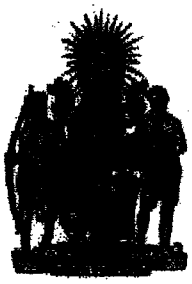

REPORT

TO

West Coast District Health Board

Review of General Surgery

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For the Royal Australasian College of Surgeons

27 August 2003

Contents

1.0 Executive summary

1.1 The West Coast District Health Board (WCDHB) resolved on 7 October 2002 to request the Royal Australasian College of Surgeons (RACS) to review the Board's General Surgery Service.

1.2 This decision was made following receipt of letters from West Coast GPs and two anaesthetists which were critical of the General Surgical service.

1.3 Terms of reference were agreed between the RACS and WCDHB.

1.4 The aim of the review was to look at the service broadly and not to conduct a formal review of the competence of any individual. It was agreed that if issues of competence arose, the reviewers would recommend ways in which such issues could be resolved.

1.5 A review group from the RACS visited Greymouth on 12-14 February and again on May 29 – 30 to review General Surgical services in the West Coast DHB region. The review group consisted of Messrs P Bagshaw (Christchurch), M Pfeifer (Invercargill)and J Simpson (Wellington) who studied relevant documents, received submissions and interviewed a number of individuals and groups including:
WCDHB employees
WCDHB Board members
GPs from the region.

1.6 The service
The team heard expressions of concern from many of those interviewed about the present state of the General Surgery service including:

1.6.1 The present reliance on locum surgeons to provide both emergency cover and to provide an elective surgery service.

1.6.2 A reduction in this reliance on locums is seen as a high priority. It was noted that some of the locums have been regarded as excellent but others have been viewed by other staff as being in some respects "unsafe".

1.6.3 A lack of continuity of care associated with locums arriving and departing with consequent transfer of clinical responsibility. This transfer did not always take place in an effective manner.

1.6.4 The urgent need to recruit permanent senior medical staff to an establishment of 3 FTE specialists in general surgery.

1.6.5 That communication (and relationships in general) between the department and the local GPs was regarded by many as inadequate and required early, radical improvement.

1.6.6 The surgical services offered were less extensive than many viewed as desirable

1.7 Clinical Leadership of the Department

1.7.1 The Chief Executive has confirmed to the reviewers that there is a Department of General Surgery and that [redacted] is head of that department

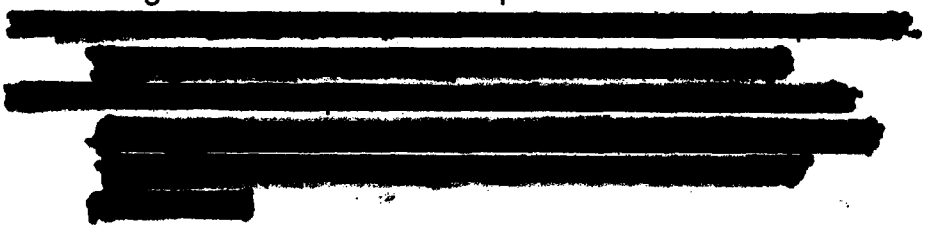
1.7.2 The Head of Department has held office for 4 years during a difficult and stressful time.

1.7.3 His commitment to the West Coast and his broader contributions to rural surgery in New Zealand are considerable and are recognized by the reviewers.

1.7.4 He is an elected senior office-holder of a national surgical organization.

1.7.5 He has been largely responsible for appointing the first trainee registrar to Grey Hospital.

1.7.6 The department received extensive media coverage in 2002 in connection with difficulties in staffing including the acute on-call roster. In addition there was local media coverage of alleged difficulties between a former senior surgeon and the Head of Department



1.7.9 The RACS is prepared to assist in this process with the agreement of the parties directly concerned.

1.8 General issues

1.8.1 The reviewers were told by a number of GPs that the relationship between the hospital and the West Coast GPs was very unsatisfactory. This is in addition to the specific issues with general surgery (see 1.6.5).

1.8.2 Examples of inadequate communication between West Coast GPs and the hospital over patient care were given to the reviewers.

1.8.3 The absence of credentialling of senior medical staff is seen as an important deficiency in the hospital process and should be rectified as soon as possible.

