse in

charge to supervise the Unit, its staff numbers were often inadequate and patients were often cared for by casual nurses. As far as the Commissioner could ascertain, Mr Fonoti was admitted to a ward as there was no observation bed available in the Medical Day Unit because it was being used as an acute admission ward rather than as an observation area.

When there was no other space in the Hospital, acute admission patients were also reported to have been placed in the Surgical Day Unit and the "Cardiac Catheter Lab" which was "tucked away", had very few drugs, inexperienced staff and little equipment.

In April 1997 the Medical Day Unit was transformed into what is now known as the Emergency Observation Area. It is now used for the assessment of patients for admission or discharge and the observation of patients who are expected to be discharged rather than as a de facto admitting ward.

Management Notified

There is evidence that management were advised of the problems experienced by doctors in tracking down their outlier patients and that doctors thought the position was unacceptable. Canterbury Health's Resource Review Report in October 1996 noted the degree of frustration and concern over the number of patients placed in inappropriate wards because home wards were full. It stated that the overflow was seen to cause problems "marrying" diagnostic reports with patients, ensuring the provision of appropriately trained nursing staff and providing appropriate and timely clinical management. The Resource Review Report advocated a return to the home ward bed management system to reduce these problems.

TRANSIT CARE AND THE MANAGEMENT OF PATIENTS WITH MAJOR TRAUMA

Patient Safety Issues

Much information was presented during the interviews about the issue of escort and care for patients in transit.

Instances of ill and confused patients being transferred without an escort and patients lying in areas for periods of time unsupervised have been observed and reported to the Commissioner's Investigators. The practice of not having a nurse present with a sick and confused patient was observed by the Commissioner's Investigators on more than one occasion, as was the fact that patients awaiting transit do not always know how to get assistance.

In addition to their health problems, many patients find a hospital environment unfamiliar and disorientating. There are noises that they do not understand, and they are placed on trolleys high off the ground and in wheelchairs which are difficult to move.

Five main areas of concern were raised relating to patient safety while in transit:

Transit of patients from wards to other departments

The major area of concern was in the transfer of patients from the wards to other areas of the Hospital for procedures or investigations, such as to Radiology or theatre.

Evidence was given that a nursing or medical escort was not necessarily provided for patients who required observation and/or care in transit from one area of the Hospital to

another. The lack of such an escort was of particular concern because the condition of a patient may well deteriorate during transit across the Hospital. The following examples were given to the Commissioner.

A patient who had been having chest pains was transferred from the Emergency Department to the Cardiology ward without an escort.

Instances were reported to the Commissioner where patients who had not fully recovered from the effects of sedation were transported back to their wards on stretchers by orderlies without any nurse escorts.

The following incidents were reported to the Commissioner where patients have been transported to the Radiology Department with an orderly only, although the patient:

had a chest drain and pneumothorax;

had intravenous fluids and infusion in place;

was receiving a blood transfusion and was transferred to theatre from x-ray;

may have received sedation;

was confused and disoriented;

was nauseated and vomiting;

was anxious and upset; or

was unwell. In this case the patient was 'found' by the Radiology staff in the department. No one had known the patient was waiting and there had been no hand-over with regard to the patient's condition or ongoing treatment needs.

Other problems included:

(i) delays in transport of patients because of unavailability of suitable escorts;

(ii) the transport of seriously ill patients by staff without suitable training and experience;

(iii) the transport of patients without clinical records or supplies of medication and fluids; and

(iv) the delivery of patients to Radiology without an effective hand-over.

A shortage of nursing staff in Radiology in 1996 prevented the effective supervision of patients brought to the Radiology Department and left waiting for procedures. The layout of the department and the fact that the nursing shift officially finished at 1630 hours compounded the problem.

Recommendations from a nurse escort review meeting (7 June 1996) indicated that the Emergency Department and other wards and departments would take responsibility for escorting their own patients around the Hospital.

Intra-hospital transport of trauma cases

Concern was expressed by members of the Department of Anaesthesia and senior medical staff that Christchurch Hospital cannot offer the expeditious trauma care that would

befit the major regional centre for the South Island. The concern was prompted by actual observation of unsatisfactory treatment of trauma patients. An example given was an Intensive Care Unit patient who was intubated but breathing spontaneously who required an escort while in the Radiology Department for placement of a duodenal feeding tube under image identification. The Anaesthetic Department was unable to offer assistance so an Intensive Care Unit registrar (not an Anaesthetic Registrar seconded to the Intensive Care Unit) escorted the patient and used the anaesthetic machine for which current familiarity was said to be essential. Having no one department designated to plan the care of critically unstable patients while moving around and between departments for investigation or procedures, nor a department nor designated equipment to support such unstable patients during transport around the Hospital, was described in a memorandum from a senior clinician to be "*a disaster waiting to happen*". Canterbury Health advised that in late 1997 steps were taken to develop appropriate teams for the management of trauma patients.

Intra-hospital transport of critically ill patients

The co-ordination of the care of the critically ill patient was a major concern of clinicians. Some medical staff "*sense a general lack of concern for the transfer of the critically ill patient between areas in the hospital and a possible lack of appreciation of the dangers that are faced by the critically ill patient in the hospital system*".

Retrieval service

Some clinicians considered that Christchurch Hospital did not have an efficient, well staffed retrieval service. Medical staffing for retrieval was a "ring-around job". There was no funding for a retrieval service.

Transfer of patients from wards to ambulances

People interviewed reported, and the Commissioner's Investigators observed, patients being left by an orderly in the Emergency Department area while awaiting transfer by an ambulance to other facilities. Prior to the refurbishment of the Emergency Department, patients were left by the ambulance bay, within sight of, but not the responsibility of, the "sorting bay" triage nurse. The waiting place was changed in April/May 1997 to a corridor between the Orthopaedic Outpatients Department and another Emergency Department assessment area. The new waiting area is further from the sight of an Emergency Department nurse and, as at May 1997, there was no formal process for hand over of care while the patient is in the Emergency Department.

Canterbury Health advised the Commissioner that patients are no longer left in the Emergency Department area while awaiting transfer by an ambulance to other facilities. As from 1 September 1997 St John Ambulance personnel collect patients directly from the wards. This ensures that:

(i) the patient is under supervision at all times throughout the transfer/discharge;

(ii) patients no longer have to wait in the Emergency Department;

(iii) patients are transferred straight onto an ambulance stretcher, rather than being transferred twice, improving patient comfort; and

(iv) nursing staff are better utilised, as they will not be required to wait with patients in the ambulance bay.

Nursing Standing Orders

While some nursing standing orders were provided by Canterbury Health which outlined expectations for the nursing care of patients being escorted and transferred between departments and to other facilities, information gathered indicated there was variance between those standards and what happened in reality. There was little consistency in practice about who should be escorted by a nurse and who must safely travel with an orderly. The decision was an individual one. Although orderlies understand that they are meant to work under the direction of a nurse, this did not often occur as orderlies had difficulty locating appropriate nurses to assist with transfers.

Responsibility for Transfers

There were clinical guidelines in some areas but no one department takes responsibility for the transfer of all patients. For example, in "*Notes for registrars working in ICU*" (the Intensive Care Unit), it is suggested to registrars that all intubated patients need a medical escort when being transported for diagnostic or therapeutic procedures. It is stated in these notes that currently this service is provided by the Department of Anaesthesia. In other places, the Commissioner was informed that Intensive Care co-ordinates the transfer of such patients.

Effects of Nursing Escort Duty on Wards

Transfer to Dunedin

The Coronary Care Unit provided patient escorts for patients being transferred to Dunedin for cardiac surgery. These transfers consumed considerable nursing time and could leave the cardiac unit short of experienced staff.

Emergency Department

Staff felt that it was not safe for the Emergency Department to be responsible for escorting its own patients because current staffing levels do not permit nurses to be taken 'out of the front line'. However, as at July 1997, the Radiology Department favoured obtaining nurses from the Emergency Department to travel with patients through to the ward, as this would improve patients' continuity of care. This option would involve either increasing the number of nurses in the Emergency Department or developing a pool of nurses based in the Emergency Department who would be able to provide the transit service required.

Staff Concerns to Management

Concern about transit care has been raised by staff with managers at various levels in the organisation. The Resource Review Report noted staff concerns over what they regarded as undesirable patient transporting arrangements and recommended the introduction of transfer nurses and home ward orderlies. On occasions Emergency Department staff were unable to obtain nurse escorts through the Duty Manager. The General Manager Christchurch Hospital Services was informed of the problem.

The Radiology nurses audited the situation in their department in August 1996. They assessed the patient risks and provided a justification for additional resources to monitor patients sent to the department. They also prepared a report detailing the number of patients who arrived in the Radiology Department unescorted but who required nursing intervention. In February 1997 the manager of Radiology requested additional nursing staff to cover lunch hours and to provide supervision for patients awaiting procedures. In May 1997 the Radiology Department rostered an observation nurse to monitor patients in the general x-ray area until 2030 hours on week nights. However, there was still a gap in assessment after-hours and at weekends, which were the busiest times for the Emergency Department. Further, this arrangement still required wards and other departments to have suitably qualified escort staff available to "special" patients with, for example, compromised airways, and to retrieve patients promptly once the procedure was completed. The Gastroenterology and Radiology Departments distributed memoranda in 1996 and 1997 instructing ward nurses that patients must be escorted after procedures in their departments. One Clinical Nurse Specialist threatened to refuse to accept patients from a ward if she could not guarantee safe care of the patient in transit.

There have been some initiatives by medical and nursing staff to address the problem, at least temporarily. For example, in some areas of the Hospital, staff are refusing to allow semi-sedated patients to leave their care without an adequate escort. However, these initiatives do not address the hospital-wide problem.

Management Responses

The General Manager Christchurch Hospital Services stated that no new initiatives were undertaken from 1994 to 1996 to improve supervised transport of patients from department to department within Christchurch Hospital, as there was already a safety standard in place for patient transfer between departments. This 1994 Safety Standard states that:

(a) all patients requiring close observation must be accompanied by a nurse when travelling to and from departments/hospitals;

(b) patients are to be escorted to the operating theatre by a qualified nurse;

(c) patients are to be escorted from Recovery by a Registered Nurse or an Enrolled Nurse if this is appropriate; and

(d) patients receiving blood products are to be escorted by a Registered Nurse to and from departments.

The General Manager advised the Commissioner that this issue is being monitored.

Commissioner Raises Concerns about Patient Transfer

The Commissioner raised with Canterbury Health the matter of patients awaiting transfer, without a hand-over to nursing staff, in the corridor near the ambulance bay in April 1997. Management replied that the matter had already been considered and patients would wait in the corridor between the Emergency Department and the Orthopaedic Outpatients Department and that this corridor was chosen so that patients would be visible to, and under the observation of, the nursing staff in the area.

After receipt of this advice, members of the Commissioner's Investigation Team observed two patients, including a confused elderly woman, waiting to be picked up in this corridor. It was no longer possible for patients to be left in the corridor near the ambulance bay because structural alterations had been made in that area of the Emergency Department. The corridor to Orthopaedics appeared to be even less satisfactory than the previous corridor. The patients were not readily visible from either of the nursing stations in the Emergency Department. The nurses in the Emergency Department were also not informed about the patients being placed there.

As a result, the Commissioner wrote again to Canterbury Health about the transfer of patients from wards to ambulances. Canterbury Health replied that it had been decided not to involve the nurses in the Emergency Department. The Commissioner was advised that a new policy issued from the office of the Director of Nursing clarified the arrangements for escort of such patients by nurses from the ward, but that the new policy would not necessarily have reached the attention of staff by the time of the incident observed by the Commissioner's team. The policy stated that patients who were clinically unwell would remain under the care of their accompanying registered nurse until transfer.

Management of Patients With Major Trauma

There was no designated trauma team to deal with severe trauma on arrival at Christchurch Hospital. Senior medical staff told the Commissioner that the transport and management of trauma patients was a safety issue at Christchurch Hospital and that Christchurch Hospital has been "*slow to recognise the need*". A review of 1996 trauma incidents showed that there is a moderate amount of trauma in Christchurch.

The Commissioner was referred to a recent case in which a gas cylinder exploded causing injuries to the face with fractures of the maxilla (the upper jaw bones) and zygoma (bridge of bone in the region of the temple). At about 1500-1530 hours the patient was sent from the Emergency Department to the Department of Radiology for an x-ray. Such a patient needs great vigilance with regard to maintenance of the airway and needs to get to the theatre promptly. In this case, while staff were alerted to the seriousness of the situation, the patient did not get operated on until about 2000 hours. An incident report was completed about the case which commented that blast injuries of that magnitude for a tertiary trauma centre should not have a four and a half hour delay from the time that the case comes to the Hospital until the patient is in the operating theatre with a secure airway.

The Clinical Director of the Emergency Department has attempted to generate interest in the management of trauma since her arrival in 1994. She was concerned about the lack of a surgical presence at trauma incidents when surgical registrars are busy. If a patient is reported by ambulance staff to be unstable, the Emergency Department would make a number of telephone calls to alert Surgical, Intensive Care, Anaesthesia and Theatre staff and whatever other support they felt would be required at the time. This is time consuming and staff did not always congregate when called as they were frequently tied up elsewhere. The Clinical Director advised the General Manager Christchurch Hospital Services that the provision of trauma services at Christchurch Hospital was not satisfactory and that there was a need for co-ordinated trauma arrangements in a tertiary hospital which is the referral centre for major trauma for Canterbury and the West Coast.

Steps are now being taken by Canterbury Health to develop appropriate teams for the management of trauma patients at Christchurch Hospital. A group has been operating since late in 1997 involving a neuro-surgeon, vascular surgeon, general surgeon, paediatric surgeon, orthopaedic surgeon, two specialists from emergency medicine and a specialist in anaesthesia. The group has developed some guidelines for a trauma service. In addition, the group has approached the Health Funding Authority and the Accident Rehabilitation and Compensation Insurance Corporation with the guidelines for a trauma team.

SUPPORT SERVICES

Radiology Department

Concerns Regarding Radiology Services

Concerns about radiology services were expressed by Clinicians in the Hospital Services Division. Interviewees, together with a service referrer survey performed in July 1996, identified the following concerns:

lack of timely access to radiology procedures, particularly Nuclear Magnetic Resonance (NMR), Computerised Tomography (CT), Endoscopic Retrograde Cholangiopancreatography (ERCP) and ultrasound;

delays in reporting results, particularly written confirmation of verbally reported results;

insufficient sub-specialisation by radiologists (neuroradiology and paediatrics received particular comment);

variable quality of both procedures and reporting for certain interventions as a result of the absence of specialisation, particularly in paediatrics;

the need for x-ray and CT facilities in the Emergency Department;

delays in transport between Emergency Department and the Radiology Department;

poor after-hours service;

inadequate observation of patients in radiology, especially out of hours; and

inadequate nursing care for patients in the Radiology Department.

Radiology was described as a shambles and was widely perceived by staff to have been in a state of crisis during 1996. This was believed to have affected the quality of service delivery. One of the deaths investigated by the Coroner concerned delays in reporting from this department.

Management Problems in 1995

The Radiology Department appeared to have lacked effective management for some years. A former employee in the Department stated:

> "*the department had not been well managed for years. It got by on a day to day basis but had no direction. It was very fragmented between the disciplines*".

A report by an independent consultant in August 1995 confirmed the difficulty Canterbury Health was having in instituting a system for managing Radiology that was acceptable to the radiologists in the department and a multi-disciplinary management group was set up by Canterbury Health to run the department. The consultant noted that neither the Business Manager nor the Clinical Director accepted this group's role, and:

> "*Radiologists* [do] *not respect group (or Business Manager) and will not be managed by group (or Business Manager)*".

The consultant concluded that there was an urgent need to clarify delegations and responsibilities of the group, and the role of the Business Manager and Clinical Director in relation to it. A Radiology Services Manager was appointed in March 1996.

Competition for Radiology Services

Canterbury Health had traditionally provided all radiology services to The Princess Margaret Hospital (PMH). Canterbury Health also had a capacity contract with Southern Regional Health Authority to provide radiology services at PMH for general practitioners. In early 1996 PMH put its radiology business out to tender and the tender was won by the Canterbury Radiology Group (CRG), Christchurch's private provider of Radiology Services. Ten of Canterbury Health's 18 radiologists were partners in this group. Only one of the radiologists then employed by Canterbury Health did not undertake private sessions for CRG.CRG's successful tender raised several issues for Canterbury Health:

The ten radiologist partners each requested a reduction of $1/10^{th}$ in their contracts with Canterbury Health to enable them to perform their PMH contract. Canterbury Health had a shortage of radiologists and this exacerbated the problem.

