Te Whatu Ora
Health New Zealand

08 July 2023

Ms Morag McDowell
Health and Disability Commissioner

Email: hdcresponses@hdc.org.nz

Kia ora Ms McDowell

Complaint: **Commissioner Initiated Investigation Southern District Health Board Cancer Services**
Your ref: **C22HDC01310**

Thank you for your final decision regarding your investigation into our non-surgical cancer services, including delays in patients obtaining first specialist assessments (FSAs), over the period of 2016 to 2022.

This report provides an update on the implementation of recommendations made in your report dated 12 April 2023.

We note that you found that we failed to provide services to patients within the Southern Blood and Cancer Service (SBCS) in a manner that minimised the potential harm to, and optimised the quality of life for those patients, and therefore that we breached Right 4(4) of the Code.

Te Whatu Ora has been aware of the long-standing issues in the SBCS prior to these being highlighted by the commissioner initiated investigation and subsequent report. As a result, many actions have been taken and continue to be undertaken to help improve the provision of cancer services in the southern district. It is important however to acknowledge that more should have been done earlier, and that despite increasing staffing by over 25 full-time equivalents (FTE) and agreeing a $2M investment in 2021, the inability to recruit into key senior medical officer (SMO) positions across the SBCS has had a negative impact on provision of services and on our staff, patients, whanau- and community.

Response to the report recommendations

a) Establishing a single point of contact

We were asked to consider establishing a system that provides a single point of contact for patients who are on the waiting list for first specialist assessment (FSA) (refer to point 146 a) on page 26 of the report).

We are pleased to report that we have successfully recruited to three patient navigator registered nurse roles (2.0 FTE) fixed term for one year. The post-holders took up these positions on 19 June 2023. They will integrate into the Cancer Nurse Coordinator team for support and guidance. The establishment of these navigator roles provides a single point of contact for patients who are waiting to be seen and provide an avenue for their continued assessment while waiting.

To inform our patients about the patient navigators and their role, we have reviewed and updated our referral receipt letter in consultation with the Community Health Council (our committee of patient, whānau and community representatives). The letter is easier to read and informs patients we have received their referral, the expected wait time, and apologises for any delay in providing an appointment. We have included a direct contact number for, and availability of, the patient navigator team, and explained the support the team are able to offer (please refer to appendix A for a copy of the letter template).

The patient navigator service is operational from July 2023.

An additional 0.2 FTE psychosocial support has been allocated to the cancer psycho-social Service (CPS) to ensure the availability of staff over the full week from 8.30 - 17.00 hours instead of Mondays to Thursdays. Providing further psychosocial support capacity to our patients and whānau experiencing distress as well as to our wider staff group if they require support themselves.

b) Implementation of SDHB review and EY report recommendations

We were also asked to provide an update on the implementation of the recommendations of the Southern District Health Board (SDHB) Review 2021 and the Ernst Young (EY) report of 2022 (refer to point 146 b, page 26 of the report) with reference to the following:

i. Progress with the design, implementation and embedding of an accountability and performance framework

The SBCS has commenced an evaluation, initially in Radiation Oncology, to collate current performance reports, to validate the data sources from which these reports are generated and to assess the value these reports contribute to performance monitoring. The output of this evaluation will be used to strengthen the performance framework, develop meaningful key performance indicators (KPIs), embed a clear process of escalation, and establish clear lines of communication and accountability.

Currently referral figures and wait times are regularly presented in each speciality service meeting. It is important to ensure this information is communicated to staff so that patients, referrers, and multi-disciplinary meetings can be informed of expected wait times . Presenting this information at the service level also provides an opportunity for staff to contribute to the narrative of key messages that need to be communicated up through the organisation's reporting channels.

Wait list information is monitored to assess service risk, quality, and performance. Through monitoring and escalation, a range of operational changes can be considered, for example, within radiation oncology, increased outsourcing and contracting additional locum resource have been utilised. There are also regular operational meetings held with SBCS clinical leaders (across all professions) and Te Aho o Te Kahu to review wait times and service performance against national targets. We report centrally to Te Aho and have shared wait list information across our regional and national networks to help Te Whatu Ora begin to understand national capacity. We hope that this will then help inform where potential pathways could be established to support Southern.

The SBCS provides regular fortnightly reporting through to the senior leadership and the Medicine Women's and Childrens Directorate Leadership team (General Manager and Clinical Leads) presents back to the wider District leadership team at the monthly performance and accountability meeting – this includes a precis of service quality, risk and performance. Recently an update and presentation were given to the Clinical Council.

Radiation Oncology has been highlighted at the National Tertiary and Quaternary group meeting and is being monitored and overseen by this group as a vulnerable service. Resulting from this, a national working group has been established with the purpose of:

- Moving towards the formation of a national clinical network bringing together the Radiation Oncology Working Group (ROWG), Te Whatu Ora and Te Aho o Te Kahu;
- Working towards forming a robust retention and recruitment strategy, including new trainees, international campaigns, International Medical Graduates (IMG) strategy, recruitment, payment, and retention incentives. The impact and complexity of on-boarding IMGs will need careful consideration, given the inherent supervision requirements.
- Developing closer engagement and partnership with private providers, Australasian engagement and developing regional and national variance response plans to support vulnerable localities, including interim clinical pathways to support Southern district;
- National consistency on referral and access criteria, waitlisting, clinical treatment protocols, service job sizing, contracting.

ii. The establishment of a clear clinical governance framework to address deficits in risk management and clinical governance and including appropriate quality and performance KPIs of the services with improved reporting mechanisms through to the Clinical Council

Work is continuing to embed our organisational clinical governance framework within the SBCS. Monthly meetings are held by each service and representatives from each staff group attend. The standing agenda covers: Performance and Capacity, Staffing,

Workforce Development, Consumer Feedback, Patient Safety, Quality Improvement, Health and Safety.

Risk management, including the regular review of risk assessments within our electronic platform “Safety1st”, will be introduced into these meetings. All key issues, updates and risk mitigation/controls are updated at the monthly Performance and Accountability Meetings and highlighted in the fortnightly reporting.

The use of Safety1st as an incident/adverse event and ‘near miss’ reporting tool is encouraged and is routinely used across the service. Instances of patients coming to harm within the service are recorded in Safety1st, reports are investigated, an assessment of harm is made, and preventative actions are agreed and implemented as needed. The use of Safety1st ensures there is visibility in the established clinical governance systems within the organisation, including the Clinical Council. In addition, clinical risks that are identified at a Service level are reported up through the Risk Assurance Committee to senior leadership and up into Regional and National risk reporting networks.

iii. The cancer services recovery plan

The foundations are in place for the SBCS to be able to recover once permanent SMO positions have been recruited to. In the interim, efforts continue to stabilise the current service to ensure our patients can access treatment, to avoid further deterioration of FSA wait times in both radiation and medical oncology and to support staff well-being.

It has become evident that any such recovery would need to consider a regional view and as such, we have initiated the formation of a Regional Operational Working Group. The purpose of this group has been to:

- Look towards establishing low volume tumour streams (and as such vulnerable) such as gynaecology, central nervous system and head and neck regional pathways.
- Decompression strategies – 1. maximising support and capacity nationally. 2. Improving/maximising Linac treatment capacity across Te Waipounamu, 3. Improve staffing and working towards aligning processes / fractionation, wait lists and standard operating procedures.
- Advocacy/business case for Linac replacement and expansion programme for Te Waipounamu region (increasing new Linac capacity to meet population demand for the future).
- Develop a coordinated clinical and service network support/representation for Te Waipounamu to ensure the views and needs of the South Island are clearly represented.
- Advocate for changes to the National Travel Assistance (NTA) scheme to ensure this reflects the increasing costs of travel and accommodation for those patients who are asked to travel to receive care.

Te Whatu Ora
Health New Zealand

iv. Implementation of a three-year workforce plan for the Southern Blood and Cancer Service (SBCS), incorporating the recommendations from the EY SBCS Action Plan and considering the work capacity of each FTE and the geographical demands of the area, and allowing for the non-clinical duties of clinicians.

In 2021 – 2022, 25 new staff were employed in the Southern Blood and Cancer Service in response in part to some of the recommendations in the EY report and the $2M Board investment.

The recommendations from the EY SBCS Action Plan have been completed as outlined in the following table.

EY recommendations SBCS Action Plan

Category	Recommendations		Action
Workforce (recruitment and retention)	Primary-intermediate	*1. Add two Booking Clerks, one non-clinical administration staff and one typist for SBCS, to ensure there is sufficient administrative support for the increased medical FTE planned for FY22 and corresponding increases in workload, given the following considerations:*	4.0FTE additional Admin introduced in April 2022. MOSAIQ Administrator 0.5FTE Booking Coordinators 2.0FTE Med Transcription Dunedin 1.0FTE Med Transcription Southland 0.5FTE **TOTAL 4.0FTE** In addition to this Te Whatu Ora Southern has had a dedicated Business Analyst working to enhance and automate Power BI analytics and reporting.
		2. Increase nursing staff FTE by an additional 2.0 to ensure there is sufficient corresponding nursing to match the increased medical FTE planned for FY22 and corresponding increases in workload.	2.0FTE additional Nursing was introduced in April 2022. **Nursing FTE split:** HCA Southland 0.05FTE HCA Dunedin 0.5FTE CNC Dunedin 0.2FTE Reduce CNC Southland - 0.2FTE Increase ACNM Southland 0.2FTE RN Dunedin 0.7FTE

Te Whatu Ora
Health New Zealand

Category	Recommendations		Action
		• *Based on considerations similarly to increased administrative FTEs, an uplift of 4.0 FTE total in Registered Nurses appears to be sensible, as the midpoint between 1.1 and 8.8 additional Nursing FTE calculated from the ratio modelling. This considers that the service has already planned to increase 2 FTE nursing staff in the FY22 uplift.* • *Distribution of this Nursing FTE in terms of speciality and location should be further discussed with the service.*	RN Southland 0.55FTE **Total** **2.0FTE**
		3. There needs to be prioritisation of recruitment of the remained budgeted FTE for FY21 (e.g., 1.375 Radiation Oncologists) and succession planning, particularly in Radiation Oncology, with recruitment efforts started in the short-term given the imminent retirement of three out of five Radiation Oncologists.	We continue to actively recruit and are pursuing a number of candidates. **Radiation Oncology** Currently 5.5FTE (4 SMOs) Budget of 8.7FTE (increased from 7.6FTE since EY report) - actively recruiting for up to 3 more SMOs. As of 18 June 2023: • 1.0FTE international candidate accepted offer – progressing to confirm start date. • 2.0FTE being interviewed – progressing to offer and reference checking • 1.0FTE fixed term locum July – Sept 2023.