1.8.4 The head of department informed the reviewers that he had met the audit requirements of the RACS by presentation of his endoscopy audit. He also stated that he maintained an audit of his surgical work although it is understood that this audit is without peer review. The reviewers were shown a list of operations but no outcome data were made available. The general surgery service does not engage in a regular formal audit process as a unit, this is seen as an important deficiency. However, a weekly clinical meeting is held.

1.8.5 The role of senior/chief medical advisor does not appear to have been fully developed although an interim chief medical advisor has just been appointed

1.8.6 There has been no job description, no generally accepted role and no salary supplement for the senior/chief medical advisor although it appears that this situation has now been rectified

1.8.7 The reviewers were informed that management has been seen at times as slow or unwilling to respond to problems and has been seen to compound some issues. This assertion is however challenged

1.8.8 A formal appointments procedure is not used for locum appointments and candidates are vetted to a variable degree.

1.9 Conclusions

1.9.1 The clinical isolation of the general surgery service at Grey Hospital, largely due to its geographical location, together with a reliance on locums, is unsatisfactory.

1.9.2 The present situation of one permanent surgeon and a succession of locums who stay for variable periods of time is unsustainable and poses, over time, significant clinical safety risks.

1.9.3 A policy must be developed to support the Head of Department of general surgery and to ensure that problems associated with this role are addressed and resolved.

1.9.4 The lack of effective communication between the hospital and the GPs on the Coast does not serve the goal of quality surgical care and requires urgent resolution with the involvement of all parties

1.9.5 Credentialling had not taken place at the time this report was written.

1.9.6 Audit is not a core activity of the general surgical service and is well below an acceptable NZ standard. The permanent surgeon together with locums who are or are not Fellows of the RACS should be expected to participate in joint audit activity..

1.9.7 The issue of clinical safety is a crucial one and at the heart of this review. In the absence of good audit data relating to the whole spectrum of general surgery, a confident statement about clinical safety cannot be made. Clinical safety issues have already been referred to in 1.9.2.

1.10 Recommendations

1.10.1 A major effort is required to have a department consisting of three permanent, vocationally registered general surgeons.

1.10.2 The sole permanent general surgeon is without doubt clinically isolated but informed the reviewers that he has developed, informal, networks with other surgeons. Despite this, the issue of clinical isolation remains a significant concern. This factor can be substantially reduced by developing formal links with one or more larger DHBs. The obvious partner for this process would be the Canterbury DHB although others such as Nelson, Otago, Capital and Coast and South Auckland could be considered.

1.10.3 The formation of a combined department of general surgery with an other DHB (with a reduction in clinical isolation and assured emergency cover) should be seriously considered.

1.10.4 To encourage the regular annual appointment of a Basic Surgical Trainee (BST) registrar to work at Grey will, in the medium to long term, aid the process of recruiting NZ trained surgeons.

1.10.5 If locums are required in the short to medium term, every effort must be made to ensure that their training and experience meet the needs of the job and that their supervision is adequate

1.10.6 The appointment process for both permanent and locum staff should be reviewed. Clearly, for very short term locums, by surgeons vocationally registered in New Zealand, the process should not be unnecessarily cumbersome. The process for all others should be formalised and an appointment committee should include the medical advisor and a RACS nominee.

1.10.7 A major initiative should be undertaken to welcome the local GPs into the hospital. This applies not only to General Surgery but to other departments as well

1.10.8 Much closer integration of primary care and secondary care in the region can be facilitated by the Board in a number of ways including appointing a GP liaison officer

1.10.9 A senior surgeon should be identified to support and advise the Head of Department of general surgery. The RACS would be prepared to assist in identifying a suitable person

1.10.10 Credentialling and clinical audit require immediate attention.

2.0 Terms of reference

Background

1. The West Coast District Health Board (WCDHB) has requested the Royal Australasian College of Surgeons (RACS) to conduct a review of its general surgery service to determine whether it is providing appropriate and safe services in the context of a hospital of its size and relatively isolated location.

2. The impetus for the review comes from the Board's wish for public reassurance following receipt of two letters written to the CEO of the WCDHB making critical comment about the general surgery service.