Canterbury Health had to relocate the general practitioner services performed from PMH. This contract represented about 65% of the radiology services carried out by Canterbury Health from PMH. Canterbury Health had to deal with the redundancies that occurred as a consequence of losing the PMH contract.

After the transferral of the general practitioner contract, radiologists refused to report on general practitioner work. The Clinical Director reported on the results himself and sent a memo reminding radiologists of their professional and ethical obligations.

The Board concluded that CRG's successful tender raised issues of conflicts of interest which should be resolved. In September 1996, negotiations commenced with CRG for a contract for services which would have resulted in the employment contracts of CRG partners with Canterbury Health being terminated. Under the contract for service, Canterbury Health would have gained control over work practices, roster cover, quality of service, leave arrangements and other issues considered by management to be essential to improve the quantity of services delivered. The issues were not able to be resolved and the contracts of employment remained in place.

Management in 1997

In April 1997 Mr Webb assumed management control of the Radiology Department. The Commissioner understands Canterbury Health is now moving away from a fee for service contract with CRG in favour of a co-operative relationship.

Operational Issues in Radiology

Clinical Staffing

The most significant staffing issue was the shortage of radiologists. Throughout 1995 Clinical Directors made numerous approaches to the General Manager, Support Services for the employment of more radiologists. In March 1996 a review by management consultants, Cowles Notley confirmed the shortage of radiologists.

There was conflicting information on workload, full time equivalents and rosters. However, general agreement appears to have been reached by management and clinical staff that the department is short of between three and four full-time radiologists if leave, teaching and administration were taken into account.

At the Board's direction, Canterbury Health sought to employ further full-time staff in 1996. These efforts were unsuccessful.

The shortage of radiologists, together with other factors, resulted in:

incomplete roster cover;

slow reporting of films, which sometimes necessitated patients being sent away before films were checked and having to be subsequently recalled;

inadequate verification of reports; and

insufficient time for quality auditing and improvement.

While much of the blame for unavailability of timely radiology services has been placed on the Department of Radiology, the view was expressed by one clinician that a lack of radiology staff meant that expensive equipment with limited capacity was not utilised most efficiently.

Sub-specialisation and Variable Performance

Concerns were expressed by clinicians and referring departments that there was insufficient specialist expertise within the department for certain procedures, and that competency in these procedures varied between radiologists.

The Commissioner was advised that Canterbury Health did not have a formal audit process and, without this, it is impossible to be confident that all radiologists are fully competent to perform and report on the range of sub-speciality procedures they are carrying out.

Rosters

Concern was expressed by managers and others that the radiologists' rosters provided insufficient cover at certain times and were not based on the needs of Canterbury Health. Absences due to staff sickness and annual or conference leave exacerbated the problem. The independent consultant's report in August 1995 commented on the "*ongoing conflict between radiologist support for this service vs private services*".

The causes were seen as being the shortage of radiologists and the unsatisfactory structuring of radiologists' workload. Attempts by management to improve cover by restructuring the roster were reported to have been unsuccessful.

After Hours Service

The level of demand for radiology services and attempts by the department to cater for outpatient and external contract work during the day meant non-urgent internal work was performed in the evenings. In 1995 the Clinical Director of Radiology observed that 40% of the day's work was conducted between 1600 and 2300 hours.

Staff confirmed that during 1995 registrars performed most of the after-hours work with a skeleton nursing staff, few medical radiation technicians and no clerical assistance. In 1996 the number of medical radiation technicians was increased and in 1997 nursing staff numbers were improved. Management have had little success in organising appropriate radiologist staffing after-hours, although the Acting Manager of Radiology considered that the staffing and skill mix was now appropriate to meet services provided after-hours.

Integration of Radiology and Hospital Services

In late 1995 a Radiology Taskforce was established to consider approaches to prioritisation and managing demand. The taskforce ceased to function about the time that nursing was restructured at Christchurch Hospital. Apart from some guidelines sent to junior house staff for ordering procedures, none of the other objectives of this taskforce were implemented.

Quality Assurance

Conflicting evidence existed as to whether or not peer review was conducted within Radiology and whether the review processes were formalised. The radiologists have told current management that peer review and audit exists. However, the Commissioner saw no documentation to confirm this.

Satellite Radiology Services

The Commissioner was advised that 23% of total procedures undertaken in Radiology at Christchurch Hospital came from the Emergency Department and that a limited survey conducted in the department indicated 32% of patients requiring an escort came from the Emergency Department. It was stated that this supports the need for Radiology Services to be closer to the Emergency Department to avoid delays in the transport of critically ill patients.

Contributing Factors in Radiology Services

Conflict of Interest

Crown Health Enterprise radiology departments have traditionally serviced three distinct markets: core imaging services (24 hour), specialist imaging (Nuclear Magnetic Resonance (NMR), Computerised Axial Tomography (CAT)) and primary referred imaging. There is active competition in the latter two areas with the private

providers of radiology services. The potential conflict of interest has become serious in Christchurch because:

the competitive environment encouraged by the health reforms has led Crown Health Enterprises to more actively compete in markets traditionally dominated by the private sector;

in Christchurch there is only one Crown Health Enterprise providing radiology and one private provider;

the majority of Canterbury Health radiologists work for or are partners of the private provider; and

Canterbury Health and the private radiology group compete directly in the areas of ultrasound, Magnetic Resonance Imaging (MRI) scanning, Accident Rehabilitation and Compensation Insurance Corporation (ACC) contracts, mammography and general practitioner procedures.

Canterbury Health receives 17.6% of its revenue from general practitioners and private patients.

Under-resourcing and Growth in Demand

Radiology was reported to be seriously under-resourced for the services it was expected to provide. Estimates of the shortfall in funding ranged from $500,000 to $1,000,000. Radiology is a support service to internal and external referrers and is highly vulnerable to increasing demand both from a resourcing and a capacity perspective. The following factors have exacerbated the workload/resourcing mismatch:

the budget did not reflect operational reality. It was based on historical cost rather than forecast outputs. The budget for 1996 was set by the finance department according to company guidelines which the former Manager of Radiology stated required a 2% cut from the previous year and 15% efficiency gains. This budget included an assumption that there would be no increase in internal referrals despite a clear historical trend of an annual increase in outputs;

there were no measures in place within Canterbury Health to manage internal demand. There is no charging mechanism to make referrer departments conscious of or responsible for the volume and cost of their outputs;

it is widely accepted that external contracts are needed in Radiology to subsidise internal services. In some cases this has proved not only justifiable, but essential. For example, to cover the capital costs of the MRI scanner it was necessary for Canterbury Health to contract with ACC; and

the contract with Southern Regional Health Authority for general practitioner procedures is a contract for unlimited volume for a set price. Demand is not managed by Canterbury Health or the Regional Health Authority which exposes Canterbury Health to unlimited financial risk and potential stress on a fixed budget.

Laboratory

Incidents Reported

On 28 February 1995 there was an incident which resulted in the release of falsely low potassium results. Prompt action was taken to correct the results and communicate with referring clinicians. A good incident report was filed according to the protocol that existed in the laboratory at that time. Review established that the error was caused by a technologist failing to follow established quality assurance procedures and it was acknowledged that a contributing factor was an imbalance in staff allocation on the day the incident occurred, compared with other days of the week. Both the

Quality Assurance Co-ordinator and a Medical Advisor reviewed the incident and confirmed the conclusions. Corrective action was taken following the incident, but was not completed over 12 months later when the Medical Advisor again reviewed the incident. However, the General Manager, Diagnostic and Support Division stated that the corrective actions to be completed at that stage were "*relatively minor and I am advised by the Quality Manager that the changes required to ensure that there is not a recurrence of this issuing of incorrect test results have already been made*".

The Laboratory was not examined in any depth by the Commissioner. Therefore the fact that no other incidents came to light in the evidence gathered does not indicate whether or not the processes in the Laboratory are of an adequate standard.

During 1996/97 the laboratory performed 2.5 million tests with an incident rate of less than 50 per month. Canterbury Health advised that it reviewed incident forms from September 1995 to May 1997 and that were no areas or incident types that form a pattern.

Customer Survey

A survey of junior medical staff in September 1996 indicated their general satisfaction with services from the laboratory. The survey was sent to 238 house surgeons and there was a 32% response rate. A similar survey of 250 senior medical staff yielded 16 responses (6%). Overall, users were generally satisfied with the service provided by Canterbury Health laboratory. A substantial number indicated that they were extremely satisfied or very satisfied. However, there were areas which did not meet user expectations and a minority of respondents indicated that they were not satisfied or extremely dissatisfied with some aspects of the service.

The dispersal of acute medical, surgical and cardiology patients all over the Hospital in winter 1996 and the frequent movement of patients within the Hospital highlighted the lack of on-line access to laboratory results throughout the Hospital. Pertinent laboratory information was not always available at the time clinical decisions were made. In the survey, junior doctors' main complaint was the need for on-line results, particularly as the phones for Labline were often engaged. There was also a request for better communication of severely abnormal results. As a result of this survey, a pilot for on-line reporting was implemented in four wards, the Emergency Department and Intensive Care Unit. This has proved very successful. The Commissioner was informed that Canterbury Health intends the Delphic "Eclair" system be established throughout the Hospital. This system allows access to laboratory results from the wards in "real time".

Telarc Accreditation

The laboratory is audited against the New Zealand Code of Laboratory Management Practice by Telarc, an agency recognised throughout New Zealand for laboratory services accreditation. A review took place in June 1996.

The report praised the laboratory for the appointment of a full-time Quality Manager and the internal audits that have been performed. It also indicated the need to monitor the quality outcome of a recent restructuring within the laboratory.

The report listed 17 instances of non-compliance with the requirements of the New Zealand Code of Laboratory Management Practice, Laboratory Accreditation in New Zealand, and applicable technical documents. These instances were subsequently cleared and the laboratory was reregistered.

Restructuring

Laboratory testing was one of the first service areas that the Southern Regional Health Authority sought to make fully competitive. Canterbury Health positioned itself to compete with other tertiary laboratory services to be the preferred provider for specialised testing in New Zealand.

Laboratory Services have undertaken a number of restructures. The first restructuring of Laboratory Services was part of an ongoing review to make its systems more akin to those in a commercial organisation. This involved implementing the Core Laboratory concept, which groups automated testing in one area. This structure is generally considered to be more efficient and is being implemented in most large hospital laboratories. This restructure was proposed in October 1994 and implemented in April 1995.

The second restructure commenced in October 1995. Service Managers were introduced above Clinical Directors in the organisational chart. It is likely that the intent of the second restructure was to establish a consistent organisational structural framework across the Crown Health Enterprise.

A further restructure at Christchurch Hospital in 1997 reintroduced a decision-making partnership between technologists and pathologists in the laboratory.

Apheresis

A Project Consultant conducted a review of the Apheresis service at Christchurch Hospital in 1997. She concluded that the Apheresis Unit is "*short of staff that can, safely and effectively, provide this developing service*" to Christchurch Hospital. At the time of the review there was only one nurse fully trained in the necessary techniques and, consequently, patients were not always able to receive timely and optimum service.

The consultant also noted that the demand for Apheresis procedures had grown significantly. As a result, the staff and other issues needed to be addressed in order to provide a safe and effective service.

Hotel Services

Food

In September 1996 Christchurch Hospital signed an external contract to manage catering. Hospitality services had previously been provided by Canterbury Health employees.

Prior to this contract for provision of food, there was a food supervisor to assist patients to decide what food they would like for the following 12 hours. The contractors have no-one to assist patients fill out their meal sheets which has created more work for nurses.

Meals were dispatched to each ward three times a day on trolleys pushed by employees of the contractor.

Comments were made by dieticians and employees of the contractor that nurses do not always supervise the handing out of meals, encourage patients to consume their supplements or assist patients with their meals. A patient's relative also complained about the handing out of tea, coffee and biscuits in the Bone Marrow Transplant Unit with ungloved hands.

A number of patients may require food at the same time which has caused problems where meal breaks for nurses occur at the same time as patient meals are delivered.

Cleaning

The cleaning at Christchurch Hospital is undertaken through a contract which is run according to the specifications of the Crown Health Enterprise and to ISO9002 standards. Employees of the contractor stated that the specifications that had been agreed by Canterbury Health had not necessarily been discussed with Clinical Nurse Facilitators. This has required the Contractor's Customer Services representative to consider the various areas where cleaning has not been undertaken as frequently as required. The cleaning specifications for theatre were originally incorrectly specified and had to be re-negotiated. The quality of cleaning is checked each fortnight and signed off by the ward staff as well as by the cleaning supervisor.

One consumer advised the Commissioner of his view that Christchurch Hospital was not a hygienic environment in which his wound could heal. He wrote to the General Manager Christchurch Hospital Services about his complaints and the cleanliness of the hospital and sent a copy of that letter to the Chief Executive. The consumer advised that he had received no reply to his letter. He also wrote to the cleaning contractors and talked with the Service and Patient Care Managers.

Problems with the level of cleanliness were also raised at a Medical Advisors Breakfast Meeting in June 1996. The meeting concluded that regular inspections of the Hospital should be carried out. The Commissioner is not aware of whether such inspections have been carried out.

Frequency of cleaning was reported to differ between departments.

INTERFACE WITH GENERAL PRACTITIONERS AND OTHER PROVIDERS

Communication with General Practitioners

The investigation revealed difficulties in communication between Christchurch Hospital and general practitioners. A senior fellow of the Royal New Zealand College of General Practitioners stated that:

"*Telephone access is far more difficult since the passage of many of Princess Margaret Hospital services over to Christchurch Hospital*". This supports the evidence given by some of the medical staff.

"*Access to information from outpatient clinics is significantly impaired with summary letters taking many many weeks to reach us or not being received, the patients not receiving appointments and our faxes not*

being received.... It is common in practices to have at least one to two hours a day for two practitioners on the phone trying to sort out communication difficulties in regard to patient information".

Lack of Administrative Support - Paediatrics

Poor written communication with general practitioners is recognised within Christchurch Hospital itself. The Clinical Director of the Department of Paediatrics described the lack of administrative support which had led to communication difficulties with other health providers as a major problem because with regard to the safe care of paediatric patients "*communication is everything*". He advised:

> "*that with rare exceptions the Paediatrics Service was unable to provide written/typed summaries for children who had been in-patients. There is at present a one page pre-printed form that is used for the discharge summary. The form is completed in handwriting at the time of discharge of the patient. In the vast majority of patients there is no other written communication to the General Practitioner*".

Further he commented that the

> "*one page hand-written form is satisfactory for children who have been admitted for a short time with a condition that is not complicated. For example, the form may be satisfactory for a child admitted with bronchiolitis or gastroenteritis. Many children are, however, admitted with complicated problems. In those cases the Paediatric Service is unable to communicate properly in writing to the General Practitioner and other health professionals who may be involved in the management of the case*".

He stressed that "*it is a major problem*". In relation to paediatric outpatients, typed letters can be provided.

Lack of Administrative Support - Surgery

The unsatisfactory state of the secretarial service in the Department of General Surgery has been dealt with in the section on Staffing and Contingency Planning. Evidence was given by consultant general surgeons that outpatient letters, operation reports, discharge summaries, endoscopy reports and general correspondence to general practitioners were not being typed in a timely manner.

PERSONAL PRIVACY

General Issues

Personal privacy is an issue in many areas of Christchurch Hospital, as it is in other public hospitals. Private hospitals do not tend to have the same problems due to their having more separate rooms for patients. Medical staff recognised that it was difficult to maintain privacy where curtains were used extensively as screens and that there is a tendency to treat curtains as soundproof walls.

While several examples of lack of privacy were given during the investigation, including that of Christchurch Hospital being so busy that acutely ill patients were lying "side by side" with only a curtain for privacy, the following particular areas were highlighted during interviews.

Examples of Lack of Privacy

Gastrointestinal Investigative Unit

Respect for personal privacy in the Gastrointestinal Investigative Unit (GIU) related mainly to the lack of any area to inform patients in private of their diagnosis. As a result, consumers have been told the results of procedures in the corridors. This was unsatisfactory due to the busy nature of the corridors adjacent to the GIU. Sometimes personal information was given to consumers in the recovery room where there may be a number of other consumers. The Commissioner was informed that the situation in the GIU was improved in June 1997.

Dental Department

The clinic design in one area was open plan with three dental chairs sharing the same area. As a result, little if any privacy was afforded to patients during consultations. In addition, new patients were required to provide personal information at the front desk, which is located in the general waiting area. In March 1998 Canterbury Health advised that Board approval had been given for confirmation of new facilities.

Coronary Care Unit

Patients in this Unit were only shielded by curtains and their beds placed immediately opposite the nurses' desk. The Unit is open plan allowing other patients to hear the noise of cardiac arrests.