Te Whatu Ora
Health New Zealand

Category	Recommendations		Action
			• 2 x part time locums (Auckland based) providing a combined full time equivalents FSA workload per week. • Waikato SMO covering four 4-day periods per month from July-October to see FSAs and on-call cover. • Auckland SMO monthly locum cover Fridays to cover on call and additional FSAs/FUs starting 21 July. • Further recruitment options on the horizon from recruitment agency to explore permanent/locum. • There has also been 2 x EOI from Australia following the recent initiative to write to all Australian head of departments. 1.0FTE locum under offer to begin September 2023 As part of the National Network, Southern has also had a number of individual SMOs providing short term locum cover to help support Southern's waitlist but, more importantly, help support local staff wellbeing and allow ongoing annual leave and continuation of CME leave. This also has the added benefit of continuing to publish a 1:5 on call roster so as not to burn out remaining staff. In addition to the immediate RO SMO deficit, one RO is retiring at the end of 2024 and a second has provided an early indication of retirement in the coming years, therefore recruitment efforts continue to be a priority and will be on-going. **Medical Oncology** Currently 7.23FTE budgeted variance of -0.8FTE. As of 18 June 2023

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			• Offer to candidate from Australia in final stages of recruitment for employment Jan 2024 • 1 locum through until July covering SMO due to return from parental leave in October • Ongoing advertising and recruitment for permanent, fixed term, locums • Recruitment ongoing. **Haematology** Currently 8.31 FTE (no vacancy) • After a lengthy period of 1.0 to 1.5FTE vacancy the department is fully recruited and has +0.5FTE over budget from 2024 when a new SMO starts. • Current 0.5FTE fixed term SMO employed until new SMO starts in 2024.
	Primary – medium term	*4. There should be an uplift of allied health resourcing and psychosocial support to better deliver a multidisciplinary team (MDT) model of care to improve patient experience and outcomes.*	Recently (May 2023) there has been a fixed term increase 0.2FTE of psychosocial support to allow patients to be better supported Monday to Friday whilst wait times have increased. This has enabled greater presence by the CPS team regularly attending MDT and ward meetings in Dunedin. The SBCS has identified further dedicated dietitian input into the service would be greatly advantageous, however the limited capacity of the current Dietetic Service struggles to meet this need.
		5. Information systems (IS) and processes need to better serve cancer services through	Te Whatu Ora Southern is currently exploring a digital solution to track the progress (pathway) of cancer patients through their diagnosis, treatment, and surveillance activities.

Te Whatu Ora
Health New Zealand

Category	Recommendations		Action
		enhanced integration and resiliency. Improved DHB Information Technology (IT)/IS engagement with the SBCS is required to achieve this. Dedicated IT support capacity should be prioritised given the IT/IS needs of the service.	This solution would show a summary of all patients currently being managed by the service (whiteboard) as well as the detailed care plan of each patient. The solution would support multiple different cancer pathways; however, each pathway will adhere to the same high-level workflow steps, registration, diagnostic, decision, treatment, and surveillance. This proposal has been worked up with Te Aho to Te Kahu / Cancer Control Agency and Te Whatu Ora Southern and needs to be considered in the context of the organisation's digital transformation. In Oct 2023 Southern will transfer onto SIPICS – the South Island wide patient information system that will provide opportunity for a regional view of patients waiting and provide improved cancer tracking capability.
		6. Continuing support of existing roles to support access and outcomes for Māori and Pasifika such as community Māori cancer navigator roles.	Recently (April 2023) 3 Patient Navigator roles (2.0FTE) have been funded to support patients waiting for FSA. Further work needs to be done to support this new service and existing staff focus on Māori and Pasifika. Te Whatu Ora Southern has developed a waitlist prioritisation tool to objectively prioritise patients on our inpatient and outpatient waitlists. The tool can be weighted by acuity/wait time, ethnicity, number of ED presentations and deprivation. These, factors present a reprioritised waitlist based on risk which can be used by booking administrators when booking patients. SBSC will be reviewing this tool to see if this could benefit the equity of outcomes and access to services for our Māori and Pasifika population. CPS are currently seeing 9% Māori and Pasifika within their workload, which is the anticipated proportion for the region.

Te Whatu Ora
Health New Zealand

Category	Recommendations		Action
			Additionally, CPS are providing more clinics in out-of-town regions – a new clinic in Queenstown, monthly clinics/home visits in Oamaru and developing them in the Balclutha region and Gore.
	Secondary	*1. Increased emphasis on increasing Māori and Pasifika workforce, and specific roles to address access to healthcare services (which may be broader than SBCS) and outcomes for these population groups, that may include co-design of healthcare services and models of care.*	Te Whatu Ora is working with Well South Maanaki team, which is a team of dedicated Māori staff who are contacting Māori and Pasifika patients one week prior to their hospital appointments. Although this does not yet include SBCS patients, some of the key learnings from this service will be adopted and considered as part of the new SBCS navigator service. Southern Pasifika Mapu o le Kahau Pasifika Young People of the Future Programme was launched in June 2023 and received interest from 42 Pasifika secondary students to find out more about careers in health. This initiative will receive support to continue into the future.
		2. Consider the role of a telehealth coordinator (administrator role) to support better utilisation of telehealth at SBCS.	Southern has a telehealth coordinator in place. They support the telehealth clinic requirements in terms of the clinicians and patients, booking / streamlining appointments, checking equipment and connectivity all of which ensures the clinics run well. The telehealth coordinator is undertaking a project with Information Technology to identify, log and resolve issues related to telehealth across the SBCS. Note: nothing (material) seems to have resulted as yet. We still have very poor IT systems across the whole district. Telehealth to/from Southland is technically poor with frequent difficulties with audio and visual streams. Whilst we experience technical

Te Whatu Ora
Health New Zealand

Category	Recommendations		Action
			challenges there has been a shift to delivering greater than 5-7 virtual FSA's per week This has added 1.0FTE FSA capacity to the service. (typical FSA caseload for 1.0FTE Radiation Oncologist is around 5 FSAs per week.
	Dependencies	*Consideration actions to maximise benefits within key dependencies that allow expansion of workforce including:* • *Private laboratory that does not provide placements for Haematology trainees.* • *General medical registrar numbers at SDHB, which is the pool from which Medical Oncology and Haematology registrars may be taken from.* • *Nursing at peripheral centres on whom the service is dependent for administration of chemotherapy, and CNS practice at these peripheral centres, and subsequent requirement for increased workforce centrally (in Dunedin) to adequately supervise and*	Southern acknowledges these key dependencies and considers all implications on workforce as part of annual service planning and to respond to the changing needs of our workforce and community population. There is a 27% deficit in required numbers of Med Reg/s RMOs for Q3 2023. This has been identified as an organisational risk being managed by CMO and RMO Unit, together with all Medical Clinical Directors, as mitigations to manage this situation. Uncovered leave periods -no cover when registrar on night shifts. Risks to registrars if denied leave (fatigue, burn out, increased error risks). There has been a programme to establish a Te Waipounamu/ South Island training programme for basic internal medicine physician trainees which will come into effect from January 2024. SBCS provides all training, oversight and supervision for our rural network of nurses that deliver infusion and oncology services across the district. They link into Southern's central education sessions that run weekly. Southern has also employed a dedicated rural nurse coordinator to provide ongoing remote support to those rural sites on their specific treatment days.

Te Whatu Ora
Health New Zealand

Category	Recommendations		Action
		support this workforce delivering services rurally.	
Workforce structure and organisation	Secondary	*1. We heard from other cancer centres about the success of different leadership arrangements, for example, having non-medical leadership arrangements for some teams and rotating clinical governance.* *There should be consideration of trialling alternative forms of leadership, in discussion and agreement with SBCS staff.*	SBCS has introduced a new fixed term Quality and Performance Manager (QM) which, in partnership with the Service Manager and Clinical Leadership Team, provides good clinical governance oversight of the departments within the service. Although the recent focus of this role has been to support immediate risk mitigation in RO, the purpose of this newly established role is to provide wider support across SBCS. Clinical lead roles are currently in place for a fixed tenure of three years. Alternate forms of leadership are always being considered, as evidenced through other medical specialities. SBCS will continue to consider options for the future, in particular as the changes within Te Whatu Ora become clearer and the establishment of National Clinical Networks evolve.
Workforce model	Primary - immediate	*1. There needs to be adequate staffing to allow staff to use their designated proportion of non-clinical time, as utilisation of this requires appropriate levels of staffing to balance clinical workload commitments.* • *As staffing increases, consideration of the size of an FTE, and the balance between*	The HDC report identified the expressed conflict between clinical staff and the previous SDHB senior leadership and CEO. This extended to the decision to remove Non-Clinical Contact Time (NCCT) and apply an increase of 15 hours to the Radiation Oncologists job size (55 hours per week). This increase in FTE, as well as a recruitment and retention allowance, was introduced due to unsuccessful attempts at recruiting RO to the department, to help attract and retain staff and to help meet patient demand.