3. The first letter dated 24 September 2002 is signed by 20 West Coast GPs in which they state: *"Our faith in surgical services is diminishing, nearing the point of no confidence. We fear for the future wellbeing and safety of our patients".*

4. The second letter dated 1 October 2002 comes from two anaesthetists, Drs Judy Forbes and Susan Newton who have worked as anaesthetic locums at Grey Hospital. They state*: "we find the experience and commitment of surgical locums highly variable and sometimes frightening. This is.... a serious flaw in the delivery of safe consistent surgical standards"*

Process

5. A RACS review team consisting of three senior fellows of the College will be appointed with the agreement of the WCDHB. If additional non-surgical expertise is required, a suitable person may be co-opted after consultation with the WCDHB.

6. The review will assess possible constraints to the delivery of appropriate and safe surgical services. Some issues (such as, but not limited to, individual competence) may be appropriate for the review team to identify but not to determine. Under such circumstances, the team may identify possible options to achieve a determination.

7. The review team will focus on systems in existence at Grey Hospital and determine whether recognised standards for service delivery and patient care are being met.

8. The review team will be given access to WCDHB reports, statistics and audit data.

9. The review team will interview persons as the team thinks appropriate:

a) Staff members of the WCDHB. (those who provide information to the review team will be informed of the review team's obligations as defined in clauses 10 and
b) Members of the WCDH Board
c) General practitioners from the region
d) Drs Forbes and Newton who have worked as locum anaesthetists at Grey Hospital
e) Others as necessary.

10. Relevant sections from a draft report will be made available to those interviewed for the purpose of correction of factual material relating to their input and for the purpose of providing an opportunity for comment on any significant issue which might give rise to an adverse conclusion.

Specific issues

11. These are:
    a) Range of general surgery available at Grey Hospital
    b) Waiting times for outpatient appointments
    c) Waiting times for general surgery
    d) Referral by GPs to Christchurch rather than Grey Hospital
    e) Recruitment, supervision and performance of locum general surgeons
    f) Appropriateness of surgery performed at Grey Hospital
    g) Evidence of systems to support safe practice.

12. The review will also assess whether constraints are present which affect the ability of the WCDHB's general surgeons to meet the RACS requirements for Continuing Professional Development (CPD) or Maintenance of Professional Standards (MOPS) including:
    a) Clinical audit with peer review
    b) Credentialling
    c) Attendance at Maintenance of Clinical Knowledge and Skills activities
    d) Clinical Governance activities.

Confidentiality

13, The review team will regard all information obtained as confidential and will not release it without the approval of the DHB: this approval will not be withheld unreasonably. The reviewers will speak to the media only at the DHB'S request.

Other matters

14. The review team will comment on any other matter that in their view impacts on the delivery of safe and appropriate surgery to the people of

the West Coast.

Reporting

15. A final report to the Board, with recommendations, will be delivered as soon as possible after April 2003.

3.0 Background

The RACS was approached in November 2002 by the acting Chair of the WCDHB, Dr Christine Robertson, with a request to conduct a review of the general surgical service. This followed a motion by the Board in October 2002 asking for such a review to be carried out. In November, the Board agreed on the broad terms of reference for such a review. Phil Bagshaw and John Simpson attended a Board meeting on 6 December 2002 and discussed with Board members the way in which a review might be conducted.

Following this meeting it was agreed that a 3-person team would carry out a review using agreed terms of reference (see 2.0). It was also agreed that the RACS and the three individual reviewers would be indemnified by the Board in respect of all aspects of the review.

The request for the review followed receipt of two letters from West Coast GPs and one from anaesthetists, Drs Sue Newton and Judy Forbes. These letters were highly critical of the service and highlighted a number of issues.

4.0 The review

4.1 Terms of reference were agreed for the review and the contractual arrangements were confirmed in a letter of engagement. The RACS (for the reviewers) and the Board signed an indemnity document relating to the review.

4.2 The reviewers visited the West Coast on two occasions Feb 12 to 14 and May 28 to 30 2003.

4.3The reviewers have interviewed the following:
The Chairman of the Board
The Deputy (and acting) Chair
The Chief Executive
The General Manager - Operations
The Head of Department of General Surgery
A former senior surgeon
Senior anaesthetist
Locum anaesthetists
Surgical registrar
Locum Surgeon
Senior Nursing Staff
General Practitioners
Board Members
Senior orthopaedic surgeon.