Department of Surgery

Staff were concerned about the lack of privacy for patients who were admitted pre-operatively or for day procedures. The Commissioner was advised that patients had been prepared for surgery in a dayroom where there were up to six other patients because there were no available beds in the ward.

Paediatric Department

Lack of space affords inadequate isolation and privacy in the Paediatric Department for children and their families.

Emergency Department

In winter 1996 clinicians and nurses in the Emergency Department were concerned about the number of patients who waited for treatment and were treated in corridors where there was no privacy. Photographs of such patient crowding were shown to the General Manager Christchurch Hospital Services. Canterbury Health advised that there is now a procedure room for patients who require additional privacy in the Emergency Department.

Customer Perceptions

The Resource Review Report contained an overview of customer perception of the quality of service delivery, prepared by the Performance Monitoring Unit in October 1996. The paper described patient privacy having been compromised when:

inadequate physical space resulted in health information being discussed in the hearing of others; and

bathroom facilities were shared between male and female patients.

SHAREHOLDER EXPECTATIONS

Statement of Shareholders' Expectations of Crown Health Enterprises

The Statement of Shareholders' Expectations of Crown Health Enterprises 1996 sets out the priorities and expectations for Crown Health Enterprises (CHEs) by the Minister of Finance and the Minister for Crown Health Enterprises (the Shareholders).

Among other things, CHEs are required to operate as successful and efficient businesses, remaining financially viable in the long term. CHEs are required to fully cover all costs, including the cost of capital. They are required to achieve a return on equity to cover the opportunity cost of the Shareholders' investment, an appropriate return being that comparable to other businesses facing low to average risk. Achieving a suitable return on equity is regarded by the Shareholders as a key objective for each CHE board in the medium term.

The Role and Influence of the Crown Company Monitoring Advisory Unit

Crown Company Monitoring Advisory Unit (CCMAU) advised the Commissioner its role is primarily to advise the shareholding Ministers of Crown owned companies, such as CHEs, in relation to the effectiveness and efficiency of the entity's operations and its financial viability. Crown Company Monitoring Advisory Unit focuses on the Shareholders' interests and expectations in CHEs including, for example, whether CHEs have set themselves targets consistent with the Statement of Shareholders' Expectations. These targets are primarily set out in CHEs' business plans and Statements of Intent.

In response to this Report, Crown Company Monitoring Advisory Unit advised:

"CCMAU represents shareholding Ministers' ownership interests in CHEs through monitoring, analysis, reporting and advice to those Ministers. CCMAU operates at a high level, focusing on organisational performance to ensure that the Crown's investment is protected by focusing primarily, but not exclusively, on a CHE's financial performance. Financial results provide valuable information about many aspects of a CHE's overall organisational success. Quality measures are taken into account, to the extent that the measures chosen have an impact on the overall organisational performance of the company.

...

In this instance, CCMAU's role complements that of both the Ministry of Health, which is responsible for monitoring the performance of the purchaser, and the Treasury, which focuses on the overall fiscal impact of CHE performance on the Crown's balance sheet.

CCMAU also performs a governance function by recommending to shareholding Ministers the appointment and removal of directors of CHEs and advising on the performance of members of the board of each CHE."

Crown Company Monitoring Advisory Unit also pointed out the inherent tension in any public health system between the issues that are encapsulated in the Code of Rights and the fiscal limitations of a Government's budget. In New Zealand this tension has been recognised by Parliament and is reflected in the legislation under which Canterbury Health, Crown Company Monitoring Advisory Unit and all other relevant bodies in the sector operate.

The 1995/98 Business Plan

Crown Company Monitoring Advisory Unit advised that a business plan is the Crown Health Enterprise's response to the Statement of Shareholders expectations. The plan explains how the organisation is expected to perform and the types of services it will deliver. The business plan does not convey precisely what services will be delivered or the standard of such services. Under the statutory framework of the Health and Disability Services Act, the nature and quality of services to be provided are dealt with in the service contracts negotiated with the purchaser. A business plan is based around a one year budget, with forecasts for the next two years. Crown Health Enterprises are asked to provide a plan that shows a path to financial viability in that time period.

Eighteen months after the formation of Canterbury Health it was placed in "workout". Crown Health Enterprises were placed in workout if they failed to produce a business plan that was financially viable. An advisor from the Crown Company Monitoring Advisory Unit was appointed to assist the Board of Canterbury Health to resolve the Crown Health Enterprise/Southern Regional Health Authority contractual deadlock, to control costs and to produce a revised business plan.

The Board, with assistance from the Crown Company Monitoring Advisory Unit advisor, gave management very clear directions as to its requirements for the 1995/98 business plan. The Board rejected management's initial draft business plans and insisted on a plan by which Canterbury Health could break even in two years. The stated objective of the Board was "*to achieve commercial viability as soon as possible*".

The Chief Executive, Mr Frame, and his senior management team had grave reservations about the wisdom of this approach to cost reduction and their ability to achieve it. Both Mr Frame and the General Manager, Diagnostic and Support Services advised the Commissioner that the Chairman made clear to senior management that only two options were available - to leave Canterbury Health's employment or implement the plan.

Dr Layton denied any direct threats were made. *"What I was aware of, and did convey to senior management, is that Chairs and Chief Executives of CHE's that were not getting on with developing and implementing realistic business plans were vulnerable. This was not a threat. It was the reality we faced, as the list of casualties among these groups shows."*

Mr Frame stated in an interview with the Commissioner *"And in Christchurch I realised the conflict and realised that the only pragmatic approach if I was going to stay in the job was to align myself more towards the position that was being taken by Government - and the Chairman was aligning himself with that."*

On 27 March 1995, by letter to the Board accompanying the business plan, Mr Frame informed the Board of the factors which would influence the success of management in implementing the business plan. In particular he noted there was a "*not insignificant level of risk associated*

with the plan". The only mention of a possible impact on patient safety in this letter is the following reference:

"*The degree to which efficiencies can be achieved in clinical areas, whilst still functioning safely, is unknown. To date there have been as many areas where staff believe we are under-resourced as there are where Management considers we are over-resourced. The only effective methods of establishing the appropriate levels of clinical resourcing are by "best practice" comparisons and staff consultation. Both of these will require a good co-operative relationship with our clinical staff*".

The Crown Company Monitoring Advisory Unit advisor informed the Commissioner he did not see this letter.

The Role of Central Government Agencies

The Crown Company Monitoring Advisory Unit advised that the business planning process underpins Crown Company Monitoring Advisory Unit's ability to monitor Crown Health Enterprise financial and organisational performance and shareholder interests, which is Crown Company Monitoring Advisory Unit's primary function. As normal commercial incentives such as bankruptcy and takeovers do not exist in this operating environment, this process in conjunction with the monitoring process, provides the main incentives on boards to perform in line with Shareholders' expectations. Crown Company Monitoring Advisory Unit and the Treasury are both involved in reviewing business plans on behalf of shareholding Ministers.

Crown Company Monitoring Advisory Unit and the Treasury jointly advised the Shareholders in a memorandum dated 6 May 1995 of the risks to the successful achievement of the business plan including:

(a) revenue increases from Southern Regional Health Authority and/or service exits insufficient to cover volume increases;

(b) the 36 efficiency projects identified in the business plan not being successfully implemented within the time-frame; and

(c) the need for clinical buy-in, in an environment where Canterbury clinicians had a history of strong resistance to change.

Officials considered the proposed efficiency gains, which were 10% of current operating cost, to be aggressive and stated there was a risk that they would not be achieved within the timelines. They considered the risks associated with the plan to be substantial, and that the plan appeared to be unrealistic in places. In a letter to shareholding Ministers, officials stated that:

"*The successful implementation of the efficiency gain and service change projects is dependent on gaining clinical buy in. The clinicians at Canterbury have a history of strongly resisting health service changes in the region. Given the significant changes proposed, there is therefore a risk that clinicians may hinder progress*".

Crown Company Monitoring Advisory Unit considered that the clinicians at Canterbury Health were traditionally opposed to change and would need to be managed carefully. Crown Company Monitoring Advisory Unit also considered that the resolution of the Southern Regional Health Authority contract would be difficult. Accordingly, officials suggested that "*it may be*

appropriate for Crown budgeting purposes to set less stringent, more realistic targets for the CHE". However, officials advised the Ministers of Crown Health Enterprises and Finance that "[c]*onveying such a message to the Board and management is not recommended as it will likely undermine their resolve to achieve the targets set*".

No regular monitoring programme was put in place during 1995 to ensure progress against targets, or to ensure that the risks were being managed appropriately.

Crown Company Monitoring Advisory Unit advised the Commissioner that it is not its role to consider how the plan might have affected Canterbury Health's ability to deliver services and that it is "*the purchaser... who has the responsibility to understand, measure, contract for and ensure delivery of service volumes and quality.*" It is not required to advise Ministers on the risk to service quality of Crown Health Enterprise business plans. However, Crown Company Monitoring Advisory Unit does appoint a clinical reviewer to assess Canterbury Health's business plan from a high level to ensure that any clinical issues do not undermine the business. Crown Company Monitoring Advisory Unit further advised the Commissioner that it "*does endeavour to keep shareholding Ministers informed about organisational risks to individual Crown Health Enterprises including macro level clinical risks. In the event that it became apparent that a business plan presented an unacceptably high level of risk, including clinical risk, then Crown Company Monitoring Advisory Unit would advise Ministers accordingly. It is for this reason that we appoint clinical reviewers*" and that the review of Canterbury Health's business plan "*did not indicate an unacceptably high level of risk.*" Crown Company Monitoring Advisory Unit further advised the Commissioner that clinical information was "*of a general nature and used in relation to our reports on overall, and not specifically, clinical, performance.*" The terms of reference required the assessment to consider the feasibility of the initiatives and the time-frames. Crown Company Monitoring Advisory Unit does not assess the plan to determine details of service quality as this would involve an intensive investigation of each service, and Crown Company Monitoring Advisory Unit does not have the clinical expertise or the statutory authority to carry out assessments of that nature. Crown Company Monitoring Advisory Unit advised the Shareholders that the assessment concluded there were no significant issues remaining which altered the viability or risks associated with the business plan.

Neither Treasury nor Crown Company Monitoring Advisory Unit were able to locate the clinical assessment of the 1995/96 business plan for the Commissioner. Crown Company Monitoring Advisory Unit advised that they remain unsure whether any actual document in fact existed and that it appeared the review may have been done verbally.

Crown Company Monitoring Advisory Unit did not consider that it was required to seek reassurance from the Board about the Board's ability to deal with the risks. However, the Shareholders in a letter to Canterbury Health dated 5 May 1995 stated that they looked to the Board "*to deal with any issues which might threaten the achievement of the* [efficiency gain] *targets set*".

Crown Company Monitoring Advisory Unit stated that it has no role in advising Ministers concerning purchasing, although it stated that if there were any such issues Crown Company Monitoring Advisory Unit would refer them to the Crown Health Enterprise, the Regional Health Authority and to the Ministry. However, Crown Company Monitoring Advisory Unit noted that it would advise shareholding Ministers where purchasing behaviour presented ownership risks (including clinical risks) when it is aware of such risks. Crown Company

Monitoring Advisory Unit relies on the Crown Health Enterprise, through its clinical expertise, to identify such risks and bring them to the Unit's attention.

In 1997 Crown Company Monitoring Advisory Unit directly intervened to prevent a protracted contractual dispute. It worked with Canterbury Health and Southern Regional Health Authority to develop Heads of Agreement within an acceptable time-frame and assisted with advice about bridging the gap between the Southern Regional Health Authority's available funding and the revenue required by Canterbury Health to deliver the services needed to contain demand at manageable levels.

The former Chairman advised that:

> *"CCMAU and/or other central agencies intervened on behalf of Canterbury Health in 1993, 1994 and 1995 (for 1995/96 and 1996/97), so there was nothing new in this regard in 1997. My letters to CCMAU about our contracting problems with SRHA became legendary for the firmness with which views were presented.*
>
> *Over time, as the quality of the data we had available to justify our prices improved we received increasing support for our claims from CCMAU.*
>
> *We spent very considerable effort improving our databases on comparative prices and costs for this purpose. We promoted the benchmark study, which led to the establishment of the National Benchmarking Agency. This was despite the strong opposition of the two biggest Auckland CHE's and some hostility from RHAs. ... the Chief Executive of the SRHA* [advised] *that my activities in seeking comparative price data were in breach of the Commerce Act, and he would report me if I did not desist. CCMAU assisted Canterbury Health in these efforts. In fact, CCMAU generously found in their own budget the $70,000 needed to establish the benchmarking study."*

REGIONAL HEALTH AUTHORITY

Introduction

This section covers issues surrounding the funding of Canterbury Health by its major purchaser, Southern Regional Health Authority (SRHA) which is now the Southern Region of the Health Funding Authority.

Southern Regional Health Authority

Southern Regional Health Authority provides approximately 86% of Canterbury Health's revenue. The manner in which Southern Regional Health Authority fulfils its purchasing responsibilities is therefore critical to the financial viability of Canterbury Health.

1994/95 Funding

In 1994/95 Canterbury Health received approximately $154 million from Southern Regional Health Authority. This revenue was based on 1992/93 volumes, which were 18% below actual case weights for 1994/95. Acute volumes are estimated to have grown at 8.4% annually (case weighted) for the three years since 1994. Approximately 5% is due to volume growth in

acute services and the remainder results from increasing case complexity. This is recognised by the case weighting system.

1995/96 and 1996/97 Funding

In preparing its 1995/96 business plan, Canterbury Health estimated the shortfall in funding from Southern Regional Health Authority for the previous year to be in the region of $33 million. Both Ernst & Young (who undertook a report for Canterbury Health) and Canterbury Health estimated that, on a conservative basis, Canterbury Health could reasonably expect $20 million of additional revenue from Southern Regional Health Authority in 1995/96, leaving a shortfall of $13 million. Efficiency gains of $14 million, net of restructuring costs, had been identified in the business plan.

Contract negotiations between Canterbury Health and Southern Regional Health Authority were protracted, and stalled in July 1995. Canterbury Health initially asked for $177.4 million but Southern Regional Health Authority offered only $157 million for all services. There was no further progress until late October 1995 when Canterbury Health issued a series of exit notices, including a threat to exit from emergency services. This resulted in an intervention by the Minister of Health who appointed a facilitator.

Negotiations between the Crown Health Enterprise and Southern Regional Health Authority for funding for 1995/96 and 1996/97 were facilitated by Mr Doug Martin. These resulted in Heads of Agreement in January 1996, seven months into the 1995/96 financial year, which increased Canterbury Health's revenue by an additional $18 million to $172 million, which compares with Canterbury Health's bid of $177.4 million. Under the Heads of Agreement Canterbury Health was essentially bulk funded for provision of services. The additional $18 million included a tertiary teaching supplement to recognise the impact of teaching on hospital costs. In 1996/97 the Regional Health Authority's bulk payment was increased by $0.5 million from 1995/96 revenues. Southern Regional Health Authority commented that the agreement was 2½% below Canterbury Health's bid, and that no other Crown Health Enterprise within Southern Regional Health Authority's jurisdiction had such a high proportion of its bid accepted.

Significant disagreement arose between Canterbury Health and Southern Regional Health Authority over interpretation of the Heads of Agreement when it came to specifying the detailed purchase framework which was to underpin the contract. There was difficulty in agreeing specifications, prices and volumes for services. The Heads of Agreement provided for a repricing exercise for the individual services provided by Canterbury Health. Where the price for individual services could not be agreed and Canterbury Health exited the service, Southern Regional Health Authority deducted from the total amount of the contract the amounts by which it repriced that service rather than the amount Southern Regional Health Authority had originally offered. This adversely affected Canterbury Health's ability to meet the financial targets agreed with its Shareholders. These targets relied on savings from service exits which had been estimated using the prices paid by Southern Regional Health Authority in 1994/95 and which closely reflected their 1995/96 initial offer.

Southern Regional Health Authority states that these pricing decisions did not adversely affect the ability of Canterbury Health to deliver services, as the actions were consistent with the Heads of Agreement. However, Canterbury Health did not agree with Southern Regional Health Authority's interpretation of the Heads of Agreement. In November 1996 the Chairman of

Canterbury Health commented on the "*frustrating two year negotiation process that has still not resulted in a satisfactory contract...*" and threatened to take the matter to arbitration. No contract was signed by the parties during the two year duration of the Heads of Agreement.

