100 Heads Road, Private Bag 3003
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9 March 2022

Dr Shane Reti
Andrea Harris
Parliament

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Tēnā koe Shane

Official Information Act Request – OIA 14134 Documentation Regarding Credentialing Review Involving General Medicine Department.

On 3 February 2022, under section 12 of the Official Information Act, you requested the following information from Whanganui District Health Board (WDHB):

Under section 12 of the Official Information Act 1982 I request all original documentation of reports, briefings around a credentialing review involving the general medicine department.

Where information is withheld, I request you provide the title and date of the communication/document withheld, the reason for refusal and the grounds in support of that reason as required by section 19 (a) (i) and (ii) of the Official Information Act.

Whanganui District Health Boards response:

Original documentation of reports, briefings around a credentialing review involving the general medicine department.

- Summary and recommendations General Medicine Departmental Credentialing Report 2020 Final Version (3 July 2020)
- Credentialing risk general medicine credentialing added to the risk register (July 2020)
- Report to the risk and audit committee February 2021
- Report to the clinical board 23 February 21
- Report to the clinical board June 21

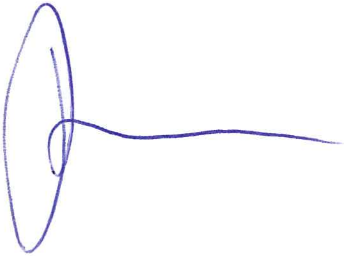
The full credentialing report has been withheld under section 9 (2) ba (i), that it was collected under an obligation of confidence, and that providing the information is likely to prejudice the candour of the suppliers of similar information through the regular departmental credentialing process within Whanganui DHB. There is also a risk under section 9 (2) ba (ii) that this information would be likely to damage the public interest. The key information is included in the summary and recommendations.

The WDHB is currently working to implement the recommendations of this review. Additional house officers have been engaged, with work underway to recruit physician registrars in the near future.

Under section 28(3) of the Act you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: **info@ombudsman.parliament.nz** or by calling 0800 802 602.

Should you have any further queries about the above information, please contact our OIA co-ordinator Anne Phoenix at anne.phoenix@wdhb.org.nz

Ngā mihi



Russell Simpson
Kaihautū Hauora –Chief Executive
Whanganui District Health Board

Credentialing Department of General Medicine, Whanganui Hospital.

7/2/2020.

Credentialing subcommittee:

External assessor:

Executive Summary:

The Whanganui community, and the house officers working in the department, benefit from a consultant-led general medical service in which SMOs closely supervise the patients under their care and make almost all of the clinical decisions. The department is staffed by six permanent full-time consultants and six house officers. General medicine has experienced a steady growth in patient numbers with the inpatient caseweights increasing from 2807 in 2017 to 3562 in 2019 and projected to be 3908 in 2020. Whanganui does not have registrars in the department of general medicine and in the evenings and especially on weekends the single house officer is often unable to keep up. The house officer is required to round on all patients admitted the night before, discharge anyone ready to go home, deal with any disasters on the ward and admit all patients referred to the service. The weekend on call covers three days so a single physician may have almost half a week's worth of patients under their care with the remainder spread over 4 (or even 5) physicians. This boom and bust variation in workload leads to unacceptably high patient numbers at times and resentment of colleagues. Apart from the stress of working weekends, house officers enjoy their experience at the hospital and benefit greatly from the close working relationship with their consultants.

There is good relationship with the emergency department for the management of acute presentations and with the geriatricians for patients requiring rehabilitation. Patients requiring short-term intensive care and jointly managed by the general physicians and anaesthetists and this works well. The skill mix and experience of the medical staff are appropriate although a physician with a specialty interest in respiratory medicine is needed. Currently they are fully staffed in general medicine but only is an RACP graduate and there are hints to suggest the professional qualities which are emphasised by RACP training may have been lacking in the training of some overseas doctors. Leadership and collegiality were not strongly demonstrated, an example being that the option of hiring registrars is currently ruled out as no member of the team will take on the (relatively minor) role of Director of Physician Training. Comments from the nursing staff indicated a hierarchical approach by many and poor appreciation of Tikanga Maori by most.