4.4 Data was supplied by the Board relating to:
Surgery performed
Contract volumes
Transfers out
Use of ICU.

4.5 Drafts of the report
Drafts of the report were summitted for comment in accordance with clause 10 of the terms of reference. The reviewers carefully considered the comments received and the final report incorporates a number of the suggestions made.

5.0 Findings

5.1 Range of surgery available at Grey Hospital

A discussion of the range of surgery is complicated somewhat by the definition of what is meant by general surgery in the context of Grey Hospital. At Grey Hospital general surgery includes aspects of all surgery with the exception of orthopaedics and obstetrics and gynaecology Thus it includes elements of urology, otolaryngology, paediatric surgery, plastic surgery and uncommonly emergency treatment that would require procedures normally regarded as part of neuro-surgery or cardio-thoracic surgery. This is in addition to those procedures generally regarded as "bread and butter" general surgery including procedures on the abdomen, head and neck and breast.

A limited service is provided by visiting specialists who attend Grey Hospital to provide a consultative service and some surgery in urology, paediatric surgery, otolaryngology and plastic surgery. These visits which have taken place for many years have been increased recently. All the specialists come from Christchurch at the present time

Notwithstanding the work of these outside specialists, the view expressed by a number of GPs was that the range of procedures being offered at Grey Hospital was getting smaller with more patients requiring transfer to Christchurch. This appeared to relate primarily to complex abdominal and pelvic surgery. It can be argued that transfer of such patients is in line with best practice standards for this type of surgery. No objective evidence was submitted to support the perception of contracting services, but the perception is a matter of sufficient concern to warrant a study of the trends over the past decade.

5.2 Waiting times for outpatient appointments

Some concern was expressed by GPs about the waiting time to be seen as an outpatient for non-urgent problems. There was general agreement that those with urgent problems such as a suspicion of cancer are seen very quickly. No documentary evidence was presented to support the view that there was an excessive waiting time for non-urgent surgery. On the contrary, documentation provided by the Board suggested that those living on the West Coast were well served compared with other areas of NZ in terms of access to OPD appointments. The reviewers, while concerned about the GPs perception, did not find evidence of a significant problem.

5.3 Waiting times for general surgery

There is no evidence of long waiting times for even non-urgent general surgery. Despite this being cited as a concern in the letter from the West Coast GPs no evidence to support this concern has been presented to the reviewers. As in 5.2, the reviewers,while concerned about the GPs perception did not find evidence of a significant

problem.

5.4 Referral by GPs to Christchurch rather than Grey Hospital
Only a small percentage of people living on the West Coast have either medical insurance or the financial resources to receive treatment in the private sector. There is effectively no private practice on the West Coast with those seeking it being treated in the main by Christchurch specialists. The reviewers were told that Canterbury DHB will not give out patients appointments to people who live outside their region. However the Chief Executive informed the reviewers that patients can be referred but that there are financial repercussions for the WCDHB. It seems that only a very small minority are able to be treated in Christchurch (in the private sector). It appears that despite dissatisfaction by some GPs with the surgical service at Grey Hospital, the number of patients referred to Christchurch is small. Without doing a detailed survey of GP referrals there is no means of quantifying the number referred. It does not appear to be a major problem at present but may well be increasing.

5.5 Recruitment, supervision and performance of locum general surgeons
The reliance of the service on locums for its very existence was a cause of major concern to almost everyone interviewed. This was probably the single most consistent comment made to the reviewers. The perceived quality of the locums varied from first class to appalling according to hospital staff members and GPs.

5.5.1 Recruitment has been achieved, often from overseas, by use of a website, journal advertising and word of mouth. The initial contact, if followed up, leads to a vetting process which includes obtaining referees reports and telephone checks on these reports. Doctors from outside New Zealand are also subject to the checks carried out by the Medical Council of New Zealand. The checks carried out by WCDHB are done in a rather informal fashion by either the Head of Department or by a senior member of the HR department. There is no formal appointments committee for locum appointments
5.5.2 Supervision of locums is the responsibility of the Head of Department who also provides General Oversight as required by the Medical Council, for all non vocationally registered practitioners (the great majority of locums). There has been criticism expressed about the level of supervision of locums, particularly when they first arrive. The reviewers were told that the orthopaedic unit was much stricter in the way that new locums are observed and assessed. It was suggested that similar standards could be applied in general surgery.