1997/98 and 1998/99 Funding

In March 1997 Canterbury Health analysed the Southern Regional Health Authority offer for the next two year contract period from 1997 to 1999 and estimated that it would be underfunded by $28 million for the 1997/98 year. This consisted of an $11 million shortfall resulting from lack of recognition of volume growth and a $17 million shortfall resulting from inappropriate pricing. Richard Webb said in a letter to Southern Regional Health Authority Chief Executive, Victor Klap, on 25 March 1997:

> "*We find the SRHA proposed inpatient volume for 1997/98 totally unrealistic. Outrageously low intervention rates have been purchased by the SRHA in Christchurch compared with the rest of the country and other provinces under SRHA's control. We find such proposals morally bankrupt and totally unacceptable. Very little of our surgery is truly deferrable and while cancer surgery and other life and limb threatening conditions may be deemed 'elective' by SRHA definition, let me assure you that our clinicians will not be asking these patients to wait.*
>
> *To date, the contracting process and position adopted by SRHA has been scandalous and results in gross underfunding of the services Canterbury Health is required to produce. This in turn has placed great stress on the organisation.*
>
> *In regard to pricing, SRHA has clearly not implemented the Minister's instructions to pay CHEs prices that will allow a CHE of average efficiency to break even by 30 June 1997.*
>
> *I intend that SRHA will be accountable for its inadequate contract and what appears to be its callous indifference to meeting national standards on price, volume and intervention rates for the public of Canterbury."*

Victor Klap's response on 4 April 1997 included the following comments:

> "*Your letter is threatening and warrants a retaliatory response, but I think it is not in the best interests of our respective organisations and the people who ultimately utilise the services we purchase. I have to say I find your concluding paragraphs offensive."*

Richard Webb forwarded copies of both letters to Karen Poutasi, Director General of Health, Kath Cook, Ministry of Health, Andrew Weeks, Crown Company Monitoring Advisory Unit and Graham Scott, Combined Regional Health Authorities.

A letter to the Chief Executive of Southern Regional Health Authority on 13 June 1997 outlined Canterbury Health's position and Canterbury Health's reasons for considering Southern Regional Health Authority's approach to be unrealistic. Canterbury Health commented that Southern Regional Health Authority's purchase offer was less than forecast 1996/97 volumes and failed to provide for growth in 1997/98. The letter warned of massive underfunding. Canterbury Health calculated, by June 1997, that it was underpaid by $18.9 million for the services it delivered in 1996/97. The new Chief Executive, Mr Webb, took Canterbury

Health's case to the Crown Company Monitoring Advisory Unit and the Transitional Health Authority. On 11 July 1997 the parties signed a Heads of Agreement in which both acknowledged that Southern Regional Health Authority was unable, within its own budget, to purchase sufficient volumes at appropriate prices, based on demand forecasts.

Volumes

The Statement of Shareholders' Expectations (SSE) of April 1996 makes it clear that Crown Health Enterprises (CHEs) are to provide only that volume of services for which the Crown Health Enterprise has a contract. However, the SSE also recognises that Crown Health Enterprises cannot turn away patients requiring immediate care. If a Regional Health Authority does not purchase volumes on the basis of the numbers admitted by a Crown Health Enterprise in the previous year plus a margin for forecast growth, the Crown Health Enterprise will exceed its contracted volumes unless it can make an equivalent reduction in elective work. In order to make this trade-off, elective work must be truly elective. Canterbury Health's business plan noted approximately 82% of its work was non-deferrable. Consequently, it had little flexibility in managing within its contracted volumes using the acute/elective trade-off mechanism.

The business plan noted the growth in acute admissions for Canterbury Health over the previous three years was 5% per annum. It forecast that admissions would continue to grow, but at a decreasing rate. Actual volumes were growing at an average 5% per annum, but the increasing complexity of cases admitted equated to a case-weighted increase in volume of over 8%. It does not appear that the coding of cases distorted this figure as Canterbury Health's caseweight coding was the lowest of the tertiary Crown Health Enterprises and lower than that of Healthcare Otago.

Southern Regional Health Authority disputed these figures stating the growth was much lower and noted that during the period there were significant changes in coding practice, admission protocols and quality of coding at Christchurch Hospital which had an impact on reported volumes and should not be overlooked. Southern Regional Health Authority advised *"SRH* [Southern Regional Health Authority] *believed that since Canterbury Health and other acute providers had a responsibility and ability to manage acute referrals, the risk should remain with a service provider."*

Capacity Contracts and Risk

Southern Regional Health Authority purchases 78% of Canterbury Health's services on a capacity contract. Canterbury Health therefore carries significant risk if actual volume exceeds contracted volume, despite the fact that Canterbury Health is relatively powerless to control demand.

The 1995/97 Heads of Agreement recognised this risk and incorporated an acute/elective volume offset if acute volume growth in 1996/97 was plus or minus 2% of forecast demand. No allowance was made for volume offset in 1995/96. This agreement was not implemented because of instructions issued to both parties by the respective Ministers. Canterbury Health received $3.4 million from Southern Regional Health Authority for the additional volume in 1996/97.

A number of factors affect acute volumes, one of which is the intervention rate (the volume of each service purchased by Southern Regional Health Authority relative to the population served). Lower intervention rates result in increased acuity of presenting cases, increasing the costs of treatment per case (the case weighting) and pushing the non-deferrable portion of work higher. An analysis of the public intervention rates of Southern Regional Health Authority for the 1994/95 year, the latest for which data is available to the Commissioner, shows that purchases of surgical services by Southern Regional Health Authority from Canterbury Health for the region were about 20% below the national intervention rates and medical services 18% below. Canterbury has the lowest intervention rate in the Southern region by a wide margin. The national intervention rates are based on the 1991 population census and population is growing at 2% per annum in the Christchurch catchment.

In April 1995 Southern Regional Health Authority advised Canterbury Health that *"It is our expectation that we will revisit the elective volumes for Canterbury in line with our intention to move toward national intervention rates."* Southern Regional Health Authority stated that it based its purchasing decisions not only on intervention rates, but also local health needs, geographic access to services and the level of provision by other sectors. Canterbury has a high level of private activity which Southern Regional Health Authority stated it took into account when deciding on the volumes of services it purchased from Canterbury Health. Southern Regional Health Authority also based its purchasing decisions on the need to purchase within available funds and the need to compensate providers for appropriate levels of acute care.

Southern Regional Health Authority contended that, over the past three years, there was a significant movement in volumes purchased from Canterbury Health to the point where intervention rates were closer to the national rate. However, the Heads of Agreement signed in July 1997 for 1997/98 acknowledges that the volume which Southern Regional Health Authority funding enables it to purchase (namely 54,035 case weighted discharges) will not be sufficient to ensure that all patients requiring non-deferrable treatment will be able to be treated. The Agreement states that an additional 4762 case weighted discharges needed to be funded to maintain throughput in 1997/98 at 1996/97 levels. The Agreement notes that Canterbury Health anticipates additional funding from the Waiting Times Fund to meet the shortfall.

Outpatient volumes have also been purchased on a capacity basis. This area is controlled by general practitioner referrers. Crown Health Enterprises have minimal control over these referrals yet carry the volume risk. The 1997/98 Heads of Agreement acknowledges a $1.3 million gap between non-DRG (outpatient) volumes forecast by Canterbury Health and those Southern Regional Health Authority is offering to purchase.

Prices

According to the Statement of Shareholders' Expectations, Regional Health Authorities have a responsibility to negotiate "*sustainable medium-term prices*". Canterbury Health stated in its 1996 - 2001 business plan that it understood this to mean prices which would allow a Crown Health Enterprise of average efficiency to break even by 30 June 1997. Appropriate pricing for services has been a key impediment to conclusion of contract negotiations and to good working relations between Crown Health Enterprises and Regional Health Authorities.

Southern Regional Health Authority believes it paid appropriate prices for services purchased from Canterbury Health as it undertook a "*comprehensive benchmarking exercise to establish*

prices for the services it purchased from all regional CHEs". Southern Regional Health Authority declined to provide information about this benchmarking exercise to the Commissioner.

Objective and comparative data to analyse Southern Regional Health Authority prices is difficult to obtain. However, indications the Southern Regional Health Authority does not pay prices comparable with other Regional Health Authorities can be gained through comparison of national averages.

The 1995/96 performance report on Regional Health Authorities indicates that the case mix adjusted price paid for all cases in 1994/95 was $2,385 and in 1995/96 was $2,276. As Canterbury Health is a tertiary Crown Health Enterprise it might be expected to have a more complex mix of cases and therefore to have a cost per case at the top end of this range. In 1995/96 and 1996/97 Canterbury Health was paid $1,861 per case weighted discharge. Canterbury Health's actual cost per case weighted discharge was $2,223.

The Crown Company Monitoring Advisory Unit (CCMAU) undertook an analysis of benchmark prices paid to Crown Health Enterprises in 1997. In a letter to Canterbury Health in May 1997, Crown Company Monitoring Advisory Unit stated that the benchmark information received in 1995/96 led them to believe that up to $14 million of the Canterbury Health's forecast operating deficit may have related to underpayment for services provided in 1996/97.

The National Benchmarking Agency is an independent research organisation specialising in health economics. Their analysis of prices offered by the four Regional Health Authorities for the 1997/98 contracting round showed a variation from $1,942 to $2,261 per case weighted discharge. Southern Regional Health Authority's price per case weighted discharge is the lowest of the Regional Health Authorities. Southern Regional Health Authority's 1997/98 price was below the average of Crown Health Enterprise costs for 82% of procedures. The agency notes that Regional Health Authority prices are below an economically sustainable level in the majority of cases.

Emergency Services

In 1994 and 1995 Canterbury Health served notice of intended exit from emergency services in order to obtain a realistic price. This resulted in Southern Regional Health Authority raising its original offer of $5.81 million to $6.84 million, which was Canterbury Health's estimated cost of providing this service in 1995.

In December 1996 Canterbury Health received comparative data on Emergency Services from the National Benchmarking Agency to which 15 Crown Health Enterprises contribute data. This study showed that Canterbury Health's Emergency Department has the lowest staffing and cost per output in the country, and that it is also the most under-funded by $2.8 million. This study appeared to be the first definitive comparative pricing information available to Canterbury Health.

This benchmarking study demonstrates that Southern Regional Health Authority paid significantly lower prices per visit to Emergency Services than the other Regional Health Authorities. In 1996 Southern Regional Health Authority paid $87.00 per visit. The National Benchmarking Agency advises that Crown Health Enterprises should expect an average of $116.00 per visit for an average triage mix.

In the Heads of Agreement negotiated for 1997/98, Southern Regional Health Authority acknowledged the deficit in funding for emergency services. Southern Regional Health

Authority indicated that, if it had sufficient funding, it would attempt to address, to some degree, this pricing shortfall.

Case Complexity

In its dealings with Southern Regional Health Authority, Canterbury Health has attempted to gain recognition and financial compensation for the increasing complexity of cases it faces each year. While actual growth in acute volumes is 5%, Canterbury Health maintains that the increasing complexity of cases being treated amounts to an additional 3% per annum which is not currently reflected in contracted volumes and prices.

There are a number of reasons for this increase in complexity. These include the length of waiting lists and target intervention rates below the national average. Both these factors increase the number and severity of acute presentations and skew the weighting of cases. There is also an argument that a strong private surgical market increases the complexity of cases managed in the public sector (e.g. orthopaedic services).

In the 1997/98 Heads of Agreement, Southern Regional Health Authority confirmed that it had underpaid Canterbury Health in offering $1,942 per case weighted discharge and that Canterbury Health should be paid at the current national average price of $2,100.

Discharge Pathways

The 1995/97 Heads of Agreement recognised the additional cost faced by Canterbury Health because blocked discharge pathways resulted in beds being occupied longer than necessary to treat an acute episode. Southern Regional Health Authority agreed to work with Canterbury Health to find appropriate solutions. The problem occurred mainly in treatment of the elderly and cardiovascular patients. Canterbury Health has estimated that blocked discharge pathways cost it approximately $1.8 million during the winter of 1995.

Timeliness of Purchaser Intentions

Canterbury Health claimed that Southern Regional Health Authority made planning for future revenue difficult as Southern Regional Health Authority failed to indicate in a timely manner future demand in the region, its intentions in relation to meeting future demand in terms of the range and volumes of services it would purchase, and the way it would purchase future services including details of budget holding, national intervention rates, integration of primary and secondary care and managed care options.

The Statement of Shareholders' Expectations requires Regional Health Authorities to give early indications of purchasing intentions to enable robust business planning. Yet the 1995/96 Heads of Agreement were not signed until January 1996. Following the Heads of Agreement, there were significant delays in developing the purchase framework which was to provide the basis for the contract. A final contract for the 1995/97 period was never signed. The failure of Southern Regional Health Authority to provide purchase information in a timely manner is claimed by Mr Frame to have constrained Canterbury Health in implementing and managing its strategy for change.

In addition, in 1996 Southern Regional Health Authority withheld the sum of $6.5 million in revenue for 1995/96 as agreed under the Heads of Agreement. In November 1996 it agreed to pay

this amount, plus interest from 1 July 1996, as part of a wider agreement on issues arising under the 1995 to 1997 Heads of Agreement.

In a letter to the Canterbury Health Board, the Crown recognised the requirement for a sustainable financial basis upon which to implement the 1995/98 business plan and acknowledged that failure to secure the agreed level of revenue would result in a delay in achieving operating viability.

Relationship between Canterbury Health and Southern Regional Health Authority

It is clear from correspondence between the two parties that the relationship between Canterbury Health and Southern Regional Health Authority was adversarial. Despite the 1996 Heads of Agreement, no formal contract for the purchase of services was signed between the two parties during the two year operation of the Heads of Agreement. Canterbury Health also resorted to threats to get progress on negotiations for purchase of services.

Mr Frame advised:

> "*The relationship between CHL and the SRHA from 1994 to 1996 was extremely strained. ... it was almost impossible to have a meaningful discussion with them about our funding problems ...* [with a new CEO and a new Chair] *the interpersonal relationships improved substantially, but the SRHA was apparently in an impossible situation itself as it was underfunded for the services that it was expected to provide ...*".

Mr Webb stated that Canterbury Health's relationship with Southern Regional Health Authority has been:

> "*an extremely difficult one and one that I have found bordering on the unrealistic*".

In a letter to Mr Victor Klap, Chief Executive of Southern Regional Health Authority, on 13 June 1997, Mr Webb questions Southern Regional Health Authority's negotiating strategy:

> "*We wonder what the SRHA negotiating strategy is when, less than three weeks out from the start of the contract period, you openly acknowledge the SRHA is under purchasing in Canterbury, you advise us that SRHA is holding back significant funds, yet the movement in the SRHA's offer is only three million and leaves the massive gaps described above*".

Mr Webb claims that the revised offer from Southern Regional Health Authority for the 1997/98 contract left Canterbury Health $11.37 million dollars short of revenue with which to meet realistic non-deferrable volumes and to address the low public intervention rates and waiting lists.

There was no sign of movement in the offer for Emergency Department services, despite the comparative benchmarking information supplied by Canterbury Health. Canterbury Health was seeking a price of $9.7 million and had informed Southern Regional Health Authority of the investment that had been required in the Emergency Department. Southern Regional Health Authority continued to offer the same price as it had paid the previous two years.

Southern Regional Health Authority indicates it has ongoing meetings with Canterbury Health regarding contractual, service and planning matters. Certainly correspondence shows that

discussions at an operational level on new initiatives or developments progressed relatively smoothly, but the fundamental issues regarding core provision were adversarial.

The Southern Regional Health Authority did not clearly communicate its purchasing policies. The processes of consultation, notice of intent and consideration of impact on Canterbury Health varied, often occurred late and sometimes did not occur at all. For example, in June 1996 Southern Regional Health Authority announced a plan to admit all acute elderly patients through Canterbury Health, but apparently did not consult Canterbury Health on the likely impact of this plan on Canterbury Health before its announcement.

Recent Changes

Canterbury Health advice to Central Government

Mr Webb has expressed Canterbury Health's difficulties with its purchase contracts at central government level, and has supported his claims with evidence from benchmarking studies. The Government is now well informed of funding pressures on Canterbury Health.

Crown Company Monitoring Advisory Unit

Crown Company Monitoring Advisory Unit facilitated completion of the latest contract negotiations so that Canterbury Health can be confident of its revenues and the management of risk from the start of the 1997/98 financial year.

Southern Regional Health Authority

There are signs of a change in the relationship between Southern Regional Health Authority (now the Health Funding Authority, Southern Region) and Canterbury Health. This is evident in the recent Heads of Agreement for 1997/98 between the parties, where it has been mutually agreed, in cases where the Health Funding Authority, Southern Region will not meet the costs of treatment for some very high cost patients, to take joint responsibility to explain to patients, families or other stake-holders, including the media, the need for rationing decisions. This is a positive step towards risk sharing and joint public accountability.

The introduction of booking systems is also a positive move to transparency of the types and levels of service available to the public of Christchurch.