Category	Recommendations		Action
		clinical and non-clinical time should be revisited, with the aim for 70% clinical time on average.	MO SMOs have virtually no protected NCCT. There is standard recompense to clinicians for substantial additional FSA clinic work. There is no agreement around "additional hours per week" in MO. NCCT continues to be a challenge with current staffing levels in Southern. In addition, much of the teaching for other staff groups is provided by SMOs which creates an additional burden of time/work. We will use the appraisal and work planning annual meetings to individually explore how we can support SMOs to identify NCCT. Nursing: Non-clinical for nursing includes regular weekly in-service education, professional development hours pro rata as per the NZNO MECA. Essentially nurses working in clinical roles do not get much non-clinical time as expressed in their collective agreement.
		2. There should be continued support of current training programmes/pathways for medical staff, oncology nursing, and for advanced training (e.g., for CNSs and Nurse Practitioners). *• However, we recommend that SBCS should endeavour to*	Medical staff: The challenges in providing staff with adequate NCCT has impacted CME, however course and conference leave has always been supported as Southern recognises the importance of ongoing professional development and supporting staff wellbeing. All staff continue to attend regular training opportunities and conferences; however, it has continued to remain challenging to represent the department

Te Whatu Ora
Health New Zealand

Category	Recommendations		Action
		ensure that staff engaging in advanced training programmes will be provided employment in these roles at the end of training.	adequately on regional and national forums due to staffing pressures. Training of Registrars is at risk across all disciplines as Te Whatu Ora experiences significantly reduced numbers of RMOs, with Southern currently 27% short of their expected cohort. This has increased the workload for SMOs and decreased the graduating workforce. The future of Radiation Oncology RMOs in Southern is vulnerable after a recent review is that is likely to revise accreditation status due to the lack of suitably qualified staff available to train and supervise. Oncology/Advanced Nursing: The Cancer Nurse Training Programme targets nurses new to cancer nursing which promotes and supports rapid knowledge and skill development. It is a rotational programme over 12 months, covering oncology, haematology, and radiation oncology clinical placements, with basic certification in both chemotherapy and radiotherapy competence. There is a programme running currently. This is a retention strategy. Advanced training programmes continue as new FTE permits, such as the registered nurse to clinical nurse specialist two-year programme, which has both clinical and academic requirements. There is a candidate currently undertaking this training with a second one possible soon. This is a career pathway and retention strategy.
	Secondary	*1. There should also be continued support for*	We continue to provide support to Radiation Therapists to develop their scope of practice. For example, in addition to

Te Whatu Ora
Health New Zealand

Category	Recommendations		Action
		opportunities for increased scope of practice for RTs.	undertaking clinical review of patients during their course of radiotherapy, we have an RT Specialist who has started to see patients who have completed their course of radiation therapy for their first follow up appointment under supervision of the Radiation Oncologist. We recognise we could do more in this area. Opportunities for role development for Radiation Therapists will be considered carefully as part of service planning to ensure that we have an appropriately skilled workforce to help deliver our plan.
		2. There was some feedback that nurses at rural centres may face unequal opportunities for professional development and career progression compared to nurses placed centrally, and SDHB should work with commissioned NGO sites to ensure appropriate training and clinical development opportunities for rural staff where possible – noting that staff in these centres are employed by DHB commissioned providers.	Nurses located in rural sites including Invercargill, Balclutha, Oamaru, and Dunstan have an avenue for ongoing cancer related education via weekly virtual education sessions. In addition, training and certification for cancer nursing competencies is centrally managed by the SBCS, as the district cancer centre. And, lastly, the SBCS nursing service holds an annual study day specifically targeting primary, community and NGO nurses to improve their knowledge of cancers, treatments, and care. The contribution of SMO staff is integral to providing many of these events and it is acknowledged their support is provided on a voluntary basis.
	Dependencies	*Consideration of key dependencies: Psychosocial and allied health currently have*	There has been a temporary increase in psychosocial resource to support any patients waiting for FSA. This is a

Te Whatu Ora
Health New Zealand

Category	Recommendations		Action
		shared roles across medical specialities, and some more designated FTE specifically for oncology should be considered, as currently they are not dedicated to this service.	dedicated resource The team have also provided in-service education for the SBCS. The service has identified further dedicated dietitian input into SBCS would be greatly advantageous, especially in HN cancers, however the limited capacity of the current Dietetic Service struggles to meet this need currently.
Other activities	Secondary	*1. Additional focus should be given to ongoing learning & development opportunities for clerical staff (e.g., MDM roles) and sufficient career progression pathways and opportunities within roles to tailor responsibilities depending on preferences.*	There is a lack of opportunity for learning and development for administration staff compared to health professionals. In-house – all staff are encouraged to learn each other's roles as a way of being skilled across the administration work. Individual requests for learning opportunities or areas of interest are supported. As an example, with the development of the Telehealth Coordinator, which was an area of strength for one of the administration team and a clear need for the service. Essentially, he was given a mandate to work through requirements and resolutions to any issue arising.
	Dependencies	*Consideration of key dependencies to allow expansion of service delivery includes ensuring sufficient physical space to allow current and future delivery of services (both inpatient and outpatient). This was highlighted as a critical area during all staff engagement, and one immediately impacting patient care due to lack of private areas*	Southern has invested in clinic space refurbishments in FY 22/23 (covered below) and will continue to work with the Building and Property team to ensure a fit for purpose environment into the future. However, space remains a critical problem. The current building is at capacity already with no additional space identified for future provision of additional clinics and increased staff numbers.

Te Whatu Ora
Health New Zealand

Category	Recommendations		Action
		for consultation with patients, and this issue will be exacerbated by increased workload associated with workforce expansion.	
Strategic	Primary - immediate	*1. It is critical that there is adequate space for service delivery in both inpatient and outpatient settings, as described above.*	To date expansion has occurred to clinic spaces x 5 by decanting the SMO teams to an alternate space outside of the Oncology and Haematology building which is sub-standard. Additional staff space within the Oncology Day Unit will be made possible by reducing the waiting room size to provide a new office area. This work commenced in June 2023. This change also reflects our space limitations and is a compromise which results in patients being closer together. A refurbishment of some of the oncology second-floor staff areas should make better use of the space and provide hot-desk space for some future proofing for additional staff. Future review of space will be undertaken, particularly considering the New Dunedin Hospital and the necessary requirements to enable the SBCS to safely operate when they are separate from the new hospital site.

In addition to the tabulated recruitment above, the Southern region now has one of the most well-resourced radiation therapy delivery teams in New Zealand. This means that for anyone requiring radiation therapy following their FSA, radiation therapy can commence within recommended guidelines. There is seldom any significant delay or capacity constraint that contributes to the commencement of radiation treatment.

Unfortunately, improved FSA wait times for patients have not been realised in Radiation Oncology, as we have been unable to recruit into permanent SMO positions. FSA wait times have been largely kept reasonable through the locum and outsourcing arrangements in place.

This is also the case for Medical Oncology which has ~1 FTE vacancies. As per the EY report, medical oncology has never achieved full SMO staffing. The department will be at its best resourcing level when a new medical oncologist commences in 2024 and will be fully recruited to budget. After the publication of the EY report, medical oncology have experienced increased workload created by the introduction of immunotherapy for lung cancer and have had to assume additional work from both CNS and prostate tumour streams which are unable to be done in the RO service. As a result, Southern continues to stay active in the recruitment market.

Only recently has our Haematology SMO team been fully recruited to, after a lengthy period of carrying 1-1.5 FTE vacancies. From 2024 when the new haematologist starts the department will be over recruited as per the EY recommendations.

A series of interim measures have been introduced to improve access, manage escalating waitlists and to support the wellbeing and burden on incumbent staff. We have:

- Employed two regular radiation oncologists that provide telehealth FSA and virtual management of a selected group of less complex patients.
- Contracted with private facilities in Christchurch and Wellington for a select group of patients requiring radiation therapy that can and are willing to travel.
- Employed visiting radiation oncologists from other public hospitals around New Zealand to support the acute and on call cover burden and see new patients.
- Employed one fixed term medical oncologist from overseas to provide some maternity leave cover.
- Employed a short-term radiation oncology locum, arriving from overseas in July, who will stay until September 2023.
- Employed two part time radiation oncologists to visit Dunedin each month to support the acute cover, on call and manage their own FSA caseload.
- Employed 0.5FTE fixed term Haematologist until the permanent haematologist starts in 2024.
- Established a range of interim pathways across New Zealand to support vulnerable tumour streams.

Existing staff have also increased their hours of work to manage more patients as they are able, however, it is recognised this is neither sustainable nor desirable.

Over the longer term, Te Whatu Ora is committed to exploring all local, regional, national, and international avenues to build SMO capacity. We have initiated and are leading both regional and national working groups that, amongst many other actions, is focused on supporting our region and the wider vulnerability of oncology services up and down the

country. We are also participating in an international recruitment campaign for the Te Waipounamu region, assisted by a recruitment agency.