5.5.3 It is difficult to make generalisations about the performance of locums with a wide range of backgrounds, experience and abilities. Some have appeared to be

unsatisfactory while others have given excellent service to the community. An example of problems encountered has been that some of the change-overs between locums have appeared to have taken place without adequate measures to ensure continuity of care. Examples were given of this happening for two patients with melanoma. This matter was attended to but could easily have had serious implications for the patients concerned.

5.5.4 The reviewers concluded that the long term use of locums by the service is inappropriate and is associated with real concerns about the quality of the service and hence patient safety.

5.6 Appropriateness of surgery performed at Grey Hospital

No evidence was presented to the reviewers of surgery being performed at Grey Hospital which was inappropriate for the skills of the staff concerned or the facilities available. It was clear to the reviewers that surgery of high complexity or risk was invariably transferred to Christchurch with its high level ICU and staff with sub-specialist surgical interests. It is the view of the reviewers that this process of transfer is inevitably a matter of clinical judgement. There is no evidence of a pattern of transfer which has been other than in the patients' best interests. There is evidence of an increase in the overall number transferred over time from Grey to Christchurch but this increase appears to be mainly due to an increase in ICU transfers with no evidence of an increase of general surgery patients. The largest category of patients transferred are those with cardiological problems. It is possible that some of the ICU transfer increase may be due to general surgical patients but the numbers of such patients is small and unlikely to be a significant factor.

5.6.1 A number of those interviewed expressed some concern about the range of surgical services offered and thought that the range had got smaller over time. No hard evidence was presented to confirm this. The trend towards transferring complex surgery to a tertiary centre is a possible contributor to any reduction in range.

5.7 Evidence of systems to support safe practice

Guidelines, protocols and patient care pathways are widely used in general surgery units in New Zealand and elsewhere to promote safe clinical practice. No evidence of the use of these processes was presented to the reviewers and no-one appeared to attach great importance to them. The conclusion drawn is that they are not totally absent but rather that they assume a low priority. The same comments would apply to unit clinical audit which is not done in a regular systematic way with peer review. These are areas where gains can be

made quite easily with a high chance of direct patient benefit. The weekly clinical meeting is likely to make a positive contribution.

5.8 Constraints to CPD

There is an obvious geographical isolation factor which does not make it as easy to meet Continuing Professional Development (CPD) requirements as it would in Christchurch or Wellington. However the Board is generous in its leave provisions with a study leave total of 10 days per year plus 5 days travelling time for senior medical staff. This leave may be aggregated for a period of 5 years. The main constraint seems to be the provision of locums although it is very rare for study leave to be cancelled for this reason. It appears that the Board tries hard to get locum cover thus enabling staff to attend conferences and courses. In summary, thanks to the policy about leave for conferences etc. there appear to be no serious constraints to the provision of CPD.

5.9 Other matters

5.9.1 Clinical leadership

This is an important issue for any service but is critically important in this instance since the service has a whole has come under criticism.

The reviewers assumed from the outset that a Department of General Surgery existed and that [redacted] held the position of Head of Department. However [redacted] subsequently informed the reviewers that there was not a Department, as such, and he had never been appointed head. The Chief Executive has informed the reviewers in writing that there is a Department and [redacted] is head of it. [redacted] later informed the reviewers that he does not have a contract as head of department.
The style of leadership has not been popular with all [redacted] However there were also a number of very positive comments about him.. The issue of clinical leadership is considered by some to impact on staff morale and retention and needs to be addressed as a matter of priority. The reviewers were informed that several locums have returned for further locum appointments. The head of department regards this as evidence that his leadership style is not dissuading locums from returning.

5.9.2 Clinical quality

A number of instances of sub-optimal clinical management were reported to the reviewers. It was not in the reviewers' terms of reference to assess whether clinical care was in particular instances, appropriate. In the absence of a well recorded and documented audit over a prolonged period of time it is not possible for the reviewers to make a totally confident statement about whether the service is safe or unsafe.. This rather disturbing position could only be resolved by means of a detailed, time-

consuming and expensive audit which is beyond the terms of reference of this review.