Crown Health Enterprise Deficits in General

The Ministry of Health in its annual report on the performance of Regional Health Authorities 1995/96, published in July 1997, notes that Crown Health Enterprises have had operating deficits in 1993/94 and 1994/95 in the order of $171 million and that:

"*the existence of the deficits places pressure on RHAs in a number of respects. RHAs have a key interest in ensuring that the CHEs in their regions are viable as there are generally no alternative providers and ultimately if a CHE failed an RHA would face service risks. At the same time RHAs must manage budgets and prioritise across all of their services.*

RHAs are required to pay CHEs a price that is financially sustainable over the medium term. This means that CHEs need to make efficiency gains to match the price. As efficiency gains are estimated there will always be debate as to whether or not prices are 'correct'. RHAs have invested considerable effort in establishing the detailed prices offered to CHEs. However, CHEs have been unable to reduce the cost of producing services to the level of RHA prices".

In 1995/96 total Crown Health Enterprise deficits were about $145 million. In 1996/97 they are estimated to be between $183-$220 million, despite Crown Health Enterprises having received an additional $17.6 million in government revenue. The Bulletin of the National Benchmarking Agency gives some insight into the make-up of this cost growth.

Total Crown Health Enterprise costs are estimated to be increasing by approximately $157 million annually. Inflation in the health sector accounts for an estimated $133 million of this growth. By comparison with general inflation in the economy as a whole of 2.55%, as indicated by the December 1996 quarter consumer price index, health sector inflation may be as high as 4.6% based on a survey of movements in salary and wages and supply costs in Crown Health Enterprises.

Despite increasing deficits, Crown Health Enterprises increased their inpatient discharges from 627,000 to 647,000 between 1994 and 1996, a 3.2% increase in productivity. If this growth can be extrapolated to outpatient areas as well, productivity growth could be as high as $132 million, for a real cost increase of $24 million.

Price analysis by the National Benchmarking Agency indicates that Regional Health Authority revenue increases have not kept up with either inflation or productivity increases and Crown Health Enterprises have not passed on to Regional Health Authorities the cost associated with inflation or volume increases through increased price bids. However, their efforts to absorb these cost increases through efficiencies have been only partially successful as increasing growth in Crown Health Enterprise deficits throughout the country testifies.

Southern Regional Health Authority advised the Commissioner that in their view the National Benchmarking Agency was biased as it is *"...a commercially based organisation, commissioned by Crown Health Enterprises to support their pricing negotiations with Regional Health Authorities"*.

Provision of Assessment, Treatment and Rehabilitation Beds

In mid 1995, following the usual peak in winter admissions during the months of May to August, there was considerable publicity over the shortage of Assessment, Treatment and Rehabilitation (AT&R) beds at Healthlink South. AT&R beds were purchased by Southern Regional Health Authority on a bed capacity rather than a case basis. There was over 90% occupancy during 1995/96 and a waiting list. Approximately 40% of admissions to these rehabilitation beds came from Canterbury Health and 60% from Christchurch general practitioners.

In the winter of 1996, the shortage of AT&R beds prevented Christchurch Hospital from discharging patients to whom its acute care responsibility had been fulfilled. As a result Canterbury Health suffered not only increased costs for which it was not reimbursed, but beds were unavailable for other acute admissions. This exacerbated the existing bed shortage in the medical wards during the winter peak and resulted in the repeated transfer of patients

between wards and the placement of patients in inappropriate wards. The lack of AT&R beds contributed to the difficulties of managing patients effectively during the winter of 1996.

The Ministry of Health produced population-based guidelines for the provision of AT&R beds in 1986. On the basis of these guidelines, 251 AT&R beds should have been purchased by Southern Regional Health Authority for the 1994/95 year (based on the 1991 population census). However, Southern Regional Health Authority purchased only 180 beds from Healthlink South for Christchurch Hospital. In August 1995 Southern Regional Health Authority purchased a further 15 beds to cover the winter months, but 195 beds still left the Canterbury region significantly short of the Ministry's guidelines.

Southern Regional Health Authority advised that these numbers do not take into account possible alternative options, including the 25 place day hospital for general AT&R patients and that this is recognised as an alternative to inpatient treatment for some patient categories. However, even if these extra 25 beds are taken into consideration, the region was still short of the guidelines (based on the 1991 census).

During 1995/96, Healthlink South and Canterbury Health wrote to Southern Regional Health Authority outlining the key issues and proposing both interim and long term solutions to the shortage of AT&R beds. Numerous meetings were held between both Crown Health Enterprises and Southern Regional Health Authority with no tangible outcome. Healthlink South sought assistance from the Minister of Health. A consumer petition was also sent to the Social Services Committee. None of these initiatives resulted in definitive action by Southern Regional Health Authority to purchase an adequate number of AT&R beds. In its 1995/97 Heads of Agreement with Canterbury Health, Southern Regional Health Authority acknowledged the need for clear discharge pathways for patients who had completed the treatment which Canterbury Health was contracted to provide. Southern Regional Health Authority was aware of the discharge problem at Canterbury Health and had held repeated discussions with both providers on the matter and acknowledged in writing the need for an increase in rehabilitation beds. In April 1996 the Southern Regional Health Authority acknowledged that there were insufficient AT&R beds for winter. Southern Regional Health Authority advised that it *"purchased the piloting of a 'discharge team', operational in 1996 and the two CHEs made significant gains in efficiency between the two services"*. However, due to growth in demand-driven services, Southern Regional Health Authority advised that there were no additional resources available for beds. Southern Regional Health Authority provided this advice to the Director General of Health and Crown Company Monitoring Advisory Unit. In June 1996, when the winter crisis was at its peak, Southern Regional Health Authority advised Canterbury Health that it would have to manage the problem itself by prioritising admissions and discharges.

Southern Regional Health Authority indicated that it was working with providers on a model to set up an age-related integrated pilot of programmed care that should be in place by the end of 1997. It stated that the reason it had taken so long to address issues first identified in 1995 was that this pilot programme represented a major change in the way services would be delivered in the future and therefore required careful planning. It stated that the purchase of 15 additional AT&R beds in 1995 and the introduction of a number of changes to discharge and transfer planning by the Crown Health Enterprises, offered a short term solution to the problem whilst the longer term strategy was developed.

An additional 6 beds were opened at The Princess Margaret Hospital to cover the 1997 winter period. A full time equivalent 0.5 geriatrician was appointed to review older patients at Christchurch Hospital in order to increase their speed of discharge where appropriate, and the waiting was reduced to two days. A Bed Manager was also employed to manage discharges, including the transfer of geriatric consumers to Healthlink South once their acute episode was over.

In March 1998 the Health Funding Authority advised that an integrated group, Elder Care Canterbury, had been established.

Auditing and Monitoring of Standards by the Southern Regional Health Authority

Background

The Southern Regional Health Authority service specifications which underlay its purchase agreements contained specific quality measures with which Crown Health Enterprises were required to comply. The standards under the "Duty of Care" section of the specifications state: "*you will provide and uphold at all times appropriate standards of care; emergency care; continuing care and transfer of care*".

The Ministry of Health has confirmed that monitoring the safety and quality of services is part of the Regional Health Authority's statutory responsibility. The Ministry of Health encouraged the Regional Health Authority to make providers responsible for informing the Regional Health Authority of safety breaches. The organisational reporting requirements accompanying the 1995/97 Heads of Agreement between Southern Regional Health Authority and Canterbury Health included the general statement "*You will provide a narrative report including your assessment of your performance in the previous quarter in meeting the requirements of the Agreement, any issues you would like to discuss with us, your responses to any previously identified issues...*".

Southern Regional Health Authority relied on Canterbury Health's monitoring activities to identify problems related to the quality of clinical service delivery. Southern Regional Health Authority confirmed that these monitoring activities did not raise any problems and implied that the need to audit these standards had therefore not been necessary.

Southern Regional Health Authority Audits

From 1994 to 1996 Southern Regional Health Authority undertook four pre-agreement audits and conducted six audits in relation to standards of service as follows: complaints processes, incident reporting, quality plan, STD services, discharge planning and appropriateness of services for children. All were self assessments and two were on-site visits regarding complaints processing and discharge planning. Southern Regional Health Authority indicated that in relation to audit, its limited resources were employed in key areas identified by an organisation-wide priority criteria.

The objective of these audits by Southern Regional Health Authority was to assess Canterbury Health's development of systems to monitor quality standards rather than to review the outcomes of such systems.

Southern Regional Health Authority relied on four activities to monitor compliance with the quality requirements in its contracts:

(a) relationship monitoring;

(b) contract monitoring;

(c) complaints resolution; and

(d) quality and safety audits of services.

Routine contract monitoring could not monitor quality issues; the number of complaints dealt with by Southern Regional Health Authority was too small to give meaningful information; and formal audits conducted since 1994 were not designed to confirm that processes to monitor standards were in place. Southern Regional Health Authority did not follow through to verify that plans for monitoring systems, submitted to comply with these audits, were implemented. Therefore, only the development of sound working relationships could be expected to flag problems with quality systems regarding clinical service delivery. This was not effective as a means of monitoring the standard of service delivery for the following reasons.

> The relationship between Canterbury Health and Southern Regional Health Authority was poor. There was minimal co-operation or trust between the parties. The dialogue which occurred focused on funding, contracts, new initiatives and waiting times funds. Little discussion took place about improving service delivery.
>
> Southern Regional Health Authority sought reassurance about applicable standards from Canterbury Health management, who appear to have provided the answers that Southern Regional Health Authority indicated it was seeking. Southern Regional Health Authority accepted the reassurances it received at face value. Southern Regional Health Authority appears to have made few attempts in auditing or monitoring to elicit further information on how these standards were being met or to check whether Canterbury Health had, in fact, done what it stated that it planned to do, or had the appropriate processes in place.

In the face of mounting concerns for patient safety at Canterbury Health, and while under specific direction from the Ministry of Health to monitor safety standards at Canterbury Health, Southern Regional Health Authority considered its obligations effectively discharged in the following manner.

(a) Southern Regional Health Authority sent a letter in December 1995 seeking reassurance from Canterbury Health management that patient safety was not at risk as the result of restructuring. To this question Mr Frame sent a short response that "*the organisational changes would not adversely affect current standards of patient care*".

(b) Southern Regional Health Authority sent a further letter on 4 March 1996 requesting further reassurance in the light of comments by the Royal Australasian College of Surgeons ("RACS"). Southern Regional Health Authority assumed that RACS had conducted a review and asked to see this. Mr Frame responded with a copy of the RACS open letter.

(c) Southern Regional Health Authority sent a letter on 25 March 1996 requesting a copy of Canterbury Health's reply to the Minister of Health on the four safety concerns raised by staff and further correspondence from RACS. Mr Frame offered the former and refused the latter on grounds of confidentiality. No other correspondence was sighted.

(d) Southern Regional Health Authority asked Canterbury Health for a copy of the Patients are Dying Report. This request appears not to have been acknowledged by the Crown Health Enterprise, and Southern Regional Health Authority had not

followed this up at the time the Commissioner requested information from Southern Regional Health Authority.

In March 1998, the Commissioner was advised by Southern Regional Health that it had verbally requested a copy of the report, but the request was declined. In a letter to Canterbury Health in March 1997, Southern Regional Health Authority wrote:

> "*it is of note that the specific patient safety issues presented to you by the staff (we understand on Christmas Eve) were not forwarded to us, but instead you relayed these matters to the Minister. Clearly, you believe the SRHA had no role in the matter and we have yet to see the report. However we would be interested to see it, and ask you to forward a copy of this to us as soon as possible."*

This written request was not responded to by Canterbury Health. Southern Regional Health further advised the Commissioner that:

> "*The Ministry of Health did not believe that this was a matter for the SRHA (in view of the SRHA's functions) but kept the SRHA informed as appropriate. However the HFA has recently accessed a copy of this report through the Ministry of Health"*.

Southern Regional Health Authority advised the Commissioner:

> "*the information we have obtained about CHL's performance over the last three years shows it has been neither markedly worse nor better than any other CHE. The Southern Regional Health Authority has sought and received assurances that they have adequate systems in place to manage their services*".

In February 1998 the Health Funding Authority responded as follows:

> *"Safety and quality of services are a key concern of the purchaser, and SRH welcomes the responsibility of monitoring service compliance. However, SRH does not have sole responsibility for those aspects. The obligation for safety and quality of services is shared among a number of entities: the purchaser, the Ministry of Health, the local authorities, the Fire Service, and, most fundamentally, the provider who has signed a contract for delivery of safe services of a suitable quality. Monitoring of clinical outcomes is primarily the domain of the providers, and ultimately the clinicians. To that end, the purchaser requires appropriate peer review mechanisms, quality management, infection control systems, etc., and requires the provider to raise with the purchaser any issues which are impacting on the provider's ability to deliver the services as in the contract.*
>
> *SRH has monitored CHL outcomes on an ongoing basis using the Ministry of Health's published statistics on risk adjusted mortality and risk adjusted readmissions. For the periods 1994/95, 1995/96, and 1996/97, CHL has been at, or better than, the national average for all these outcome measures. These results certainly did not indicate a requirement for more detailed, specific reviews on issues of patient care."*

INTRODUCTION

Section 67 of the Health and Disability Commissioner Act allows parties to provide a written statement in answer to adverse comment.

Some parties requested their written statement to be appended. In all cases I considered the responses and where relevant amended or included matters throughout the Report to ensure clarity and fairness. The following are extracts and summaries of responses to adverse comments where I did not include the matters in the Report.

CANTERBURY HEALTH LIMITED

The following are summarised comments made by Canterbury Health:

- It questioned the relevance of the Australasian College for Emergency Medicine Guidelines, saying they were not designed to ensure compliance with Right 4(1) and noted that Australian Emergency Departments operate differently to those in New Zealand. It advised that the guidelines do not represent the basic accepted level of staffing in New Zealand Emergency Departments.

- It stated that the number of attendances at Christchurch Hospital Emergency Department was not 65,000 because 5,000 of those patients attended the Orthopaedic Outpatients Department and were therefore not treated by the Emergency Department.

- It claimed that a snapshot examination of the number of doctors present at any one time is not necessarily an adequate reflection of staffing levels in the Emergency Department.

- It disputed that it was inappropriate to include Emergency Observation Area nurses in the calculation of total Emergency Department nurses.

- It maintained that Mr Fonoti was monitored carefully saying this was evident from the neuro-observation chart in the medical notes which shows observations having been made regularly from 0300 to 0600 hours.

- It advised that Mr Fonoti's admission to a Urology Ward was irrelevant to the outcome of the case because the nurse allocated to look after Mr Fonoti did so in a separate room in the Urology Ward and had experience with patients with head injuries.

- It advised that General Practitioners may arrange for direct admission specifically to wards and that this occurs in other New Zealand hospitals and has nothing to do with the availability of beds in the Emergency Department.

- It responded that the triage category allocated to Mrs Malcolm had nothing to do with the demands on the Emergency Department.

- It strongly denied that it placed a high reliance on autopsies and said that any extra emphasis was due to the fact that autopsies were a Crown Company Monitoring Advisory Unit measure.

- It refuted that there was insufficient sub-specialisation by radiologists advising the need for sub-specialisation was open to debate.

- In response to the criticism of inadequate training of surgical staff it noted that there had only been one failure of the RACS Part II examination in the last 14 years.

- It disputed Patient Care Managers were on a steep learning curve in 1996 saying that they were chosen for their appropriate experience and each Patient Care Manager underwent a competitive interview process.

The following is an extract of a letter received from Canterbury Health:

"SUMMARY OF ACHIEVEMENTS - 1997/98

1. FOCUS & PRIORITY

In consultation with staff and the Board, we decided to concentrate on some specific major issues in 1997 and these were -

- *Improve the input in decision making by all areas involving doctors and medical staff.*

- *Provide better information to doctors to help them do their job better.*

- *Focus on health planning, not just business plan and budgets, so that we could deliver better health care, not just save money.*

- *Improve our funding and ensure more health dollars get to the patients to help reduce waiting lists.*

- *Focus on quality improvement of services and ensure people and processes are in place to enable it to happen.*

- *Improve our communication with staff, public, patients and other health providers including GPs and Healthlink South.*

- *Be more efficient and effective.*

We are committed to learn from past difficulties, but build a new future.

2. SPECIFIC INITIATIVES & DEVELOPMENTS

The establishment of a Heart Unit in Christchurch Hospital is a medical milestone for Canterbury. This completes the range of tertiary services we can provide.