Much of the senior clinical and managerial team's time has been dedicated to SMO recruitment. All previous recruitment contacts have been reviewed to assess if any suitable candidates can be approached. Haematology have recruited to its vacant post. Medical oncology have recruited to one of its vacant posts and continues to stay active in the market. A further 1.0FTE is the minimum SMO staffing requirement for the medical oncology service to reach a level where it is no longer the most poorly resourced in New Zealand.

Radiation oncology continues to advertise vacancies and has interviewed six overseas candidates over the past three months. One offer has been accepted and progressing to the next stage, two further are progressing to reference checking and offer, as well as a series of short-term locum cover arrangements. Many of the applicants we are receiving require a period of supervision and as such, we have been proactive with working with the Medical Council and The Royal Australian and New Zealand College of Radiologists Faculty of Radiation Oncology to streamline and support IMG candidates to work in New Zealand. This has also been part of the national network's agenda and has received widespread support.

The SBCS is currently undertaking a service planning exercise to cover a five-year period commencing this financial year. Workforce planning is a major component and will incorporate the recommendations from the EY Action Plan where these have not already been implemented. Workforce planning will encompass all staff groups.

v. The assessment of staff wellbeing, particularly regarding current hours of work, non-clinical duties, capacity for leave, and planning of sabbaticals across the three oncology services

The SBCS leadership team recognises the importance of staff wellbeing. This is especially important as system pressures continue, and staff continue to experience high levels of stress. Our Cancer Psychosocial Service (CPS) have started to develop support for staff and have delivered sessions to the Radiation Therapists staff group. Tailoring of this support offer to other staff groups is planned. The CPS Team Lead and Clinical lead for Haematology have been successful in securing funding to join the Schwartz centres and are now looking to roll out Schwartz Rounds to staff in the SBCS.

In addition, our employee assistance programme is available to staff via Vitae, which offers free counselling sessions. Health-system-wide pressure on staff resource continues to impact significantly on our ability to recruit and thus to alter the current context in which our staff work, and in which our service is delivered.

Haematology

There has been significant stress within the haematology service due to workloads and chronic short staffing for many years. This was also identified as a significant problem impacting on wellbeing and work relationships during haematology credentialling in 2021. This led to the department having facilitation in September 2022.

Sabbaticals had been approved in 2016 but, due to being short staffed and a lack of securing locum cover, these have been very difficult to do – internal cover finally allowed one SMO to have their sabbatical in 2022, and there are another three planned within the next 1-2 years.

Leave balances are very high, due to difficulties taking leave when we were very short-staffed, and this was compounded by COVID-19. SMOs would like to take this extended leave, but again there is difficulty in doing so due to ability to find cover for this. Non-clinical duties have routinely been done after hours – we hope that this will now improve as we have very recently become fully staffed.

Medical Oncology

Medical oncologists continue to work under pressure, which has been exacerbated by the resignation of some of their radiation oncology colleagues and the impact of waitlists and outsourcing on the whole service.

The hours of work remain unchanged, with a heavy administrative burden compared to other departments in the country. Non-clinical duties also include teaching commitments and travel time to regional clinics. This activity adds further logistical and administrative tasks and there is very little managerial support for medical staff.

Capacity for leave is limited and requires careful planning, which is challenging with several of the team who have family overseas. There is a high leave balance in medical oncology, particularly among those who have worked in this service for >5 years. Any leave taken currently results in an immediate deficit in the number of FSA and follow up appointments available, which consequently increases the waitlist.

The departure of the current locum will again increase the medical oncology SMO workload, as the locum has been seeing significant numbers of our follow up patients, all of whom will be returned to the permanent medical oncology staff.

This will improve with the return of a colleague from parental leave this October and the successful recruitment of an oncologist from Australia early 2024, but an additional 1.0 FTE over budget would allow for leave cover without increasing the waitlist. At least one sabbatical is overdue, with another couple anticipated over the next two years.

Radiation Oncology

Due to the low number of radiation oncologists, there is no probability of sabbaticals taking place until staffing levels are improved.
Radiation oncologists are currently operating in very vulnerable environment with significant workload pressure following the resignation of one full-time SMO in January 2023. A second full-time SMO has also resigned and is due to leave the service in August 2023. This will leave the service in a highly vulnerable state and further impact workloads.

Many of the tumour-streams are at risk with the loss of specialist expertise, and the service is only able to manage `50% of referrals with the current staff complement. The remaining patients are currently either being referred to other centres (both public and private) in New Zealand or their care is provided by clinicians remotely who are subcontracted to the service.

The national Radiation Oncology Working Group has been established to support the service, and a current recruitment drive has identified three probable candidates for 2024, who are progressing through the recruitment and accreditation process.

Leave has been carefully managed and scheduled to enable staff to undertake CME and annual leave successfully and locums are being used to support alleviating the acute cover and on call burden left. We remain cognisant of the impact having such a compromised workforce is having on all staff.

c) Review of patients on harm registers

We were asked to review the circumstances of those patients identified as having been harmed in the harm registers referred to in this report, to ensure that ACC treatment injury claims have been made as appropriate. Upon review, only two patients who were listed on the historical harm register had had SAC 1, 2 or 3 adverse events raised, neither of these patients had ACC treatment injury claims raised.

The harm register referred to in the HDC report was generated on two occasions January/February 2021 and March/April 2021 by medical oncology SMOs, as no account was taken of previous reports of any systemic failings at the previous executive level.

Te Whatu Ora National Office Response to the report recommendations

In response to the recommendation that Te Whatu Ora National Office provide HDC with an update, within three months of the date of this report, on work underway to:

i. Reduce the geographical disparities in patient access to cancer services across the country, in particular, ensuring timely access to services.

There have been a number of actions in the last six months to reduce any actual or perceived disparities in patient access to cancer services including national and regional initiatives summarised below:

National Radiation Oncology working group

- Formation of a national working group bringing together ROWG, Te Whatu Ora and Te Aho te Kahu. This group is working towards how it could be an early adopter as a National Clinical Network (NCN.)
- Identified the need to form a robust retention and recruitment strategy and to deliver some immediate actions to help support the national workforce shortage.
  - Te Whatu Ora has approved funding for an additional five RO training positions which will ease workforce pressures in the medium-longer term. This initiative is in line with RANZCR's recommendation to grow RO trainee numbers.
  - The additional five radiation oncologist training positions have been advertised and processed, with interviews to commence shortly.
  - Two fellow positions have been established and are being advertised. The fellow positions are for newly graduated SMO's to leave specialised skills in a supportive environment. The fellow positions are for brachytherapy training.
  - The recurring funding for all training positions is vital to grow a sustainable workforce. Additionally, there is a need to ensure a strong recruitment and retention focus for the RO SMO workforce to support trainees and meet

supervision requirements, or centres will not be able to provide placements for them.
  - Another initiative being explored is whether we can recruit locums to work in New Zealand. Advertising has been placed through all channels, including the Royal Australian and New Zealand College of Radiation website.
  - Development of new initiatives with Medical Council and the College to support IMG recruitment, onboarding and supervision requirements.
- Group leading the collation and analysis of waitlist and wait time data through Te Aho to ensure equity of access to Radiation Therapy across the motu.
- Develop a picture of national capacity (both workforce and Linac) building from the work completed by ROWG to develop a national capacity and demand picture of Radiation Oncology to help inform future workforce and capital investment.
- Enable regional service network input and voice to understand local and regional capacity constraints, high risk areas to deliver equitable access to Radiation across Aotearoa.
- Engage the collective knowledge of the group to work towards partnering with private providers and seek out options to support a vulnerable public system.
- National consistency on referral and access criteria, waitlisting, clinical treatment protocols, service job sizing, contracting and payments.
- Utilise this national network to develop various interim pathways to support vulnerable tumour streams and the lack of immediate capacity in Southern.

Regional Operational Radiation Oncology group

There has been progression toward the development of a regional and inter-regional model of care that is consistent with the aims and objectives of the health reform.

Currently Waitaha/Canterbury are not able to support the Southern district, as they currently have resource constraints for FSAs and delays to treatment. Adding more patients will increase the clinical risk beyond an acceptable level.

Conversations continue as part of the Te Waipounamu regional group who are meeting fortnightly to look at strategies to decompress Canterbury to enable regional pathway solutions for particular vulnerable tumour streams (CNS, gynaecology and head and neck). *Decompression strategies include:*

- Continuing to explore changes to traditional DHB boundaries and better utilise FSA and treatment capacity – these feed into the national group, as there are dependencies on accessing capacity outside of the South Island.
- Discussions are progressing with improving the utilisation of treatment capacity in Southern (potentially for South Canterbury patients).
- Maximise the partnership with private facilities to support the lack of regional public capacity. Consideration is also being given to potential outsourcing patients to Australia.

Other key focus areas for the regional operational group include:

- Aligning processes / fractionation, wait lists and standard operating procedures etc
- Exploring the digital opportunities with SI PICS (patient management system) roll out in the Southern district in October 2023 for cancer services.
- Advocacy/business case for Linac replacement and expansion programme for Te Waipounamu region.

- Clinical and service network support/representation for Te Waipounamu.
- Exploration of developing a regional view of clinical G=governance, quality and safety opportunities for the future.

ii. Consider the impact of the introduction of new technologies and new cancer medications on capacity;

Investment in data and digital systems

- Te Whatu Ora recently became aware of error reports related to Hawkes Bay radiology data management systems. These pose serious risk to patient safety and service quality.
- After conducting an independent external review and validating the reports, our leadership team have agreed to a substantial list of recommendations to address identified system technical IT and clinical governance, quality, and patient safety issues.
- It is likely that investments in data and digital systems will be required to address and resolve the patient safety issues.
- Investment for all centres has been agreed with the investment into ProKnow. This system will support remote supervision of ROs and greater peer support across the centre. This supports access to dosimetry planning and treatment as patients are treated across the various region centres.
- The recommendation to invest in digital radiology solutions is in line with the RANZCR priority that asks for national and strategic investment in technology to maximise efficiency and provide more equitable patient care across New Zealand.

