# 2007/08 Financial review of the Whanganui District Health Board

Report of the Health Committee

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Recommendation
The Health Committee has conducted the financial review of the 2007/08 performance and current operations of the Whanganui District Health Board and recommends that the House take note of its report.

Introduction
The Whanganui District Health Board’s district is sparsely populated, and includes the Wanganui and Rangitikei Territorial Authority areas, and the Ruapehu Territorial Authority area wards of Waimarino and Waiouru, known as South Ruapehu. Its population has a larger than average percentage of Māori (23 percent), many of whom are under 15 years of age. The district health board (DHB) operates one major hospital and three rural health centres.\(^1\)

The DHB has been the subject of several negative reviews in recent years, including one concerning failed sterilisations, and a clinical services review by the Ministry of Health. Its women’s and children’s health services were criticised in a report by the Health and Disability Commissioner in February 2008.\(^2\)

Financial Performance
In the Office of the Auditor-General’s assessment, the Whanganui DHB received a “good” grade for its management control environment, and a “needs improvement” grade for its financial information systems and controls. The Auditor-General’s report recommended that deficiencies in the payroll and general ledger systems required some attention.

We note that as at 31 December 2008, the DHB had a deficit of $6.771 million, which is $1.108 million more than projected for the period. The ministry also gave the DHB a capital injection of $3.2 million during the financial year. The Crown Health Financing Agency regards the DHB as being at risk because of its negative operating cash flows, which need continual support. The extent of the underlying operating deficit necessitated a “letter of comfort” from the Ministers of Health and Finance, stating that the DHB was still a going concern.

The ministry allocated capital funds of $8.8 million in equity toward the original cost of the DHB’s major hospital redevelopment (the Health Services Redesign project). There is an estimated budget overrun of $3.75 million on the project.

We are concerned to hear about the DHB’s growing deficit, and look forward to hearing of improvements to its financial management.

\(^1\) Rangitikei, Taihape, and Waimarino.
\(^2\) Health and Disability Commissioner, “Dr Roman Hasil and Whanganui District Health Board 2005-2006”.
Governance

The Whanganui DHB is under “intensive” monitoring by the ministry and has two Crown monitors to help it with governance. We note several changes of personnel in key management positions during the year in review. We consider that this has contributed, with the governance issues, to difficulty in developing an effective plan to improve the deficit.

We consider that an important focus for the DHB’s board and new management should be to develop a credible plan to turn the deficit around.

Public perception of the DHB

The DHB told us that the public’s perception of the board and its hospital was still poor, and it would take time to restore local confidence and rebuild its national reputation. It acknowledged serious performance problems in the recent past, but said it was making many systems improvements. Many of these changes are related to the National Incident Management Strategy, which provides a framework for managing adverse events.

The DHB said that referral rates were no lower than normal, and there was no evidence that people were going elsewhere for gynaecological or other services as a consequence of negative public perception.

Staffing pressures

Given the DHB’s recent problems, we asked if staff morale was affected, and whether that had affected the DHB’s ability to recruit good-quality staff. The DHB acknowledged that staff morale had initially been affected, but it had improved because the hospital was now almost fully staffed, and consequently there was less stress.

The DHB explained that, like many other provincial DHBs, the Whanganui DHB struggles to attract and retain medical staff. It is particularly dependent on overseas medical graduates, and most of its surgical team are locums. We noted that reliance on locums was not clinically or financially sustainable, but the DHB pointed out that overseas graduates often want to come to New Zealand temporarily, and subsequently decide whether to settle. The DHB advised that it had been discussing sharing registrars with MidCentral DHB.

The DHB reiterated that it would not provide services if there was any question of compromising patient safety. In that situation a service would be suspended until staff numbers were sufficient.

We were pleased to hear that the DHB’s staffing pressures had eased somewhat, and that it had a full complement of surgical staff.

Ratio of national to international staff

The DHB told us that four of its 42 specialists were trained in New Zealand. Despite a recent increase in their numbers, there were still not enough students being trained for the DHBs to increase their ratio of New Zealand staff. It noted that there was an international marketplace for medical staff, and there were better research facilities, pay rates, and working conditions elsewhere in the world. It was expected that a percentage of New
Zealand’s graduates would go overseas and some would never return. The DHB believed a medical bonding scheme would offer only temporary help, and solely with junior doctors. Some specialities require further training abroad. The DHB commented that the contribution of overseas graduates was positive in many ways.

**Performance against health targets**

While we were encouraged by staffing improvements, we asked whether full staffing would bring an improvement to the volume of discharges delivered by the DHB. We were pleased to hear that discharges are currently running at 106 percent of contract, so there has been a significant improvement. The DHB told us it has made a commitment to increase its discharge figures again in 2010. It considers that it will be able to do this while improving its financial performance.