6.0 Relationship with local GPs

6.1 The relationship between the West Coast GPs and Grey Hospital, in general, and the general surgical service in particular, leaves a lot to be desired. Evidence for this is provided by the letters to the DHB by West Coast GPs. The act of writing a highly critical letter signed by all or nearly all the GPs is in the experience of the reviewers, a unique event. There is little contact between the hospital and the GPs and the level of trust is at a quite unacceptably low level. This report relates to the general surgery service only but it appears that the above comments apply to more than just general surgery.

6.2 Locums

The long standing reliance on locums to maintain the service is widely regarded as unacceptable and unsustainable. Good continuity of care is hard to achieve with a regular change over of staff and this was commented on by many of those interviewed. Opinions were expressed also about the variable quality of the locums. The processes for vetting and appointing locums were described as being less rigorous than would be expected.

6.3 Recruitment and retention of permanent staff

This is a problem in the majority of the non-Metropolitan hospitals in New Zealand. A very small minority of NZ trainees are choosing to work in smaller, relatively isolated, hospitals at the completion of their training. The RACS has plans to enable those trainees with an interest in a career in a rural hospital to get training that equips them for such a career. This means that they must get the opportunity, during their training, to experience rural surgery to determine whether working in a hospital such as Grey is right for them and their families. With many spouses pursuing independent professional careers, this has become an issue of major importance. In addition, it is important that surgeons in training acquire the correct skill mix to equip them for practice in a hospital where sub-specialists are most unlikely to be employed and where emergency treatment outside the field of general surgery may be required. This does not mean that they necessarily need to train in neurosurgery and thoracic surgery, for example, but they should have an understanding of the broad principles of trauma care as it applies to chest and head injuries.

6.4 Use of new technology

A relationship exists now with these departments in Christchurch but future developments could see new technology such as telemedicine being used, for example, to aid West Coast surgeons in managing cases of trauma to the head or chest when either time or weather conditions make a transfer impossible or inadvisable. Technology of

the sort developed by Mobile Surgical Services (the surgical bus) using a high speed, high-resolution IT link between an operating theatre and a surgeon at another site, could be very valuable. Such technology could enable a neuro-surgeon, for example, to see the extent of bleeding in or around the brain and advise the best way to carry out effective first aid prior to transfer to the specialist unit. This technology also is effective for enabling clinico-pathological and clinico-radiological meetings to take place between participants in more than one centre. Effective use of this technology will inevitably become part of a rural surgeon's training. The reviewers have been informed that a tele-video link has been established between Greymouth and Christchurch. This link uses dated technology and offers a very limited range of services which is the likely explanation of its poor rate of utilisation.

6.5 Basic trainee registrar

The reviewers are pleased that WCDHB have on the advice of the Head of Department, made an appointment in 2003 of a basic trainee registrar in general surgery. This is seen as a very positive way of introducing a relatively junior trainee to a rural hospital environment. It is vital that appointments such as this should be funded for the foreseeable future so that a clear commitment to rural surgery is evident to all.

7.0 Recommendations

7.1 Permanent staffing of the department

The present arrangement of the department with one permanent and two or occasionally three locum surgeons is unsatisfactory and needs to be replaced with an establishment of three permanent surgeons. The difficulties of recruitment are acknowledged and the problem may not be solvable in the immediate future.

In the short to medium term, other solutions might be possible. For example, as an alternative to one or two permanent appointees, the concept of limited term appointments could be pursued. These could for be for periods of 1 to 2 years or perhaps longer. The present medical indemnity crisis in Australia may present an opportunity to recruit surgeons of age 55+ to such positions. An advertising campaign could be directed at the 200 or so Australian surgeons who have stated their intention to retire from their practices on 1 July 2003 and could be interested in working in NZ for a period. These surgeons could well solve some of the immediate problems of staffing for Grey and other similar NZ hospitals.