New Cancer medications on Medical Oncology and Haematology Capacity

National cancer services have seen rapid increases in demand and delivery for systemic anti-cancer therapies. New drugs and regimens being additive to a sequence of therapies rather than replacing has had a significant impact on service capacity.

Current SACT services have no capacity to absorb this demand or any further expansion of systemic anti-cancer treatments down the track. Following the recent consultation by Pharmac to fund four new cancer medicines, Te Whata Ora had a time limited window of opportunity to address immediate service capacity constraints in preparation for this and future medicines.

Te Aho O Te Kahu has undertaken a high-level impact assessment of the workforce and infrastructure needed to respond to these four new medicines. The approach and methodology developed by this rapid assessment has also been used to preview the impact of funding for a new immune checkpoint inhibitor for non-small cell lung cancer (NSCLC), signalled by Pharmac for likely implementation in 12 months' time.

The resulting Systemic Anti-Cancer Therapy (SACT) new cancer medicines report has been informed by advice from Pharmac, Chairs of the Medical Oncology Working Group and Haematology Working Groups, and Clinical Director Medical Oncology, Canterbury Blood and Cancer Service. Additionally, two semi-quantitative surveys were circulated to the Medical Oncology and Haematology Working Group members and their operational and nursing leads to capture the sector's perspectives on the current four medicines released for consultation, as well as capacity to manage existing demand. Inpatient and outpatient settings were considered.

1. This high-level assessment found that immediate action is needed to address existing and future SACT demand on services given the expansion of new cancer medicines funded by Pharmac. In the short term (next 12 months) preliminary modelling suggests the following hours and Full Time Equivalents (FTEs) will be required using high and low estimates:

Table One[1]: Hours & Full Time Equivalents (FTE's) using high & low estimates for the next 12 months.				
Additional hours	**High estimate**	**FTE equivalent**	**Low estimate**	**FTE equivalent**
Nursing time (hours per week)	392.6	9.82	124.3	3.11
Senior Medical Officer time (SMO) - First Specialist Appointment and On treatment reviews, hours per week	325.8	17.22	180.5	3.47
Pharmacy time (hours per week)	233.3	5.83	59.9	1.5

NB: Details on the assumptions made in this modelling, are contained within the SACT New Medicines Report Supporting Documents June 2022.

A series of workshops were held with a joint collaborative partnership between Te Whatu Ora and Te Aho o Te Kahu to develop a national coordinated approach and framework to meet SACT workforce requirements (including recruitment) over the next 12 months and in preparation for new checkpoint inhibitors for lung cancer, as well as any additional funded cancer therapeutics.

The service implications of such across SMO, nursing and allied have yet to be reconciled or resolved.

iii. Consider the actions arising from the EY report to better align SBCS workforce with other centres, and report back on FSA and treatment capacity issues in Southern and other centres.

Please refer to Section b) iv. EY SBCS action plan regarding actions arising from the EY report to better align SBCS workforce.

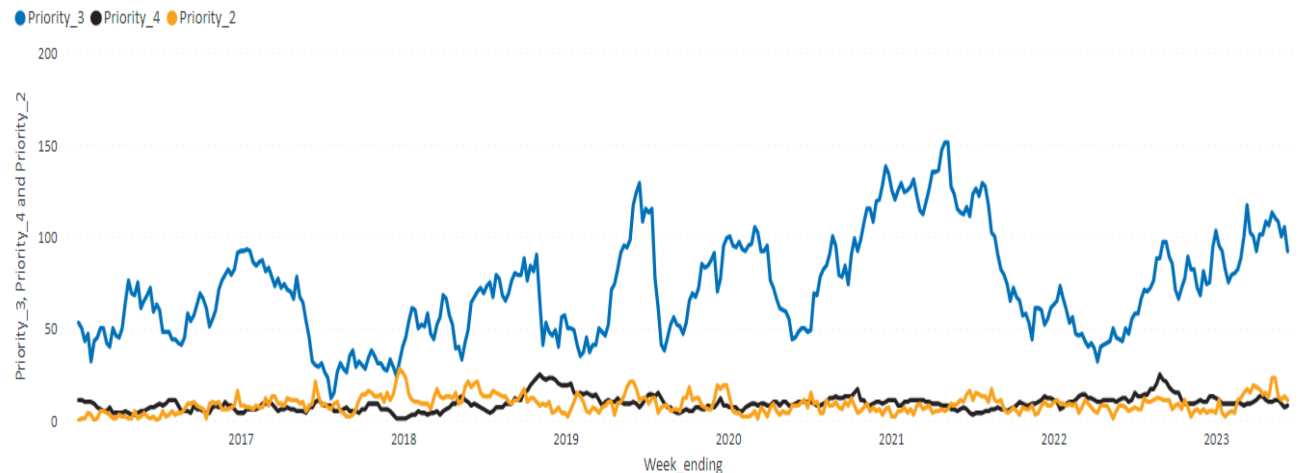
FSA and treatment capacity issues in Southern

Radiation Oncology Service summary:

- The Southern district completes around 1200 courses of radiation per year (approx. 200 per 1.0FTE equating to approx. 5 new patients (NP) per week). This requires a minimum staffing level of ~6 full time radiation oncologists.
- We currently have four ROs which will drop to three in July 2024. There is further risk this may also drop to two by January 2024.

- We outsource 40-50% of the NP workload (either to locums by way of virtual FSA or sending patients to private facilities). There are a small number of CNS tumour patients currently also being sent to Wellington, Christchurch and Waikato public hospitals.
- We have maintained a 1:5 on-call roster for 2023, covering gaps with locum staff. This is to support the wellbeing of incumbent staff and to avoid excessive acute cover and on call burden which would otherwise be a reality with current workforce numbers.

Radiation Oncology FSA wait list



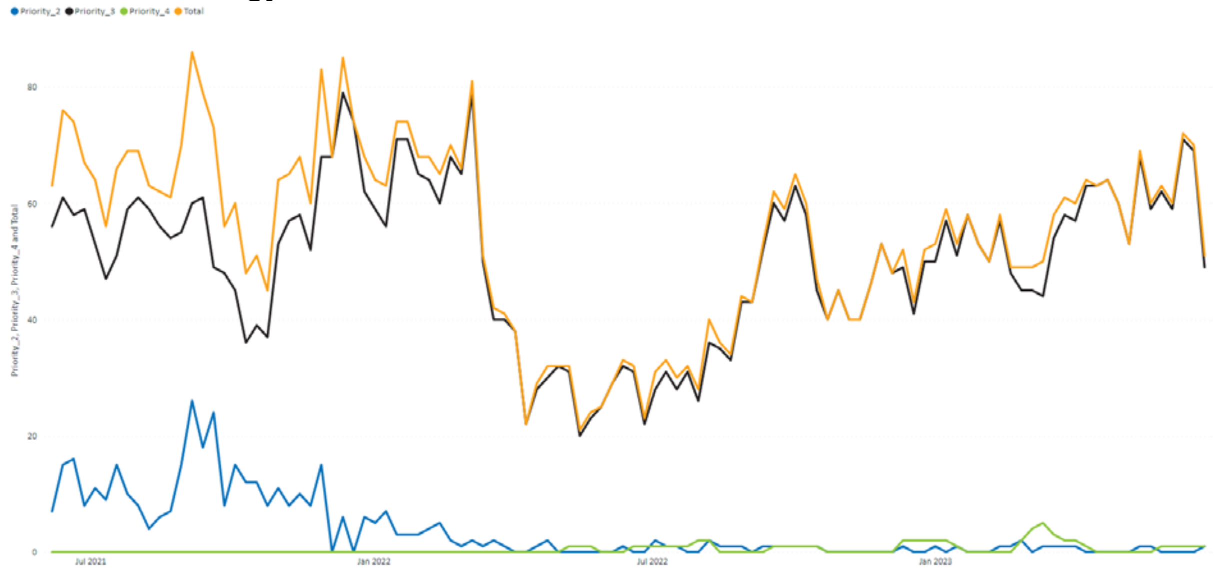
<u>Radiation Oncology As of 25 June 2023</u>

Current FSA waitlist 105 down from 143 in March 2023 and down from the peak of 164 in May 2021. The reduction and maintenance of the waitlist has been achieved by outsourcing as mentioned previously.

Current wait times by priority:

- P2 (Target to see within 2 weeks) with 1/3 (33%) currently waiting outside of targeted wait times.
- P3 (Target to see within 4 weeks) with 28/89 (31%) currently waiting outside of targeted wait times.
- P4 (Target to see within 16 weeks) with 1/12 (8%) currently waiting outside of targeted wait times.
- Treatment waitlist 61, with no significant capacity constraint impacting commencing treatment.