- *The Women's Health Division, including Christchurch Women's Hospital, Rangiora, Lincoln and Lyndhurst Hospitals, along with Community Health Services, was transferred from the other Christchurch CHE, Healthlink South, to Canterbury Health on 1 December 1997.*

- *A Paediatric Surgical Service for the South Island is being developed. From December 1997, this has involved Christchurch Hospital's two specialist children's surgeons travelling to areas such as the West Coast, Invercargill and Nelson on a regular basis to undertake surgery which children there, previously, often had to travel to the North Island or Australia to have performed.*

- *We have been very successful in obtaining additional money for waiting list operations from the Waiting Times Fund -*

  - *We have had $15 million approved in Waiting Times Fund applications.*

- *We performed no waiting time fund services in 1995/96, an extra $1 million operations/assessments in 1996/97 (last six months) and plan $6 million in the year 1997/98.*

- *Canterbury Health is responsible for the rural hospitals, including Ashburton. Ashburton has been able to assist Christchurch Hospital by undertaking gallbladder operations for many patients on the Christchurch waiting list who would not otherwise have received their operation.*

- *Christchurch Hospital coped much better last winter in spite of increased patient numbers. Unlike the previous winter, no elective surgery had to be canceled. These improvements were because of -*

  - *A $3 million upgrade of the Emergency Department which includes increased staff. This included a 200% increase in resuscitation rooms and more effective layout of facilities with increased equipment.*

  - *The expansion of the Emergency Department's Observation & Acute Assessment Area from 12 to 18 beds. The Unit now runs 24 hours a day and has increased numbers of experienced staff. This has been a major initiative which has been enormously important in improving our patient care and efficiency within the Emergency Department. Holding seriously ill (not critical) patients at night has also improved efficiency and safety for staff and patients.*

  - *The creation of a Respiratory Rehabilitation Ward at Burwood Hospital, which takes recuperating respiratory patients from the Christchurch ward. This has eased stress on Christchurch Hospital and improved care for patients.*

  - *18 more beds available at The Princess Margaret Hospital during winter months for the transfer of elderly patients, again easing pressure on Christchurch Hospital.*

  - *Better liaison with Healthlink South Geriatricians who assessed elderly patients and speeded up their transfer, where appropriate, to other facilities specialising in care for the elderly.*

  - *Reduction of one day to three for all medical patients, i.e. better transfers, quicker diagnosis and more appropriate care.*

  - *Staff increases of doctors and nurses in Cardiology, General Medicine, Emergency and General Surgery have also improved service and eased pressure.*

  - *Patients who belonged in specialty wards such as General Medicine and Respiratory were not this year spread out through many different wards, but stayed in the appropriate specialty ward. This made it faster and easier for each department's doctors to reach and treat them.*

- *There have been changes in the structure at Christchurch Hospital so both doctors and nurses are now responsible for financial decision-making of patient care. They are also, for the first time, directly involved in negotiations with funding providers. They most effectively argue the case for their specialties having increased funding and resources.*

- *The management structure has been changed so Service Managers who previously made the finance decision and had doctors to report to them in departments no longer do this. This responsibility has been given to doctors (Clinical Directors) with the Service*

Managers providing them with support.

- *Changes include the appointment of a Director of Nursing responsible for all nursing resources and holding a budget of $50 million.*
- *Quality management has been a major focus with four new positions created - Quality Manager, Risk Manager, Quality Assurance Co-ordinator, Nursing Co-ordinator, and Accreditation Co-ordinator.*
- *We now have enhanced reviews of quality, incidents, patient complaints and other key service issues. Most services are now ranked 'very good' or 'good' by 80% of patients surveyed, making us one of the highest performing CHEs.*
- *Clinical input and advice about important issues facing the CHE are now decided in consultation with Clinical Directors and Senior Nursing staff. Major policy matters are channelled through a newly created committee of largely elected staff who meet regularly with the CEO and have access to the Board. The Committee is called the Clinical Policy & Planning Committee.*
- *Considerable progress has been made in establishing a process for monitoring the quality of service we provide patients.*
- *Carparking - a new carpark building providing 360 parks will be available this winter, easing the long-standing parking problem around the hospital.*
- *Collaboration with Elder Care Canterbury; a joint venture with Canterbury Health, Healthlink South and the Pegasus Medical Group.*
- *Recruitment of joint appointments with Healthlink South (Geriatricians).*
- *Year 2000 stocktake - we have completed a stocktake of all technology in our hospitals which may not work following the start of the Year 2000. We will upgrade or replace equipment where necessary.*
- *A multi-million dollar contract to perform surgical work for ACC has been won by Burwood Hospital. This orthopaedic and special spinal work started before Christmas and has assured the future of the Hospital.*
- *To have improved communication with our junior doctors, regular (two weekly) meetings are being held between them and management.*
- *Employment of 'pool' nurses means less casual and bureau staff. The orientation programmes for new staff have been expanded.*
- *We have improved links and liaison with General Practitioners and the other Christchurch CHE, Healthlink South. We are working co-operatively with them on important new projects such as Elder Care Canterbury, aimed at improving the way we deliver care to older people.*
- *Prestigious accreditation for quality health care has been gained by Burwood Hospital's Spinal Unit (ISO 9002) - a first for an acute Unit in New Zealand; Christchurch Hospital's Physiotherapy Department (ISO 9002) and Ashburton Hospital, which has accreditation by NZ Health Care Standards.*
- *Improvement in procedures for monitoring and responding to patients' concerns and*

complaints.

- *Improved community communications.*
- *Internal communication improved with weekly and monthly newsletters and forums for staff on a three monthly basis with Chief Executive. These forums allow staff to ask Chief Executive anything and get straight answers.*
- *Comparing ourselves clinically with nine major Australian and one New Zealand tertiary teaching hospitals.*
- *Three workshops with over 120 clinicians (all disciplines) to review and change our health delivery.*

4. CHALLENGES FOR 1998

Significant issues to address in the coming year will include -

- *Improving our quality of care.*
- *Obtaining fair and equitable price and volumes from the new Health Funding Authority.*
- *Reducing waiting lists.*
- *Achieving more collaboration with GPs, Healthlink South and other health providers to save money and to improve care and services. Continuing to enhance the confidence of our own patients in our services.*
- *Developing further our tertiary services for all people in the South Island.*
- *Continuing to enhance teaching and research at Christchurch Hospital, as the major tertiary teaching hospital in the South Island.*
- *Developing further the collaboration between all staff."*

DR B. LAYTON

The following are summarised comments made by Dr Layton:

Business Plan

- Dr Layton considered that the written evidence shows that the Chief Executive was committed to the Plan and advised that projected efficiency gains were achievable.
- In relation to the Commissioner's comments in paragraph 8, Section 1, Dr Layton stated that because Crown Company Monitoring Advisory Unit undertook its own assessment of the Business Plan it was aware of the risks involved and similarly that Southern Regional Health Authority was aware that the revenue it offered Canterbury Health was insufficient. In relation to the comment in paragraph 8 that "Canterbury Health did not recognise that it was providing inappropriate services ..", Dr Layton noted that Canterbury Health's staff are reported to have been aware of inappropriate services and says that paragraph 8 is therefore inconsistent with the facts contained in the rest of the Report.
- Dr Layton gave the following reasons why Canterbury Health did not withhold essential information about Shareholders' expectations:

- clinical staff were aware that the Shareholders expected Canterbury Health to be financially viable and efficient;

- clinical staff were aware that Canterbury Health could only provide the services it was contracted to provide;

- the expected efficiency savings were outlined at the 5 December 1995 meeting;

- the Ministry of Health's overall strategy and expectations of the Crown regarding Crown Health Enterprises were promoted by the distribution of the Ministry of Health publication "Advancing Health"; and

- Canterbury Health provided an opportunity for all staff to meet the Minister in December 1995.

Leadership

- In response to the claim that some clinical staff were critical of the leadership shown by the Board and Executive of Canterbury Health and that the Board did not demonstrate inspiration, strength of conviction etc. (paragraph 3.5 Section 1 and paragraph 1.10 of Section 7), Dr Layton provided numerous examples of occasions on which he and Professor O'Donnell displayed these attributes. He also gave examples of their leadership experience.

- Dr Layton stated that the Commissioner cannot criticise the Board's leadership abilities without interviewing more of the Directors of Canterbury Health. He further noted that clinicians make allegations of lack of leadership when they disagree with leaders' opinions or when leaders fail to fulfil some ambition clinicians have.

- The November 1995 Canterbury Association of Physicians motion indicating a lack of confidence in Dr Layton showed that failure to obtain necessary funding was at that time central to the staff's lack of faith in his leadership.

- Dr Layton questioned whether it was the role of the Board to provide leadership to staff. He said that leadership of staff is a management role and the Board should only become involved when something goes wrong.

- In relation to the staff meeting of 5 December 1995 and his comments at that meeting, Dr Layton made the following points:

  - many of the Directors of Canterbury Health and non-health professional employees present at the 5 December meeting were not interviewed;

  - other Board members did not criticise Dr Layton's actions at the 5 December meeting and some congratulated him on his performance at the meeting;

  - several senior clinicians orchestrated a campaign against Dr Layton during 1995/96 because of the perception that he was a public defender of health reforms because of his role as Chair of the Crown Health Association; and

  - his comments were based on a concern about the need to introduce a further layer into the organisation and about its budgetary impact.

- Dr Layton gave the following reasons why the 5 December meeting was a significant event for the majority of medical staff interviewed:

- some members of Christchurch Hospitals' Medical Staff Association have used the meeting in their orchestrated campaign to slur his character;

- it was made clear at this meeting that the Board was not going to override management and agree to the demands of clinical staff that Unit Nurse Managers should not be made redundant; and

- at this meeting staff were informed of the extra efficiency gains necessary and the fact that Dr Layton thought these were achievable, and in the context of the summer shutdown. Dr Layton reminded staff the Canterbury Health was only permitted to provide those services Southern Regional Health Authority purchased.

Patient Safety

- Dr Layton states that the Board was not aware of requests for additional staff until late 1996 when it acted immediately after receiving the information. He suggests that if staff were not getting an appropriate response from more immediate management the issue should have been raised directly with the General Manager, the Chief Executive, and then the Board.

- Dr Layton states that the behaviour of certain clinical staff should be mentioned in the Opinion.

- Dr Layton provided the following summary of the Board's focus:

  - Board papers always contained a report on clinical issues and this was dealt with on a par with the financial performance indicators;

  - the Board received a monthly report on medico-legal matters;

  - the Board received and considered requests for capital equipment and these invariably involved issues of the quality of patient care, patient safety and the provision of appropriate services;

  - the Board had on it a medically trained person and later sought a trained nurse; and

  - the Board met with Christchurch Hospitals' Medical Staff Association in May and November 1996 to hear its concerns and the clinically trained Directors met with Christchurch Hospitals' Medical Staff Association in July 1996.

- He also said that concern for patient care can be indicated by matters other than correspondence, such as the linking of the remuneration of senior management to performance on quality indicators.

- Dr Layton could not recall problems identified in relation to admitting, treatment and discharge processes being raised with the Board in mid-1995. He said that the Board dealt with all problems as soon as it was notified of them.

- He noted that although senior staff were not present at Board meetings until August 1996, their input in written form had always been there. He said that the Board received and considered a range of clinical quality indicators and in the past clinically trained directors had been asked to review undesirable trends.

- In respect to other matters Dr Layton advised the Board never required proof of problems, only sufficient information for management to investigate, for options to be assessed and remedial action decided upon. In regard to supervision of nurses he noted that the formal process for the supervision of less experienced nursing staff constituted a nurse being supervised by a Clinical

Care Leader, a Clinical Care Leader being supervised by a Clinical Nurse Facilitator, and a Clinical Nurse Facilitator being supervised by a Patient Care Manager. He noted that because many of the Patient Care Managers were senior nurses they had little to learn in a job that essentially involved the management of nurses and would have been well placed to provide nurse leadership support.

MR I. FRAME

The following are summarised comments made by Mr Frame:

- Canterbury Health had no option but to comply with the provisions in the collective employment contracts applying to all senior doctors and to virtually all nursing staff and therefore it did not involve staff further in the Proposals for Change. While senior doctors were required to be treated in the manner prescribed by their contract, the Professional Nursing Advisor was not a party to the nurses' collective employment contract and was therefore able to be formally involved in developing the Proposals for Change. He noted that with respect to the management of change process there were no resulting personal grievance claims except for one by a senior nurse who disputed the quantum of her redundancy payment.

- In terms of the relevance of the Australasian College for Emergency Medicine Guidelines, Mr Frame commented that if the Southern Regional Health Authority had specified these guidelines as its required standard, Canterbury Health would have priced accordingly. He says that in the absence of this information and in the absence of an effective purchase agreement Canterbury Health "*continued to resource and price essentially on a status quo basis."*

- If the Southern Regional Health Authority did not plan and purchase the level of service required in the Emergency Department, Canterbury Health cannot be held accountable for its subsequent inability to manage the actual demand for acute services if the Emergency Department was inadequately resourced.

- In respect to implementing the restructuring plans, he stated " *it is my personal conviction that an influential group of Senior Medical Staff conducted a campaign of non-cooperation in order to create a crisis and achieve their objectives"*.

- In terms of cooperation Mr Frame noted that during his time at Canterbury Health there were numerous examples where clinical staff and the executive worked together to resolve issues and implement solutions. He said the situation continued right through 1995/96 when relationships with some staff were seriously strained.

- He noted that it was incorrect to suggest that clinical staff became frustrated due to inadequate delegation because in 1993, 1994 and 1995 a high level of responsibility was delegated to clinical staff.

- In terms of the Proposal significantly changing the formal status of Clinical Directors, he commented that the concept of having Medical Directors instead of Clinical Directors was not a new concept as it had already been introduced in some areas of Canterbury Health.

- With a few notable exceptions, there was a general acceptance by senior medical staff that the introduction of Service Managers would be a constructive step towards resolving the problem that the General Manager had in not being sufficiently accessible.

- Mr Frame denied that Canterbury Health "delayed taking action" saying Canterbury Health was unable to take action due to budgetary constraints and that under the Health and Disability

Services Act 1993 Canterbury Health could only provide services in accordance with its Statement of Intent and any purchase agreement entered into.

- He noted that clinicians were heavily involved in clinical policy making while all commercial policy making was done by the Board.

- In terms of management of change, he contended that management did involve staff and in any case denied that staff involvement alone would have ensured that any change management programme was successfully implemented.

- Mr Frame disagreed with the comments relating to leadership.

- While the Chief Executive was absent from some early meetings, Mr Frame stated he was available to return from leave to attend any meetings required but was not asked by his staff to do so.

- Canterbury Health was in "fire-fighting mode" for much of 1996 and the situation arose largely because of the disruptive industrial tactics employed by some clinical staff and the inadequacies of the Southern Regional Health Authority in carrying out the planning and purchasing role in the face of an exceptionally high winter peak demand for acute services.

- The job descriptions of the General Managers defined the financial responsibility between them and the respected budgets. He noted that the distinction was very clear from his dealings with them.

- Mr Frame noted that the General Manager Diagnostic and Support Services division never raised concerns about the size and span of his control and would have expected him to do so if it had been an issue.

- Disaster planning and purchasing of services is the responsibility of the Southern Regional Health Authority and Canterbury Health was only required to provide those services for which it had a purchase agreement.

- Mr Frame commented that "fear of reprisals" was an underlying theme spread by Christchurch Hospital Medical Staff Association and NZNO which in itself would have created any fear that existed. He said that if "reprisals" had occurred this would have led to personal grievance claims by the staff concerned and there were no such claims.

- In respect to job descriptions Mr Frame noted "clinical directors did not have job descriptions because they refused the accept the job descriptions developed by the executive managers, largely because they were not prepared to accept a financial accountability in the absence of adequate information systems.

- In relation to clinicians not being involved in preparing the restructuring proposals Mr Frame commented "the General Managers did obtain clinical input from both senior doctors and nurses on an informal basis, and subsequently on a formal basis through the agreed management of change process prior to the restructuring plan being finalised".

- Mr Frame advised that he sought to have a representative group of senior medical staff attend the March and April board meetings in 1995, when the Business Plan was being discussed. The Crown Health Enterprise invited all managers to the one meeting, but declined its request to have 6 senior medical staff (including 3 medical advisors) also attend the meeting. Mr Frame thought that the Crown Health Enterprise was not receptive to having other than executive management staff attend Board meetings for reasons of accountability.

- Mr Frame commented that Canterbury Health's clinicians were involved in the negotiations with the Southern Regional Health Authority from 1993 onwards although they were not involved in financial negotiations during 1994 and 1995 because that process had become such a time wasting event.

- The response to lack of consultation Mr Frame referred to the oral presentation to the NZNO who although initially thought to be supportive of the changes, later issued a bulletin distancing itself from the proposals. This was considered by Mr Frame to be a serious breach of trust and incited by him as an example of the difficulty that Canterbury Health had in taking NZNO into its confidence.