The longer-term solution undoubtedly lies with recruiting NZ trained surgeons who want to have a career in rural surgery. The Board can contribute to achieving this aim by:

a) Improving the working environment and job satisfaction of permanent staff by; enhancing regional collegial communication and co-operation, encouraging speciality interests, and improving support mechanisms within the organization.
b) Continuing to fund a basic training post in general surgery;
c) Being prepared to make appointments of surgeons well ahead of their starting date so that completion of training may be achieved knowing that they have a assured job to come to;.
d) Ensuring that salaries and employment conditions are at least comparable with the bigger NZ hospitals.

7.2 Locum surgeons

As already stated, the present use of locums is not serving the Coast well despite the efforts of some individual locums who been regarded as excellent. The following suggestions are made when it is essential to employ locums to maintain an acute surgical service

a) A formal process should be developed for vetting every locum;
b) An appointments committee should be set up for both locum and permanent positions;
c) A process for enhanced supervision of locums should be developed;
d) Audit of their work is essential..

7.3 Clinical isolation

The present situation in which a single permanently appointed surgeon works with a succession of locums is unacceptable and serves neither

the interests of the community or the surgeon. This situation poses a number of problems:

a) The uncertainty of rostering for acute call leaving the single surgeon vulnerable to being on continuous call in the event of sick or other leave occurring at the same time as a gap between locums;
b) The absence of a senior peer for advice and consultation about clinical and other problems;
c) The absence of a colleague to share administrative duties and to provide peer review for ongoing audit;
d) The absence of opportunities to meet with a group of peers for clinical meetings and other CME.

The reviewers recommend the establishment of strong links (perhaps even a joint department) with another larger District Health Board. Opportunities should be explored with Canterbury with whom there are existing links, but it is not necessary to restrict the discussions to one neighbouring DHB. However, it clearly makes sense to have such links with the tertiary hospital to which the great majority of patient transfers are sent. A joint department offers both professional support and also the opportunity for provision of emergency cover in the event of staff absences or shortages.

7.4 Support for Head of Department

The reviewers consider that the present Head of Department has borne a heavy burden of work and responsibility for too long without either senior support or the opportunity to "recharge the batteries". It is recommended that the following steps be taken:

a) Formation of a joint department (see above);
b) Identification of a senior colleague to act as mentor and friend for the Head of Department;
c) Arrange, in the immediate future, a period of study and clinical experience in a large tertiary hospital with a view to developing or enhancing skills relevant to his practice at Grey hospital;
d) Engage in a discussion about his future role at Grey so that a role can be developed that will be stimulating and challenging to him, used his skills and experience and fitting in with future planning for services at Grey.

7.5 Relationship with General Practitioners

This is an area of major concern. The two GP letters provide ample evidence of a serious separation of hospital and primary care on the West Coast. This separation must ultimately result in an effect on the quality of patient care. It must be an immediate priority to develop a plan to close the gap and thus reduce risks to patient care. The reviewers make the following suggestions:

a) Form a liaison committee between GPs, administrative staff of the Board and hospital medical staff;

b) Appoint a GP liaison officer to work on the interface on a day-to-day basis;

c) Take steps to welcome the GPs into the hospital;

d) Arrange regular social events to get hospital staff and GPs together;

e) Indicate strongly to hospital staff that this is a crucial relationship.

f) Consider the development of a regional telemedicine network, linking hospitals and GPs.

7.6 Other matters

7.6.1 **Audit** with peer review is a RACS requirement for meeting Continuing Professional Development criteria for Medical Council of NZ recertification. The RACS identifies a number of forms of audit that are acceptable to it. The reviewers suggest that a clinical unit audit involving all the members of the department is the form most likely to contribute to clinical quality. There is no unit audit of this sort at the present time. This should be implemented.

7.6.2 Credentialling is also a RACS requirement for CPD and it is MOH policy that all Senior Medical Officers should be credentialled. This process has not taken place in the General Surgery service at Grey hospital. This is a requirement that must be implemented.

7.6.3 Senior or chief medical advisor role
There is a rather informal appointment, at present, without a job description and with no salary supplement. Many DHBs make great use of the person in this role and the WCDHB appears to be missing an opportunity to have a senior person who would organise such activities as appointments committees, audit and credentialling and generally provide high-level advice to management. The reviewers recommend that this role be developed in the very near future. The reviewers are delighted to hear that progress has already been made in this respect.