Medical Oncology FSA wait list

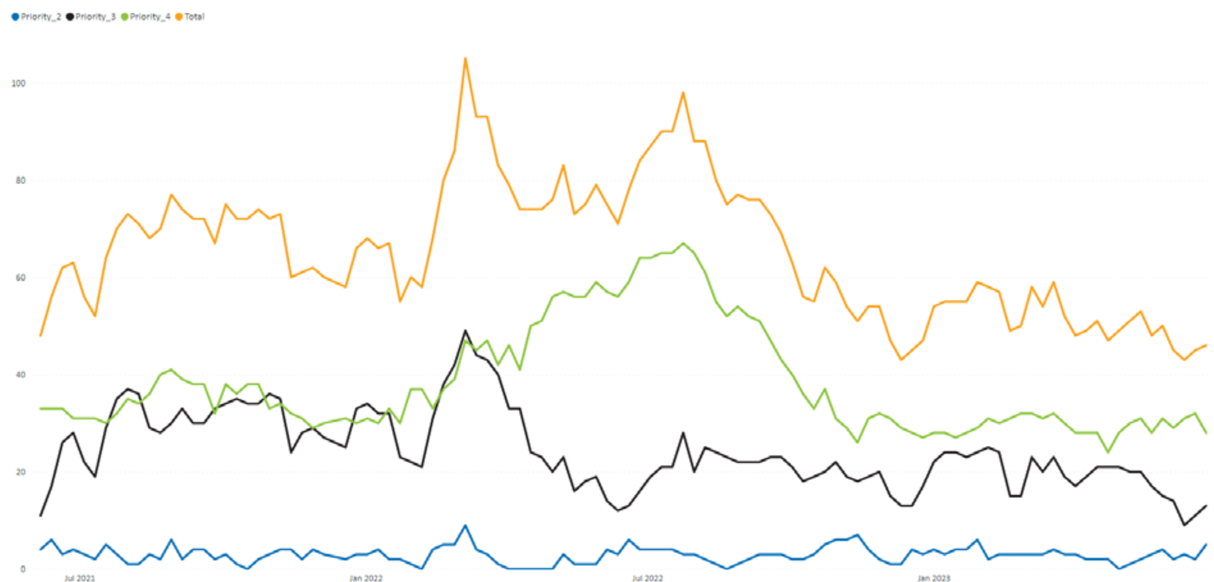


<u>Medical Oncology as of 25 June 2023</u>

Current FSA waitlist 51 down from 72 earlier in the month and down from the peak of 86 in September 2021.

Current wait times by priority:

- AC1 (Target to see within 1 week) with 0/1 (0%) currently waiting outside of targeted wait times.
- AC2 (Target to see within 3 weeks) with 4/11 (36%) currently waiting outside of targeted wait times.
- AC3 (Target to see within 4 weeks) with 19/38 (50%) currently waiting outside of targeted wait times. Wait times are 4-7 weeks for those not meeting targets.



Haematology as of 25 June 2023

Current FSA waitlist 44 down from 98 in July 2022 and down from the peak of 105 in March 2022.

Current wait times by priority:

- P2 (Target to see within 1 week) with 2/5 (40%) currently waiting outside of targeted wait times.
- P3 (Target to see within 3 weeks) with 5/12 (41%) currently waiting outside of targeted wait times.
- P4 (Target to see within 4 months) with 1/27 (4%) currently waiting outside of targeted wait times.

Thank you for the opportunity to provide your office with an update on the learnings taken and implementation of the recommendations thus far.

Ngā mihi

Hamish Brown
Interim Lead Hospital and Specialist Services
Southern

Te Whatu Ora
Health New Zealand

22 September 2023

Morag McDowell
Health and Disability Commissioner

Kia ora Ms McDowell,

Complaint: Commissioner Initiated Investigation Te Whatu Ora - Southern Cancer Services
Our ref: 22HDC01310.

Thank you for your letter dated 4 September 2023 which included further advice from Dr Pidgeon and sought additional information to assist with your assessment of whether your recommendations for Te Whatu Ora - Southern Cancer Services have been satisfactorily met.

I also note there is a separate letter received from you also dated 4 September 2023 but addressed to Mr Hamish Brown regarding the same HDC ref 22HDC01310. This correspondence is requesting further information and response to a range of different questions. As not to confuse both responses, the latter will be responded to separately by Mr Hamish Brown.

In response to Dr Pidgeon's comments in your response, I will address these in turn:

"A cancer services recovery plan has been developed for Te Whatu Ora Southern (discussed under point 2), and any relevant actions taken by Te Whatu Ora National Office."

1.1. Embedding of an accountability and performance framework:

Te Whatu Ora - Southern continues to progress its accountability and performance framework through introducing a more robust service meeting structure, monitoring of key indicators, and involving clinical teams in regular forums to review performance. The most recent example of material discussed at these performance review meetings is attached as appendix A.

There is also a separate monthly performance and accountability meeting with local senior leadership members to discuss performance and risk related issues and to provide further assurance and accountability.

1.2. Clinical governance framework to address deficits in risk management, including appropriate quality and performance KPI's and reporting:

Southern continues to improve on its clinical governance systems and processes. For example, clinical governance of the Southern Blood & Cancer Service (SBCS) is conducted through the meetings outlined above (refer Appendix A). This covers off many aspects of workforce, health and safety, risk, quality and patient safety.

The Safety-first system used in Southern enables them to capture, monitor and report on key issues, staff incidents, risks and adverse events. I am advised these issues are discussed at a service level and can be escalated via a newly established Risk and Assurance Committee (RAC), which includes operational and clinical leaders, where any new, poorly controlled, or high/extreme risks can be discussed with the leadership team.

SBCS has also presented to the Southern clinical council and sought feedback and consumer engagement on key things such as the revised waitlist letter.

1.3. Cancer services recovery plan:

The recovery plan for SBCS has three components, being staffing, infrastructure and regional networking, as outlined below.

1.3.1. Staffing

Radiation Oncologists

Local recruitment initiatives – through direct engagement in the regional and national forums and established clinical networks, Southern has successfully managed to contract three part time Radiation Oncologists. One provides telehealth support only and the other two provide regular onsite visits to Dunedin and provide additional support via telehealth.

Southern has also managed to maintain a 1:5 acute and on-call cover roster with the support of other visiting Radiation Oncologists from (Auckland, Waikato, Wellington and Christchurch since January 2023). This has directly enabled Southern to locally support its incumbent permanent staff without shifting any additional acute and on-call burden on to them.

A Southern Radiation Oncologist recruitment campaign launched with HainesAttract on May 16th. The strategy was multi-faceted, focusing on attracting candidates through a strategic media campaign, and direct sourcing. From this campaign (up until August 2023), 1109 candidates were contacted, 24 were actively engaged and expressed genuine interest, many of which are still being communicated with. I am advised that this campaign led to three offers being made which disappointingly did not lead to any permanent offers being secured due to issues with qualifications and changes in personal circumstances.

Despite no permanent appointments, Southern has however managed to confirm three international fixed term locum Radiation Oncologists and one short term national locum between the period July 2023 and Feb 2024. This has enabled Southern to continue to offer a full range of cancer treatment locally and manage its wait times. These candidates have also either expressed interest in returning and or extending their term and one who initially had applied for a permanent position wanted to visit on a fixed term period first with his family before committing to any permanent move.

The Te Whatu Ora Hospital and Specialist Services Leadership Team has continued to support Southern recruitment efforts by also writing to all Radiation Oncology head of departments in Australia to seek their assistance, working with local and regional recruitment teams and will review the Remuneration and Employment Packages for Radiation Oncologists and consider incentive models.

Southern acknowledges the primary issue for SBCS is Senior Medical Officer recruitment and our local, regional, and national recruitment activities remains our central focus.

For reference, a broad summary of full time equivalent (FTE) to budget from month ending August 2023 is below:

Staff type	Actual FTE	Budgeted FTE	FTE Variance	Notes
Radiation Oncologists	4.5	8.7	-4.2	Number of locum and outsourcing mitigations
Oncology & Haematology Medical Staff	14.6	16	-1.4	One Medical Oncologist and One Haematologist to start 2024
Physics	10.4	11.9	-1.5	One new Physicist starting in August
Radiation Therapists	28.6	30	-1.4	
Nursing	51.1	54.1	-3.0	
Pharmacists	1.1	0.5	0.6	
Admin	13.3	13.9	-0.6	

Support services

SBCS continues to have one of the better resourced treatment teams in New Zealand including Radiation Therapists, Medical Physicists, Nursing, and administrative support.

In addition to this Southern have since employed:

- A Service Manager focused on connecting with clinical teams in SBCS and driving operational outcomes.
- A new Performance and Quality Manager to support Southern implement the proposed recommendations and improve the overall quality, patient safety and clinical governance to support SBCS.
- Southern has also increased its psychosocial resource to ensure fuller weekday coverage to support patients.
- A new National Travel Assistance coordinator that has dedicated focus on supporting patients in Southern with their travel and accommodation needs.

SBCS has embedded its previously mentioned Patient Navigator team that supports patients on the wait list, for example by assessing patients' condition, and providing advice on managing symptoms and options for accessing care.

1.3.2. Infrastructure

Te Whatu Ora has commenced a Nationwide Clinical Services Plan for cancer service delivery which will include the future planning for location of LINACs, and the required infrastructure planning.

Te Waipounamu has also prepared and supported plans to increase LINAC and infrastructure for the future provision of Radiation Oncology in the South Island. This indicates there will be additional LINAC

capacity and investment required for both Canterbury and Southern in order to keep up with demand for the future.

1.4. Regional networking

The Regional Working Group continues to meet every fortnight and are in the process of setting up a steering group to ensure all national and local approaches to broader range of non-surgical cancer services (Radiation Oncology, Medical Oncology and Haematology) are coordinated.