Mr Frame introduced the following matters he considered had an impact on the ability to provide effective management:

> *"The Report also fails to recognise the inconsistent leadership provided by Central Government in:*
>
> - *introducing the commercially focussed* (sic) *Health Reforms (ie, based upon the Health and Disability Services Act 1993) in a manner that left many unresolved issues in Christchurch;*
>
> - *establishing standard terms and conditions of employment for CHE Chief Executives that where* (sic) *heavily focussed* (sic) *on commercial objectives as opposed to health quality objectives...;*
>
> - *directing the CHE Boards and Chief Executives to adopt a soft "seamless transition" approach throughout the 1993/94 year whilst minimising administration costs and putting the funds so saved into providing increased patient care services;*
>
> - *reversing this approach in 1995 by applying intense pressure on CHE Boards and executives to achieve unrealistically ambitious financial targets (ie, achieve commercial viability for CHEs in the face of inadequate funding from Government to the RHAs). Public statements on 22 November 1997 by the Chair of the Transitional Health Authority, Dr Graham Scott, confirm the over-optimistic Government expectations underlying the Health Reforms;*
>
> - *softening this hard-nosed commercial approach in the lead up to the 1996 General Election. In March 1996, the newly-appointed Minister of CHEs, Mr Bill English, announced in his key-note address at a CCMAU conference in Wellington attended by CHE Directors, Managers, Clinicians and Nurses, that:*
>
> - *this conference marks the beginning of a new era for the public health system*
>
> - *much of the discussion has been dominated by balance sheets, deficits, user charges, commercial disciplines and so on*
>
> - *this conference marks the end of that period*
>
> - *this conference is a clear sign that the way ahead is as much about health as it is about enterprise.*
>
> *(It is important to note that whether the newly appointed Minister intended it or not, the message taken by the health professionals attending this conference was that the hard-nosed commercial approach to publicly-funded health services was now going to soften*

and this interpretation had an undermining effect on Canterbury Health management who had been pursuing the more hard-nosed approach in line with previous direction.)

In the wake of these actions by Government, and Government's expectation that CHE Boards and executives would act to protect Government from public criticism in the media, it is understandable how Canterbury Health had great difficulty in keeping its staff informed about future direction, knowing the disconcerting predilection of some of its staff to take issues of contention straight to the media and the media's readiness to give a high profile to any such issues.

CHE Chairs' and CEOs' concerns about the uncertain and variable Government direction in the sector was well recorded in the minutes of Crown Health Association meetings and also in correspondence between CHA and the CHE Shareholding Ministers. The Opinion gives little recognition to these factors."

"The Commissioner also overlooks the role played by Canterbury Health's clinical staff in not providing reasonable cooperation with the Board and the executive. These staff are an integral part of Canterbury Health and, therefore, their behaviour should have been covered in this investigation and commented upon in the conclusion."

DR J. COUGHLAN

The following are summarised comments made by Dr Coughlan:

- In respect of the restructure, he advised while the Clinical Directors' status changed, the relationships with the individuals they worked with did not alter dramatically.
- The nursing restructure did not cause patient safety issues and therefore the restructure was successful.
- A significant number of clinicians continued to work effectively within the 1996 organisational structure and found that Service Managers were knowledgeable and keen to participate.
- The view of the power struggle between clinicians and Service Mangers was not generally held by Service Managers. Whenever he met with Clinical Directors Dr Coughlan tried to ensure that Service Managers were available to attend the meeting to be kept informed. Senior management did support the Service Managers.
- Senior medical staff also had a leadership role and while a number filled this there was some who did not provide leadership in their departments.
- Of the many ideas put forward by clinicians, some were implemented, others could not be implemented, others contravened legislation, and others needed clinicians rather than management to action the ideas.
- While occasionally correspondence may have gone unanswered by Dr Coughlan this was not his policy. Most people commented on his breadth of understanding of the Hospital and the promptness of his replies.
- Dr Coughlan noted that he received a lot of positive feedback on the "Critical Pathways" document and he believes it resolved the confusion about case management and the way case management would be implemented.

- Dr Coughlan considered that he provided vision and leadership but because some people did not agree with him he was attacked personally. *"As the General Manager of Christchurch Hospital my job involved balancing up and assessing different options, some of which will make certain groups unhappy, but this was always done in the best interest of the patients that we serve*."

- Dr Coughlan stated that it was his view that he had acted reasonably in all the circumstances. In his view critical pathways were central to how a medical profession should be acting and noted that the description "cookbook medicine" was unfair and that the Ethics Committee had said it was not unethical to impose a case management system. He drew attention to the paragraph of the report relating to thrombolysis and thought the implication of the paragraph was that Dr Coughlan as a manager should have developed such protocols. However he thought was for the clinicians to produce such protocols rather than him. He was an advocate of protocols and the use of guidelines.

- Dr Coughlan described the environment in which he was working in the winter of 1996 stating that Mr Frame had resigned earlier in 1996 and the acting CEO had a financial background and no understanding of health matters. By default therefore Dr Coughlan was leading the organisation and representing it in the media, with the Chairman liaising directly with him. He noted that during the winter of 1996 he introduced about 20 measures to manage the winter demand which included employing extra nurses, transferring ICU patients and negotiating with the Regional Health Authority. In his view he demonstrated leadership and had done everything he could do during the period to manage acuity and staff sickness.

- Dr Coughlan noted that the think tanks were his initiative and that of the 18 recommendations many related to matters that were solely within the power of clinicians, for example the recommendations that there should be daily communication between registrars and consultants and that consultants should do more ward rounds. These were not things which could be initiated by management and clinicians had not fulfilled their responsibilities. In fact many of their ideas were commonsense and did not need management to action them.

- He noted that as a manager his job was to minimise risk and that no hospital could be 100% safe. He described the situation in which he found himself. There was enormous financial pressure "from the top" that was transmitted through the Board and CEO and an aggressive business plan which led to the restructuring. He did not agree with everything proposed in the restructuring plan but he was overruled as a second tier manager. It was his view that he could not be blamed for the decisions which were made or criticised for them.

- In conclusion Dr Coughlan thought he had acted professionally and that no one could have done better in the circumstances. He thought the difference between Canterbury Health and other Crown Health Enterprises was that there were better relationships between staff and management elsewhere. The Report could significantly affect his career and he thought he had worked effectively with both Chief Executives and that blaming the restructuring on him was not fair.

MINISTRY OF HEALTH

The following are summarised comments made by the Ministry of Health:

- It did not accept that it failed to meet certain aspects of its responsibilities.

- The Ministry of Health denied compounding problems at Canterbury Health by encroaching on the responsibility of the Southern Regional Health Authority.

- The Ministry of Health's analysis of total medical/surgical discharges by sub-regions in 1994/95 in "Hospital Throughput" does not support this contention. Furthermore, hospital throughput for the relevant year does not demonstrate that Canterbury Health has the lowest intervention rate.

- In response to the statement that the Ministry's report was mainly about nursing issues, the Ministry said that clinicians did not provide the Minister or Ministry with data that could be verified or substantiated and the Ministry therefore had to confine itself to the wider relevant systems issues which largely concerned nursing issues.

- The Ministry's performance monitoring of hospital safety does not support the contention that Canterbury Health provided a lower quality of care than the national average.

- In response to the claim the lack of a formal contract should have indicated a review was necessary, the Ministry stated the Canterbury Health was not alone in not signing a formal contract and that there was no evidence that the lack of a contract indicates a safety issue as services are normally continued under a roll-over clause in the previous contract.

- In terms of the letter advising the Ministry that there were no further funds to provide additional beds for older people in Christchurch, the Ministry said this letter was provided to it for information purposes only and that the responsibility for this issue lay with the two Christchurch Crown Health Enterprises and the Southern Regional Health Authority.

In addition, the following is an extract from the Ministry's response:

> *"The Minister of Health and the Ministry have a legitimate interest in hospital safety. That interest derives specifically from jurisdiction under the Hospitals Act 1957 and Health and Disability Services Act 1993, and generally from the Minister/Ministry role in regulatory oversight of the public health system.*
>
> *Your report concedes that the current legislative framework permits multiplicity of review. You do not, however, accurately convey either the logical consequences of this, or the breadth and subtlety of responsibilities that apply in this highly complex sector."*
>
> *"The Ministry of Health believes that* [the Summary] *paragraph contains a number of sweeping statements which do not fairly reflect the Ministry of Health's involvement in this matter. There seems to be confusion throughout your report over the roles and responsibilities of the various agencies involved."*

HEALTH FUNDING AUTHORITY

The following are summarised comments made by the Health Funding Authority:

- ***In relation to the claim that SRHA did not contract sufficient volumes based on intervention rates, the Health Funding Authority advised that national intervention rates refer to publicly performed health care and not the level of care undertaken in the private sector, which in Christchurch is high compared to the amount of private work undertaken nationally.***

- ***The Health Funding Authority claimed that the paragraphs on volumes and capacity contracts do not adequately describe the environment within which Southern Regional Health Authority and Canterbury Health were working during the 1995 to 1997 period. Southern Regional Health Authority says that it was facing considerable budgetary pressure due to growth in pharmaceuticals***

expenditure and was essentially faced with purchasing more services with reduced funds. It was required under its Funding Agreement with the Ministry of Health not to exceed its purchasing budget. The Health Funding Authority advised that given the constrained funding and increase in demand, any increases in the purchasing of acute services required reductions in other service areas.

- ***In response to the claim that Southern Regional Health Authority did not contract sufficient volumes relative to Canterbury Health's population when measured by national intervention rates, Southern Regional Health Authority advised that over the past four years it had progressively increased the amount of acute services purchased in Christchurch relative to other centres. It said that national intervention rates have little to do with local demand and are useful only as a guide to establish relative levels of service to meet acute needs taking a number of factors into account.***

- ***The Health Funding Authority believes that the Report suggests Southern Regional Health Authority disregarded the views of Canterbury Health and failed to purchase adequate volumes. In response the Health Funding Authority comments that agreements were reached in 1995/96 and in 1996/97 on the extent of acute volumes to be purchased. However, the major issue was the extent of elective or deferrable volumes purchased. It advised that during the 1995/96 and 1996/97 contract discussions the relationship with Canterbury Health was positive and constructive and issues were approached from a problem solving perspective.***
- The Health Funding Authority emphasised that Southern Regional Health Authority needed to retain the right to specify volumes for services at all times. It was aware of its obligation to ensure the people of Canterbury could continue to access high quality acute care but saw its responsibility as ensuring Canterbury Health took all reasonable steps to manage acute growth and to protect elective volumes. This led Southern Regional Health Authority to require Canterbury Health to demonstrate this before agreeing to shift funds from other service areas.

- ***The Health Funding Authority believes Section 7 of the report suggested Southern Regional Health Authority set volumes in isolation and without due regard to the needs of local people or providers and advised that the price paid for acute services was not on a price/volume basis. Southern Regional Health Authority sought to use volumes to establish an overall price for the service to be available, recognising the fluctuating demand and the need to maintain a readiness to treat.***

- ***Extensive dialogue took place between the two organisations and extensive joint efforts were made to analyse and manage the pressures facing Crown Health Enterprises. The provider/purchaser relationship introduced significant tension.***

- ***Crown Health Enterprises have significant ability to influence outpatient referrals and have been actively engaged in developing referral criteria, triage processes and improving communications with General Practitioners to improve control over outpatient referrals.***

- ***Volume growth is approximately 2.5% per annum and the increase in complexity is about 3% per annum over the last 2 years. The costweight system, which has been used for Canterbury Health in 1996/97 and 1997/98, recognises case complexity. Canterbury Health has not previously raised this as an issue with Southern Regional Health Authority.***

- ***Although the 1995/96 Heads of Agreement was not signed until January 1996, this does not mean that volumes were not agreed until that date.***

- ***Canterbury Health did not raise during 1995 or 1996, any concerns about problems with the Emergency Department or the more general issue of lack of equipment and skilled staff, and definitely did not mention under pricing.***

- ***The Health Funding Authority disagreed that Southern Regional Health Authority did not pay sufficient revenue either in terms of the price paid or the volume purchased. It contends that the information is consistent with a recent Ministry of Health report. The Health Funding Authority is also concerned that the analysis looks at only one price, the costweight price, and stresses that Canterbury Health was paid its requested price of $6.832 million for emergency services in 1995/96 and 1996/97.***

- ***In relation to the claim that Southern Regional Health Authority did not necessarily honour its agreements the Health Funding Authority advised that Cabinet required payment to be made once the two organisations had signed a two year contract. In spite of the Cabinet directive not to pay prior to the signing, as a sign of goodwill Southern Regional Health Authority decided to pay the money. In addition they agreed to pay interest.***

- ***In response to the statement that the purpose of Southern Regional Health Authority audits should have been to ensure that policies were implemented and operating to maintain standards, the Health Funding Authority advised that Southern Regional Health Authority was aware that its quality standards were new and would require time for providers to implement.***

- ***In relation to the "self assessments" described in the Report, the Health Funding Authority commented that Southern Regional Health Authority does not duplicate systems which are required to be in place at the provider level. Southern Regional Health Authority had no reason to distrust the responses provided by Canterbury Health Limited in the numerous audit and monitoring processes.***

- ***In response to the comment about Southern Regional Health Authority inappropriately discharging its obligations by writing letters to the Chief Executive, The Health Funding Authority commented that Southern Regional Health Authority noted the media references to clinical concerns at Canterbury Health, but in the absence of specific information could only refer in general terms by way of correspondence to the Chief Executive. Southern Regional Health Authority reviewed, on a number of occasions, its own information about Canterbury Health Limited compliance with its contract and did not see special intervention as appropriate.***

- ***In relation to the comment that only sound working relationships could flag problems, the Health Funding Authority advised that relationships are not the only way to effectively flag problems. It said that the relationships between Southern Regional Health Authority audit and monitoring staff and Canterbury Health quality management and service staff have been consistently constructive.***

The following is an extract of a response received from Health Funding Authority:

> *"The conflict between the CHE seeking compensation for cost increases, and the absence of an inflation adjustment to RHA funding was a fundamental cause of tension between the parties. The SRH had at the time in question very clear obligations as an agent of the Crown. An overriding obligation was that SRH live within its funding allocation. One of the areas highlighting this tension is the pressure on funding from growth in primary care spending on pharmaceuticals. This rate of growth exceeded the rate of growth in SRH funding. We were unable to increase funding available to CHEs compensating for this growth. In addition, the growth in demand for acute services left us with little option but to reduce the purchase of other medical/surgical services. This pressure also severally limited SRHs ability to address inequities in the provision of elective surgery in the region.*
>
> *Since the writing of this report many changes have taken place as part of the natural evolution of the purchasing process. In particular, the move to a national funding agency (HFA) is providing the framework for many of the issues relating to national consistency and benchmarking to be addressed. A more positive and inclusive approach to decision making is receiving support from CHL and other providers. In addition, the introduction of more integrated ways of purchasing services for the elderly in Christchurch will relieve some of the pressures on acute services at Christchurch Hospital. Funding pressures on Christchurch Hospital will be eased as the Health Funding Authority intends to pay nationally consistent prices to all providers commencing July 1998. In the evolution of changing methods of providing health services generally throughout New Zealand, the HFA is working in a transparent and open consultative manner with all CHEs, of which CHL is one, to ensure that each party understands and can effectively operate within the developing methodologies of pricing, volumes and service delivery."*

In respect of future audits, the Health Funding Authority noted:

> *"SRH continues to enhance its audit and monitoring programmes, as illustrated below:*

- *As planned, SRH audits have increasingly included assessments of implementation, outcomes, and consumer satisfaction. For example, the 1997 service audit of the CHL Brain Injury Rehabilitation Service, considered structure, process and outcomes, including a full case note review, a facility review, and interviews with management, staff and patients.*

- *Some of the key CHE systems audited in the early programme are scheduled for implementation reviews in the near future. These include quality plans and discharge planning.*

- *Over recent months, providers' views on the Organisational Quality Standards have been assessed, in preparation for re-drafting the clauses where warranted. Seventy providers were sent an anonymous survey to evaluate the extent to which each standard was implemented, the effectiveness of the implementation, and the importance of each standard to quality outcomes. In addition, key staff at three CHEs were interviewed on these and other matters related to quality. At CHL, the interviews were held with the Christchurch Hospital Quality Manager and the Risk Manager. These CHL staff were well informed about the standards, and stated they found them useful in practice to support the organisation's performance management systems.*

- *In 1998/99, HFA Southern intends to review CHE systems for dissemination of purchase agreement requirements throughout their organisation. The focus will be on how the CHE services know they comply with the contract, and actions taken where non-compliances are identified.*

- *HFA Southern plans to facilitate the establishment of a network of quality co-odinators across the region. The network will further raise the profile of the Organisational Quality Standards, and provide a forum for information sharing on how to put the standards into practice".*

In respect of Southern Regional Health Authority's relationship with Canterbury Health, the Health Funding Authority noted:

> *"Several references in the Commissioner's report refer to difficult relationships between Canterbury Health and SRH, and the report implies that the reasons for this lay with SRH.*
>
> *The Commissioner's inquiry staff did not obtain SRH views on the relationship that existed with Canterbury Health. Had SRH been invited to comment, the responses (and where appropriate, supported by relevant documentation) would have been as follows:*
>
> - *SRH and the CHEs were functioning in a "competitive model" environment and were required to follow accepted commercial practice, including being subject of* (sic) *the provisions of the Commerce Act.*
>
> - *Not unnaturally, there were tensions at Chair and CEO levels as to the level of purchasing in certain areas; the timing of contract closure; auditing and reporting responsibilities; and very specifically around the major issue existing for* [the] *whole period under review of the provision of cardiac surgery in Christchurch.*
>
> *While at a senior level, relationships were strained at times, at an operational level relationships remained positive. Tensions are inevitable in an environment where demand for services inevitably exceed the resources available.*
>
> *Significant progress has been made in developing a common understanding of processes and in jointly agreeing priorities. There have also been some very positive relationships developed at*

middle management level and with clinicians, between the organisations. The Canterbury Health relationship staff in the Christchurch office of SRH met monthly with their counterparts at Christchurch Hospital, headed by the General Manager of Hospital Services at Christchurch Hospital, Dr John Coughlan and these meetings were generally very positive.