In general the facilities at the hospital are excellent, with the exception of the IT system which was noted to be very slow for such things as access to Clinical Portal. There appeared to be a stable nursing workforce with some very experienced staff and the skill mix on both the wards and outpatient clinics was said to be good. Back up for tertiary level care is provided by Wellington Hospital, Palmerston North for dialysis, and soon Auckland for

hyper-acute stroke. This appears to work well with the exception of access to neurology specialist services which is poor.

The retirement of within the next two years is a cause for concern. has worked as a consultant at Whanganui Hospital since 1994 and provided great stability over that time. He is highly respected across the organization as a leader who models dedication and hard work and within the department he is respected for the fairness with which he apportions work and leave. He carries a full clinical load despite his management responsibilities which include overseeing the radiology department.

The Medicine Department delivers a good service to the community of Whanganui, however there are some concerns particularly around leadership, interpersonal relationships and communication, respect for other staff members, patients and Tikanga Maori. There is room for improvement and we have made some recommendations at the end of the report.

Recommendations:

At the end of a day during which there was excellent participation by staff across the hospital our impression was that opportunities for improvement fell in to three categories. The first was a series of changes needed to redistribute and reduce the current workload. Some of these are urgently required and others are necessary to provide capacity for growth in the very near future.

The second set relates to capital expenditure suggestions which would improve the standard of care offered to our patients and also contribute to improving job satisfaction and morale among the SMOs

The third set of recommendations relate to improving relationships within the department, and with other services.

Suggestions for operational changes, staffing and workflow

1) Additional HO each day on weekends (urgent). The weekend days require the same cover as public holidays, not less. The existing house officer cannot provide an adequate service alone so patients are put at risk and there are delays with weekend admissions and discharges.
2) The DHB should explore suitable options (for example the Tairawhiti model) for employing registrars. A hospital of this size struggles to deliver the required service without registrars. Probably four registrars would be needed.
3) One of the SMOs would need to take on the role of Director of Physician Training.
4) Stop the 3-day weekend consultant calls. Consider separating the Friday call from the weekend or allocating some of the weekend admissions to another consultant.
5) Review of outpatient clinics – including methods of triaging referrals, (ensuring equitable distribution) standardising templates and behaviour in regard to virtual and real clinic ratios
6) Review the need for and process for patient hand back (in order to reduce disputes)
7) The DHB and the team of physicians should improve and spread the leadership in the department. carries a heavy leadership and administrative load which could be shared by the other physicians. He is likely to retire in the next two years, so the DHB should be planning for his replacement.
8) The other physicians should participate in additional non-clinical activities.
9) Consider accessing private neurologist clinics.
10) Consider providing CT coronary angiography. This may require a visiting cardiologist or radiologist with the necessary expertise.

Capex issues

11) The existing IT system are clinical portal are inadequate. There is an urgent need for a comprehensive digital solution, especially for electronic medical records.
12) Providing laptops for ward rounds (ensure reliable Wi-Fi in all locations on the medical and AT&R wards)
13) Providing dragon software or similar dictating software.
14) Purchase of an additional POC ultrasound machine (to be based in the medical ward and available for use in OPD.)

Suggestions for improving collegiality:

Staff outside the department describe variability in the general medical SMOs approach to work and observe a lack of collegiality between them. The nursing staff described hierarchical rather than patient-focussed consultations on ward rounds and very little appreciation of Tikanga Maori. It is likely that uneven, and sometimes excessive (in the weekends in particular) workloads are contributing to conflict and changes suggested above may help with this. Other suggestions are

15) Consider SMO participation in a weekly MDT meeting.
16) All physicians to attend Hapai Te Hoe for Tikanga Maori training
17) Consider external facilitation of workshops to set behavioural expectations and to develop respectful collegiality between all members of the general medical staff. Consider attending workshops such as the MPS "Mastering Professional Interactions" and "Mastering Difficult Interactions with Patients" workshops. https://www.medicalprotection.org/newzealand/events-e-learning/workshops

Risk Name
Inadequate credentialing in General Medical department leads to unsafe practices and underperformance of clinicians

Risk description
Credentialing is a process used by health and disability service providers to assign specific clinical responsibilities to health practitioners on the basis of their education and training, qualifications, experience and fitness to practice within a defined context. The focus of credentialing is patient safety. The Ministry of Health provided a credentialing framework for New Zealand health professionals in 2010.