The aims of the steering group would be to achieve:

- Greater regional collaboration and support for non-surgical cancer services, including formalising partnerships with Te Aka Whai Ora, Te Aho o Te Kahu, consumer representatives, clinical and operational leaders.
- Improved utilization of our regional capacity and capability e.g., LINAC capacity, specialist expertise to support low volume complex tumour streams, improved access, and greater operational agility to meet current and future patient demand.
- Standardisation of operating procedures, treatment guidelines, work plans, referral and access criteria, data and reporting protocols.
- Opportunities with regional contract management, outsourcing, procurement and the prioritisation of future regional capital investment and service planning.
- Enhanced workforce capability – develop a regional recruitment and retention strategy, consider new innovative ways to support training and workforce development.

Further local and regional planning continues into key additional focus areas including:

- Ongoing provision of Southland and rural radiation services.
- Reprioritising / focusing capacity and capability in Dunedin to meet demand, including establishing plans for various scenarios including:
    a. how to support vulnerable tumour streams where there is no specialist capability.
    b. how to manage the remaining demand for tumour streams where we still may have the capability by not sufficient capacity and
    c. how to plan to manage acute cover, in-patient work, and on-call services.
- Other options to support the ongoing viability of radiation services in Southern including models of care for primary care, other speciality services and wider SBCS services, locum and outsourcing strategies, workforce recruitment and retention.

National key areas of planning include:

- Establishment of a National Clinical Cancer Network.
- A focused review of the Remuneration and Employment Packages for Radiation Oncologists and including incentive models.
- Review the opportunities with the private sector and develop an approach that is nationally consistent to engage the workforce and providers in solutions.
- The development of the Cancer Production Plan for 2024-27 including LINAC capacity.

Many of the key national initiatives are supported by Te Aho o Te Kahu and extend much wider than the brief of this HDC response into improving cancer services into the future and achieving

Matepukupuku – People living with cancer, as one of the six key priority areas of focus for our health system.

"Comparative data regarding capacity issues at other centres, and how SBCS compares with its waitlist or achievement of target waiting times."

Please be assured that there is an immense amount of work underway to ensure we are better capturing and reporting on the key measures that monitor what matters, accurately and transparently.

Nationally, Te Whatu Ora's delivery of cancer services, including assessment and treatment, is monitored by Te Aho o Te Kahu | Cancer Control Agency. The performance metrics selected to monitor performance are Faster Cancer Treatment (FCT) which is split into two time-based targets: that 85% of patients commence treatment within 31 days from decision to treat, and 90% of patients with a high suspicion of cancer commence treatment within 62 days of referral. Table 1 below sets out each district's performance against those targets for the period January to June 2023.

It is important to note these metrics cover a wider range of first line interventions predominantly involving surgical input and therefore reflect a wider range of services than those provided by the SBCS.

Table 1: Achievement of the Faster Cancer Treatment targets for each district for the period January to June 2023. The targets are that 85% of patients commence treatment within 31 days from decision to treat, and 90% of patients with a high suspicion of cancer commence treatment within 62 days of referral. Green shading indicates where targets were achieved.

	31 day target (Jan – June 2023)	62 day target (Jan – June 2023)
Auckland	83.7%	77.3%
Bay of Plenty	81.1%	72.6%
Canterbury	84.0%	87.3%
Capital and Coast	85.8%	75.0%
Counties Manukau	82.7%	66.7%
Hawkes Bay	69.4%	50.0%
Hutt Valley	92.6%	89.7%
Lakes	87.0%	94.6%
MidCentral	80.8%	84.4%
Nelson Marlborough	84.5%	81.1%
Northland	81.9%	81.3%
South Canterbury	82.6%	100.0%
Southern	84.9%	66.7%
Tairawhiti	90.9%	66.7%
Taranaki	87.3%	69.4%
Waikato	78.2%	50.3%
Wairarapa	89.0%	92.9%
Waitemata	88.3%	79.7%
West Coast	64.2%	58.8%
Whanganui	81.8%	80.7%
National total	**83.7%**	**75.4%**

This table provides preliminary achievement data for Quarter 4 2022/23 (which is based on patients who received their first cancer treatment or other management) between 1 Apr 2023 and 30 Jun 2023).

Achievement of targets across the motu is challenged by a combination of workforce shortages (particularly radiation oncologists) and increased demand. As such, while three districts are achieving the 62-day target (MidCentral, South Canterbury and Wairarapa) the national average is below target, at 75.4%. Seven districts met the 31-day target within the time period, with the national average being much closer to target for this measure at 83.7%.

Capacity is particularly challenged for both assessments and treatment in Hawke's Bay and the West Coast, with time to treatment also longer in Counties Manukau, Southern, Tairawhiti, Taranaki, and Waikato.

Regarding comparative data on capacity issues at other centres, and how SBCS compares with its waitlist or achievement of target waiting times (discussed under point 3), we attach Te Aho o Te Kahu comparative data they collate and report back to the national working group on a fortnightly basis as appendix B (below).

"Further, that it would be helpful to understand what work is being done around reducing disparities in access to oncology and haematology services rather than just radiation oncology."

As you are aware, the establishment of Te Whatu Ora enables the opportunity, for the first time, to establish a single, consistent national process to address inter-regional availability. Who you are or where you live should not determine the range and quality of services you receive. The reforms will give people access to consistent quality care when they need it, to help people live longer in good health and have the best quality of life.

1.5. National Radiation Oncology Group

A National Radiation Oncology Group has been in place for several months now with clinical and operational leads from across New Zealand. It has been instrumental in getting additional radiation oncology trainees, standardising some pathways, and supporting the movement of patients to reduce wait times for treatment.

1.6. National Clinical Networks

The Radiation Oncology National Clinical Network will be established in the coming months, with recruitment to commence in the coming week. This is the first step in the establishment of a National Clinical Cancer Network as referenced in point 1.7. National Clinical Networks will:

i. identify ways to address variation in service quality and outcomes and inequity,
ii. develop innovative, efficient, and evidence-based solutions that will inform investments and workforce planning and be applied nationally, and
iii. collaborate with relevant national, regional, and local stakeholders to identify what care and services are required at different levels, who should provide these services, and how the services or care should be delivered.

1.7. National Cancer Programme

In addition, Te Whatu Ora is standing up a National Cancer Programme alongside regional cancer service networks, in partnership with Te Aho o Te Kahu and Te Aka Whai Ora, to improve the delivery of cancer services nationally, starting with a focus on establishing a Te Waipounamu Cancer Services Network.

The national team will work on a number of elements, including:

- Addressing unwarranted variation
- Workforce
- Equity
- National production and capacity plans
- Models of care
- System performance (screening, incidence, access, equity, progress against production plans, completion of treatment pathways)

The regional team will work on:

- Coordinate and develop the regional workforce
- Timely access to FSAs and treatment
- Delivery against production plans and implement agreed models of care

With the advantages we now have through the health reforms, it is a priority of Te Whatu Ora's to eliminate the inconsistency patients experience when they need any treatment. While it will take time for Te Whatu Ora to reach that point, progress is being made and districts are already sharing capacity across regions to improve equity of access. Every change we make is one step closer to achieving the health outcomes and way of life that New Zealander need to thrive now and in the future.

Thank you for the opportunity to provide your office with further information on our work programme to improve the delivery of cancer services, particularly in Southern.

Nāku noa, nā

Fepulea'i Margie Apa
Tumu Whakarae | Chef Executive
Te Whatu Ora – Health New Zealand

21 September 2023

Ms Morag McDowell
Health and Disability Commissioner

Email: INVFiles@hdc.org.nz

Kia ora Ms McDowell

Complaint: Commissioner Initiated Investigation Southern District Health Board Cancer Services
Your ref: 22HDC01310

Thank you for your letter, dated 4 September 2023, outlining your assessment of the information we have previously provided and whether the HDC report recommendations have been satisfactorily met.

In response to your request for additional information, please see detail provided below.

1. **Whether information regarding alternate options for accessing care including private medical options is being provided to patients on the waiting list for an FSA.**

   Patients placed on the Southern Blood and Cancer Service (SBCS) wait list receive our wait list acknowledgement letter that asks them to contact their GP if they would like to explore other treatment options such as private care provision. Our Patient Navigator team are able to offer advice to patients in relation to accessing private medical options but are unable to make a referral to private services on the patient's behalf, a referral needs to be made either by the patient's GP or from the speciality that referred the patient to our service. This is a consistent approach across all specialties and a core role of general practice. Discussion with the Chief Medical Officer of the Primary Health Organisation has also confirmed this approach is valid and is consistent with our revised transfer of care documentation, due out in the next fortnight, that has been consulted with general practice on. It is worth noting that access to private oncology services in Southern is extremely limited, there are no private Radiation Oncology treatment providers and only limited access to Medical Oncology services. The nearest Radiation Oncology provider is St George's Cancer Care in Christchurch, following this it is ICON's Bowen Cancer Care in Wellington.

   We are aware of St George's recent expansion of Radiation and Medical Oncologist pre and post treatment care and continue to work with them to ensure patients are aware of all available options to them.

Separately to this, where patients on the public Radiation Oncology wait list can be outsourced to private care providers through our current contractual arrangements, our Patient Navigators and our Administrators advise patients regarding this process and make the arrangements for the transfer of their care directly. There is no capacity or capability (for treatment of complex patients) within the private oncology sector within the South Island or New Zealand to absorb all patients from Southern.

2. **Comment on Dr Pidgeon's suggestion around:**

   a. **On going assessment and analysis of patient harm, such as the continued presentation of Patient Harm Registers on a regular basis.**

   The ongoing assessment and analysis of harm no longer takes the form of Patient Harm Registers, instead instances of harm are reported into Safety1st, the organisation's incident reporting database. This provides visibility of these reports within the organisation's clinical governance framework and provides an audit trail for the investigation, actions identified and dissemination of learning from such events.