Under the new national funding structure we expect to see far more transparency in decision making, agreement of joint objectives and workplans with providers and a longer term perspective to developing services for the region.

The development of nationally consistent purchase units, prices and service descriptions is already receiving wide support from providers. CHL has co-operated with this process fully.

CHL and SRH are currently formulating a joint approach to the negotiations for the 1998/99 contract which is likely to see an increased level of input from clinical staff in discussions on volumes and service developments. We are very supportive of this approach and see it as providing a sound foundation for future planning.

SRH is committed to developing and enhancing its relationship with Canterbury Health. Meetings have already been held between Kath Fox, the new Regional Director, Southern and Richard Webb to progress this, and to encouraging a co-operative and collaborative relationship as we seek to improve health outcomes, and use available resources in the best possible way."

CROWN COMPANY MONITORING ADVISORY UNIT

The following are summarised comments made by Crown Company Monitoring Advisory Unit:

- In response to the allegation that Crown Company Monitoring Advisory Unit gave insufficient consideration to the effect that the Business Plan might have on the quality of services, Crown Company Monitoring Advisory Unit stated that it is neither its role nor responsibility to monitor the impact of a Business Plan on the quality of services. This is the role of the purchaser.

- In response to the allegation that the Crown misled the Board, Crown Company Monitoring Advisory Unit advised that it is entirely appropriate for Crown Company Monitoring Advisory Unit, in advising Ministers in their capacity as shareholders, to reflect concerns as to whether the objectives in the Business Plan may be met, so that the Minister can take those concerns into account for budgeting purposes. Further Crown Company Monitoring Advisory Unit emphasised that it was under no obligation to advise the Board of its reservations and that the Chief Executive of Canterbury Health himself had concerns as to whether the objectives in the Business Plan could be met. Crown Company Monitoring Advisory Unit say it was the Chief Executive's responsibility and that of the Board to ensure that whatever services were provided met the standards required under relevant legislation and required by the purchaser.

- Crown Company Monitoring Advisory Unit objected to the Commissioner's comment about the impact of the Business Plan on the decline in standards of service.

- Crown Company Monitoring Advisory Unit was concerned that the Commissioner's comments implied that Business Plans were somehow a Crown Company Monitoring Advisory Unit product and stated that every Crown Health Enterprise's business plan is prepared and owned by the management team and is subsequently scrutinised, endorsed and adopted by the Board of Directors. Crown Company Monitoring Advisory Unit stated that it did encourage the Crown Health Enterprise to address in its Business Plan the need to achieve organisational financial viability over the medium term.

- The Chief Executive's view, expressed in Section 7, that Treasury and the Crown Company Monitoring Advisory Unit had formed a view as to what savings should be put into Canterbury Health's Business Plan on the basis of inadequate information should be removed as it represents a prejudicial view.

The following is an extract of the letter from the Crown Company Monitoring Advisory Unit:

The "Present Circumstances"

As per Justice Tipping's comments the crux of this matter, from a health consumer's perspective, is the present circumstances and it is these that your report should concentrate on and give due and balanced recognition to the significant progress that has been made in identifying and addressing these issues in the health sector.

Your report raises a variety of issues arising both pre and post 1 July 1996. The point is that as of the date of your report, and indeed during the pre and post July 1996 period this Unit and the other agencies involved have also, within the scope of their respective roles, identified issues which we or the other agencies need to address. In particular, CCMAU has assumed a significant role in taking many of these issues forward to ensure that appropriate solutions have been identified and will be implemented. Examples ... are:

- *resolution of the contract dispute between CHL and HFA;*
- *resolution of underpricing in the sector;*

In addition, we have also achieved:

- *resolution of governance issues at CHL, e.g. the appointment of a new chair and close liaison with the new chief executive;*
- *continued development of a holistic approach to monitoring of and advising Ministers about structural and organisational health sector issues in response to the new direction arising out of the Coalition Agreement;*
- *cooperation between Canterbury Health and Healthlink South resulting in a transfer of women's health services and care of the elderly to CHL;*
- *continued investigation of improved clinical performance indicators similar to those used by the Australian Council of Health Care Standards;*
- *continued development of effective relationships with all other areas of the health sector.*

We also believe it is essential to include reference to the important changes in CHL, since late 1996. These include amongst others:

- *progress towards greater clinician involvement in the management process;*
- *improved relationships with hospital clinical staff and GPs.*

Conclusion

We have endeavoured, in the time available, to respond in detail to the various matters that arise out of your draft report. In essence, while we are concerned that the report misconstrues the role of CCMAU and goes much further than it should do in seeking to criticise the actions of CCMAU, our overriding concerns are that:

- *the current draft does not provide a platform from which any remaining issues can be identified and resolved in a constructive manner; and*

- *by not giving due recognition of and prominence to the subsequent actions and the present circumstances, needlessly risks distressing health consumers and damaging public confidence in this major hospital.*

It is particularly in relation to these concerns that the draft report is not consistent with what Justice Tipping envisaged back in April 1997.

We can see that it may be relevant to observe that pressures arising from endeavours to meet the objectives of the business plan may have contributed to operational problems in terms of standards of service provided. To conclude they caused a breach of the Code is another matter altogether. As we have indicated we see no evidence supporting such a conclusion in the extracts in the report which you have provided to us and consider the emotive and sweeping nature of your comments to be unfair and inappropriate.

Our point is that even if your conclusion has some basis (and you have not provided any supporting evidence), many of the observations and comments made in relation to CCMAU arise from misunderstandings of CCMAU's role and are gratuitous in the sense that they are unnecessary, damaging and in our view wrong."

TREASURY

The following are summarised comments made by Treasury:

- The Crown representative on the Board during the workout programme was not there to usurp the role and responsibility of the Board or management. In Treasury's opinion, a letter from the Shareholding Ministers to the Chairman in May 1995 that enabled the service exit process to be invoked indicated that it was not the Minister's expectation that service quality would be compromised in the event of Crown Health Enterprise costs exceeding the price for a service.

- In response to the statement that it should have conveyed information to the Board, Treasury responded that Canterbury Health management had already been informed by the Chief Executive of the risks associated with the Business Plan.

- Treasury disagreed that the aggressive Business Plan was to blame for the alleged decline in standards of service saying that the repeated delay by clinicians in providing information on patient safety incidents and the unexplained increase in acute volumes during the winter of 96 conspired to bring about patient safety concerns.

- Treasury rejects any finding that Crown Company Monitoring Advisory Unit or itself has a role in ensuring that services are provided in a safe manner.

The following is an extract of a response received from Treasury:

"The statement is made that CCMAU ... gave insufficient regard to the impact the business plan might have on the quality of services. We disagree strongly with this statement.

Clinical safety is fundamental to the effective provision of health services. Both Treasury and CCMAU are charged with advising Government on aspects of the operation of the health system. We are responsible for providing economic and financial advice to government. To ensure that the appropriate levels of safety are maintained we rely on a variety of functions within the health system.

These include:

- *the responsibility of the board and management of CHEs for clinical safety;*
- *the ethical and professional obligations of CHE clinicians;*
- *the role of the purchaser in specifying the quality of the services it wishes to purchase from CHEs; and*
- *the Ministry of Health as the regulatory body with oversight of clinical safety in CHEs.*

Commissioning a clinical review of the business plan, introduced for the first time in 1995, was a further safeguard."

CHRISTCHURCH HOSPITALS' MEDICAL STAFF ASSOCIATION

The following are summarised comments made by Christchurch Hospitals' Medical Staff Association:

- Christchurch Hospitals' Medical Staff Association advised that it could not present the Patients Are Dying report any earlier. It was a struggle to complete the report before the Christmas break outside of work hours. In any case Canterbury Health received advance notification of the dangers of its policy over a long period of time through individual contact with managers, individual members of the Board and at numerous meetings. In response to the claim that the Report did not contain the scope or detail necessary to offer Canterbury Health solutions. Christchurch Hospitals' Medical Staff Association said that solutions had previously been offered to management and to the Board.
- Christchurch Hospitals' Medical Staff Association claimed that it had seen little sign of change from the authoritarian model of central control and direction that had existed at Canterbury Health for the past five years, despite the comment in the Report that Canterbury Health was taking proactive steps to address issues at Canterbury Health. In response to the comment that Christchurch Hospitals' Medical Staff Association members are required to operate within standard management processes, Christchurch Hospitals' Medical Staff Association said that the vast majority of senior staff thought that management directives led to a fall in patient safety standards and were central to the election of the new Christchurch Hospitals' Medical Staff Association Executive in 1996.

Governor-General

ORDER IN COUNCIL

At Wellington this day of 1996

Present:

IN COUNCIL

PURSUANT to section 74(1) of the Health and Disability Commissioner Act 1994, His Excellency the Governor-General, acting by and with the advice and consent of the Executive Council, hereby makes the following regulations.

REGULATIONS

1. **Title and commencement** - (1) These regulations may be cited as the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

   (2) These regulations shall come into force on the 1st day of July 1996.

2. **Code of Health and Disability Services Consumers' Rights** - There shall be a Code of Health and Disability Services Consumers' Rights, which shall be the code set out in the Schedule to these regulations.

SCHEDULE

CODE OF HEALTH AND DISABILITY SERVICES CONSUMERS' RIGHTS

1 Consumers have Rights and Providers have Duties:

1) Every consumer has the rights in this Code.

2) Every provider is subject to the duties in this Code.

3) Every provider must take action to -

a) Inform consumers of their rights; and

b) Enable consumers to exercise their rights.

2 Rights of Consumers and Duties of Providers:

The rights of consumers and the duties of providers under this Code are as follows:

RIGHT 1

Right to be Treated with Respect

1) *Every consumer has the right to be treated with respect.*

2) *Every consumer has the right to have his or her privacy respected.*

3) *Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Maori.*

RIGHT 2

Right to Freedom from Discrimination, Coercion, Harassment, and Exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

RIGHT 3

Right to Dignity and Independence

Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.

RIGHT 4

Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

3) *Every consumer has the right to have services provided in a manner consistent with his or her needs.*

4) *Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.*

5) *Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

RIGHT 5

Right to Effective Communication

1) *Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.*

2) *Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.*

RIGHT 6

Right to be Fully Informed

1) *Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including -*

   a) *An explanation of his or her condition; and*

   b) *An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and*

   c) *Advice of the estimated time within which the services will be provided; and*

   d) *Notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and*

   e) *Any other information required by legal, professional, ethical, and other relevant standards; and*

   f) *The results of tests; and*

   g) *The results of procedures.*

2) *Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.*

3) *Every consumer has the right to honest and accurate answers to questions relating to services, including questions about -*

   a) *The identity and qualifications of the provider; and*

   b) *The recommendation of the provider; and*

   c) *How to obtain an opinion from another provider; and*

   d) *The results of research.*

4) *Every consumer has the right to receive, on request, a written summary of information provided.*

RIGHT 7

Right to Make an Informed Choice and Give Informed Consent

1) *Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.*

2) *Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.*

3) *Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.*

4) *Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where -*

   a) *It is in the best interests of the consumer; and*

b) Reasonable steps have been taken to ascertain the views of the consumer; and

c) Either, -

i. If the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or

ii. If the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

5) Every consumer may use an advance directive in accordance with the common law.

6) Where informed consent to a health care procedure is required, it must be in writing if -

a) The consumer is to participate in any research; or

b) The procedure is experimental; or

c) The consumer will be under general anaesthetic; or

d) There is a significant risk of adverse effects on the consumer.

7) Every consumer has the right to refuse services and to withdraw consent to services.

8) Every consumer has the right to express a preference as to who will provide services and have that preference met where practicable.

9) Every consumer has the right to make a decision about the return or disposal of any body parts or bodily substances removed or obtained in the course of a health care procedure.

10) Any body parts or bodily substances removed or obtained in the course of a health care procedure may be stored, preserved, or utilised only with the informed consent of the consumer.

RIGHT 8

Right to Support

Every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer's rights may be unreasonably infringed.

RIGHT 9

Rights in Respect of Teaching or Research

The rights in this Code extend to those occasions when a consumer is participating in, or it is proposed that a consumer participate in, teaching or research.

RIGHT 10

Right to Complain

1) Every consumer has the right to complain about a provider in any form appropriate to the consumer.

2) Every consumer may make a complaint to -

a) The individual or individuals who provided the services complained of; and

b) Any person authorised to receive complaints about that provider; and

c) Any other appropriate person, including -

i. An independent advocate provided under the Health and Disability Commissioner Act 1994; and

ii. The Health and Disability Commissioner.

3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.

4) Every provider must inform a consumer about progress on the consumer's complaint at intervals of not more than 1 month.

5) Every provider must comply with all the other relevant rights in this Code when dealing with complaints.

6) Every provider, unless an employee of a provider, must have a complaints procedure that ensures that -

a) The complaint is acknowledged in writing within 5 working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period; and

b) The consumer is informed of any relevant internal and external complaints procedures, including the availability of -

i. Independent advocates provided under the Health and Disability Commissioner Act 1994; and

ii. The Health and Disability Commissioner; and

c) The consumer's complaint and the actions of the provider regarding that complaint are documented; and

d) The consumer receives all information held by the provider that is or may be relevant to the complaint.

7) Within 10 working days of giving written acknowledgement of a complaint, the provider must, -

a) Decide whether the provider -

i. Accepts that the complaint is justified; or

ii. Does not accept that the complaint is justified; or

b) If it decides that more time is needed to investigate the complaint, -

i. Determine how much additional time is needed; and

ii. If that additional time is more than 20 working days, inform the consumer of that determination and of the reasons for it.

8) As soon as practicable after a provider decides whether or not it accepts that a complaint is justified, the provider must inform the consumer of -

i. The reasons for the decision; and

ii. Any actions the provider proposes to take; and

iii. Any appeal procedure the provider has in place.

3 Provider Compliance

1) A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.

2) The onus is on the provider to prove that it took reasonable actions.

3) For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

4 Definitions

In this Code, unless the context otherwise requires, -

"Advance directive" means a written or oral directive -

a) By which a consumer makes a choice about a possible future health care procedure; and

b) That is intended to be effective only when he or she is not competent:

"Choice" means a decision -

a) To receive services:

b) To refuse services:

c) To withdraw consent to services:

"Consumer" means a health consumer or a disability services consumer; and, for the purposes of rights 5, 6, 7(1), 7(7) to 7(10), and 10, includes a person entitled to give consent on behalf of that consumer:

"Discrimination" means discrimination that is unlawful by virtue of Part II of the Human Rights Act 1993:

"Duties" includes duties and obligations corresponding to the rights in this Code:

"Exploitation" includes any abuse of a position of trust, breach of a fiduciary duty, or exercise of undue influence:

"Optimise the quality of life" means to take a holistic view of the needs of the consumer in order to achieve the best possible outcome in the circumstances:

"Privacy" means all matters of privacy in respect of a consumer, other than matters of privacy that may be the subject of a complaint under Part VII or Part VIII of the Privacy Act 1993 or matters to which Part X of that Act relates:

"Provider" means a health care provider or disability services provider:

"Research" means health research or disability research:

"Rights" includes rights corresponding to the duties in this Code:

"Services" means health services, or disability services, or both; and includes health care procedures:

"Teaching" includes training of providers.

5 Other Enactments

Nothing in this Code requires a provider to act in breach of any duty or obligation imposed by any enactment or prevents a provider doing an act authorised by any enactment.

6 Other Rights Not Affected

An existing right is not overridden or restricted simply because the right is not included in this Code or is included only in part.