Whanganui DHB employs a Credentialing Committee of medical practitioners to consider applications by medical practitioners for clinical activity approval in association with their appointment initially and thereafter on a regular three to five-year basis. The principal aim is to ensure that all work carried out by medical practitioners is consistent with their qualifications, training, experience and competence.

Individuals are reviewed initially and every five years following; departments are reviewed every five years and a credentialing audit is completed every three years. The basis of this risk is due to the five-year review of the General Medical department in
February 2020.

Risk Owner

ELT Owner

Causes
Inadequate staffing levels during nights and weekends to meet the growing population of clients
No registrars employed in the department
Unequitable distribution of outpatient clinic
Uneven spread of leadership
Inadequate succession planning
Inadequate IT system

Consequences
Unsafe practices and inadequate time to provide patient care
Heavy workload on clinicians who work weekends
Delays with weekend admissions and discharges
Heavy reliance on one leader/manager
Unwillingness to participate in non-clinical activities
Difficulty in finding time to participate in MDT meetings
Difficult to be patient focused when overloaded

Controls (what do we have in place to minimise the risk?)
Recent credentialing review completed which has made 17 recommendations based on operational activity, capex and culture – initiative in place to implement recommendations (Control owner:) – Partially effective

Locums being used where necessary to reduce heavy workload of individuals on weekends until recruitment proposal completed (Control owner:) – Mostly effective

Proposal to recruit additional house officer on weekends underway
(Control owner:) – Not effective – once recruited will be partially effective, however to be fully effective the skill mix needs to include medical registrars

Exploring suitable options for employing registrars is underway (Control owner:) – Not effective until this is implemented. In order to attract medical registrars to Whanganui, the medical department needs to gain accreditation for training.

Treatments (what further actions can we do to strengthen controls and minimise risk?)
Other recommendations from credentialing review to be considered/completed:
Operational:

- Recruitment of proposed staff
- Review 3-day weekend consultant calls
- Review outpatient clinic allocation
- Consider accessing private neurologist clinics
- Review the need for and process for patient hand back (allocation of patients re-presenting for the same condition within the past 30-days)

Capital investment:

- Improving the speed of clinical portal
- Laptops for ward rounds
- Providing dragon software for dictating
- Purchase a point of care ultrasound machine

Culture:

- Consider SMO participation in a weekly MDT meeting
- All physicians to attend hapai te hoe
- Consider externally facilitated workshops such as MPS mastering professional interactions and mastering difficult interactions

Risk Ratings

Inherent Risk (without any controls):

Consequence – Moderate / Likelihood – Likely Risk Rating - High

Residual Risk (with controls):

Consequence – Moderate / Likelihood – Likely Risk Rating - High

Acceptable Risk (what we want to get to):

Consequence – Minor / Likelihood – Unlikely Risk Rating - Low

Top operational risks description	Inherent risk rating	Current controls	Control effectiveness	Residual risk rating	Further actions/comments	Acceptable risk rating	EMT owner/ Risk Owner	Consequence category
02: Patient safety and staff performance risks identified in general medicine department credentialing could lead to sub optimal patient care *The basis of this risk is due to the five-year review of the General Medical department in February 2020.*	**High (Moderate/ Likely)**	Recent credentialing review completed which has made 17 recommendations based on operational activity, capex and culture – initiative in place to implement recommendations. Locums being used where necessary to reduce heavy workload of individuals on weekends until recruitment proposal completed Proposal to recruit additional house officer on weekends has been approved. New staffing will be in place from 18 January (Q1 2021)	Partially effective	**High (Moderate/ Likely)**	Other recommendations from credentialing review to be considered/completed: Operational: ▪ Recruitment of proposed staff ▪ Review 3-day weekend consultant calls ▪ Review outpatient clinic allocation ▪ Consider accessing private neurologist clinics ▪ Review the need for and process for patient hand back (allocation of patients re-presenting for the same condition within the past 30-days)	Low (Minor/ Unlikely)	Action owners:	Patient Care Clinical Staff

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