**Quality improvement initiatives**

In describing its quality improvement initiatives, the DHB focused on the National Incident Management Strategy, because it believes managing its adverse events will help it to restore public confidence. This strategy involved collaboration with other DHBs as well as internal measures. Improving communication at the handover of clinical documentation was an internal priority for the DHB, as this was the area where most errors occurred. It was also standardising processes and equipment, to reduce variability and the potential for error. Though inherently difficult, the DHB was adamant that this was a worthwhile project. It expected clinical leadership and support for system improvements from all staff, and planned to restructure its clinical governance framework, including its Centre for Patient Safety and Quality. Best practice guidelines for all specialities were being developed.

We referred to a Health and Disability Commissioner report discussed in the last committee review, on failed sterilisation procedures undertaken by a former surgeon. We were anxious to know how this procedure is being monitored, and were assured that all sterilisations are being audited externally.

**Collaboration**

The DHB has been encouraged to collaborate with MidCentral DHB and we asked about the progress of the collaboration, and how extensive it might become. While the DHB had only just received formal approval for its alliance with MidCentral DHB, background and planning work had been going on for some time. The collaborative model is based on that of Otago and Southland DHBs, and will address clinical networks before administrative ones. The board is aware that for the collaboration to be successful long term, it needs to be clinically led.

Work has begun on collaboration in the women’s and children’s services. A proposal for a joint clinical director for the women’s services departments has been accepted, and the position advertised. In the children’s department, the current shared clinical network was continuing, but other forms of collaboration have not yet begun.

We asked how high-risk obstetric cases were to be handled and neonatal facilities shared under the new configuration. The DHB reiterated that the collaboration is clinically-led and there are guidelines for high-risk patients. It will rely on early recognition of issues, discussion between clinicians, and correct transfer and access procedures. This work was
already being discussed. It said that its baby unit was part of a well-established neonatal network. High-risk cases were transferred either to MidCentral or to Capital and Coast DHB.

The DHB is committed to sustainable change, with the support of its staff. The public will be consulted on the DHB’s collaboration during its normal district strategic plan consultation round.

The DHB commented that a national workforce project led by District Health Boards New Zealand on the DHBs’ behalf was nearing completion, and it would prefer that the ministry support that programme, rather than any alternative project that might cut across its expected benefits.

**Primary Health Organisations**

We were interested to hear about the district’s primary health organisations (PHOs), and whether they have met the DHB’s population health targets.

The DHB told us that it had one very large PHO, and a smaller Māori provider. Both organisations have dynamic leaders, and they work closely together. The DHB has a very good relationship with them, and believes that its PHOs are seen as leaders in the field. Both providers offer chronic disease outreach and diabetes programmes, and are doing elective work on skin lesions.

Although the DHB told us that its immunisation rates were some of the best in the country, we noted that it had not met its immunisation target, and that it could not provide evidence of its high rates because of technical problems. We expressed our concern about the inaccuracy and unreliability of the DHB’s immunisation data. We realise that the lack of data is not peculiar to this DHB, and would like to see reporting in this area improved generally by the next review.

**National and local government support**

We noted the DHB’s problems with clinical and financial sustainability, and asked what kind of Government, ministry, and national support would be of assistance.

The DHB pointed out that it had recently made extensive submissions to the Medical Council on the supervision regime for overseas graduates. While it supported the council’s proposals generally, the DHB considered it essential that the council’s objectives be met in a flexible way. The DHB noted that the ministry has been supportive in giving it realistic financial targets. It suggested more national consistency would help, along with a new national IT system. A simpler, less onerous accountability reporting system would also be appreciated. The attitude of Government and national organisations towards helping the DHB make the best use of its financial resources is important.
Appendix

Approach to this financial review
We met on 1 and 8 April 2009 to consider the financial review of the Whanganui District Health Board. We heard evidence from the DHB and received advice from the Office of the Auditor-General.

Committee members
Dr Paul Hutchison (Chairperson)
Hon Ruth Dyson
Dr Jackie Blue
Hon John Carter (from 11 December 2008 until 18 February 2009)
Kevin Hague
Hon Luamanuvao Winnie Laban
Iain Lees-Galloway
Eric Roy (from 18 February 2009)
Nicky Wagner
Michael Woodhouse

Evidence and advice received
We considered the following evidence and advice during this financial review:
Whanganui District Health Board, Statement of Intent 2006/07–2008/09
Whanganui District Health Board, Responses to questions, received 30 March 2009.
Office of the Auditor-General, Financial Review Briefing to the Health Select Committee, dated 1 April 2009.
Organisation briefing paper on the Whanganui District Health Board, prepared by committee staff, dated 16 December 2008.