   Further work is being undertaken in conjunction with the Patient Safety Team to strengthen this approach to reporting. Based on models already developed in Southern services, the first incident reporting 'trigger meeting' was held on 2 August 2023. In this forum the multi-disciplinary team (MDT) review instances of potential harm that may trigger the need for reporting into Safety1st. Each case is reviewed and if it is determined that an incident has occurred, the level of harm is assessed, and the level of investigation and response needed in each case is agreed upon. Work is underway to develop an event trigger form to assist in collating cases for discussion in the trigger meetings.

   This is an additional process that provides direct clinician involvement into all incidents. This supports the routine regular adverse event meetings that take place with the Directorate Leadership Team (including Patient Safety Facilitators, Director of Nursing, Director of Allied Health, Medical Director and General Manager) that oversee all incidents and SAC1 and 2 events, monitor all investigations and recommendations.

b. **Data to assess performance of the various cancer services, with reference to Dr Pidgeon's observation that ideally clinicians should determine the data set that provides the most appropriate measures of performance and risk (as opposed to raw waitlist data).**

Performance data (appendix 1) is being validated and its presentation has been reviewed. The use of statistical process control charts has been introduced (initially in Radiation Oncology, appendix 3) to monitor key performance indicators. This further highlights some detail of quality assurance and clinical governance over the service's performance, patient safety and accountability. This work will be further refined in consultation with the clinical team until the most clinically meaningful measures of performance and risk are demonstrated across the service.

c. Patient representatives being involved in the clinical governance structures, including the Clinical Council.

The Southern Blood and Cancer Service (SBCS) has worked with the Community Health Council for discrete projects, such as the development of the new wait list acknowledgement letter. In addition, patient involvement is sought when undertaking improvement work. Patient representatives are not yet involved in the service level governance meetings, as these structures are still being embedded. However, Community Health Council representatives are core members of the Clinical Council and have an important role to play in terms of patient advocacy in this clinical governance forum.

d. A targeted plan for SMO recruitment such as improved working conditions, a period of enhanced renumeration, and over-recruitment.

A Te Whatu Ora Southern Radiation Oncologist recruitment campaign launched with Haines Attract on 16 May 2023 (appendix 2). The strategy was multi-faceted, focusing on attracting candidates through a strategic media campaign, and direct sourcing. From this campaign up until August 2023, 1,109 candidates were contacted, 24 were actively engaged and expressed genuine interest, many of whom are still being actively communicated with. This campaign led to three verbal offers being initially accepted in Southern, which disappointingly did not lead to any permanent offers being secured due to issues with qualifications and changes in personal circumstances.

Despite no permanent offers, Southern has however managed to confirm three international fixed term locum Radiation Oncologists and one short term national locum between the period July 2023 and February 2024. This has enabled Southern to continue to offer a full range of cancer treatment locally and manage its wait times. These candidates have also either expressed interest in returning and or extending their term and one who initially had applied for a permanent position wanted to visit on a fixed term period first with his family before committing to any permanent move.

Te Whatu Ora National Office has continued to support Southern recruitment efforts by also writing to all Radiation Oncology head of departments in Australia, working with local and regional recruitment teams and is currently looking to review the remuneration and employment packages for Radiation Oncologists and consider incentive models.

Southern acknowledges the primary issue for SBSC is SMO recruitment and our local, regional and national recruitment activities remains our central focus.

A broad summary of FTE to budget from month ending August 2023 is set out below:

Staff type	Actual FTE	Budgeted FTE	FTE Variance	
Radiation Oncologists	4.5	8.7	-4.2	number of locum and outsourcing mitigations
Oncology and Haematology Medical Staff	14.6	16	-1.4	1 Medical Oncologist and 1 Haematologist to start 2024
Physics	10.4	11.9	-1.5	One new Physicist starting in August

Staff type	Actual FTE	Budgeted FTE	FTE Variance	
Radiation Therapists	28.6	30	-1.4	
Nursing	51.1	54.1	-3.0	
Pharmacists	1.1	0.5	0.6	
Admin	13.3	13.9	-0.6	

There are considerable national recruitment plans underway, looking at things like incentive packages / renumeration, locum and permanent recruitment strategies, engaging expertise of Haines attract and other locum agencies. Te Aho Te Kahu are also supporting the national recruitment team in the recruitment plans.

3. **Review the circumstances of those patients identified as having been harmed in the harm registers referred to in this report, to ensure that ACC treatment injury claims have been made as appropriate.**

In respect of the above recommendation, Te Whatu Ora Southern commits to undertaking a retrospective review of all patients identified as having been harmed in the harm registers referred to in the original report and, where appropriate, ACC treatment injury claims will be lodged. We commit to complete this work by the end of December 2023.

Additional resource will be allocated to this review and a methodological approach for it will be developed in conjunction with our clinicians.

All cases will be collated for review.

- A clinical assessment of harm will be undertaken
- All cases where harm is identified will be entered in Safety1st
- Patients and their families and whānau will be kept informed
- ACC treatment injury claims will be made as appropriate
- A summary report will be generated detailing the process, outcomes, lessons learnt from this retrospective review.

We note your commentary on approaching the staff interviewed to determine their response to commentary Thank you for this opportunity to provide your office with this additional information.

Ngā mihi

Hamish Brown
Group Director of Operations
Southern

25 January 2024

Ms Morag McDowell
Health and Disability Commissioner

By Email: hdcinvestigations@hdc.org.nz

Tēnā koe Ms McDowell

C22HDC01310: Commissioner Initiated Investigation Te Whatu Ora Southern Cancer Services - With Addendum

Thank you for the email of 21 December 2023 from Marissa Brown regarding the addendum to your Opinion 22HDC01310, based on your investigation into Health New Zealand - Te Whatu Ora Southern's non-surgical cancer service.

I note that you intend to publish this addendum on your website after feedback on the addendum has been received from relevant parties. I note that you also intend to proactively release responses to the recommendations from Te Whatu Ora with the addendum, and the date of publication will be communicated to us once confirmed.

Thank you for the opportunity to provide a response to the addendum and/or proposed actions. We comment on paragraphs in your addendum (in italics) as follows:

Para 5: *Having reviewed the information received following the conclusion of my investigation, it appears that considerable work has been undertaken, in collaboration with Te Aho o Te Kahu | Cancer Control Agency, to make improvements to the service. However, it is evident that progress is greatly hindered by the difficulties in recruitment of the SMO workforce, and the service has faced significant challenges since the publication of my report.*

Southern has successfully managed to reduce Radiation Oncology wait times for patients through a series of locum and contracting arrangements whilst we continue to progress permanent SMO recruitment. The current number of people waiting for First Specialist Assessments (FSAs) as at December 2023 was 75, compared to the peak of 144 in May 2023.

Southern has continued to take a lead through convening the national and regional Te Waipounamu radiation oncology working groups. This work has strengthened national and local recruitment processes and involved reviewing models of care.

Medical Oncology is currently fully recruited to budget but continues to be actively recruiting to meet future demand. Waitlists have continued to be maintained at a steady volume of around 60 – 70 after a peak of 86 in 2022.

Haematology is also currently fully recruited to budget and is managing similar waitlist volumes of around 70 after a peak in 2022 of over 90.

All three specialities continue to be vulnerable to an increasing demand and workforce pressures.

Para 6: *Dr E told HDC that the radiation oncology department is sorely understaffed in respect of SMO resource, and the service is more at risk now than it was when the report was written. Dr B stated that the medical oncology service remains understaffed and therefore wait times remain unsatisfactory, and this creates a significant burden on the staff and means cancer outcomes are potentially compromised.*

Southern continues to have vacancies that we are actively recruiting to. The current mitigations in place have improved current wait times for Radiation Oncology and resulted in less burden on staff. (refer to response to para 5).

We continue to rate the service risk as high, and we will continue to do so until more permanent solutions are secured.

Para 7: *Te Whatu Ora acknowledges that the primary issue for SBCS is SMO recruitment and reports that its local, regional and national recruitment activities remain its central focus.*

Para 8: *In my view, until these workforces are stabilised and enhanced, there is no guarantee that patients will be seen and treated within appropriate timeframes, and therefore there is no guarantee there will not be ongoing patient harm, nor improved staff wellbeing and working conditions.*

We agree the long-term service sustainability in Southern remains a concern. We are cognisant that there is limited national capacity (both publicly and privately) to support the service without the maintenance of SMO capacity in Southern.

Para 9: *At present Te Whatu Ora Southern is utilising locums and outsourcing services to manage capacity issues, which, as I highlighted in my original report, are not long-term solutions and can increase the workload on incumbent permanent staff. Existing staff have also increased their hours of work to manage more patients as they are able, which Te Whatu Ora acknowledges is unsustainable. However, it appears that Te Whatu Ora has been active in seeking solutions to enhance the SMO workforce. I am sympathetic to the disappointing outcomes of significant efforts to recruit for radiation oncologists.*

Para 10: *I am pleased to see that, where possible, patients are being transferred to other regions in order to maximise service availability across Aotearoa New Zealand. However, given workforce shortages and capacity constraints across the country, national service capacity remains limited, meaning these arrangements are also at best interim and short-term. We should also bear in mind that demand for cancer services is only likely to increase into the future.*

We acknowledge the impact that receiving treatment outside of their districts has on patients and whānau. That is why our priority has been to continue to bring the specialist capacity to Southern, as opposed to having patients travel away from home. This has been successful, with only a small number of lower complexity patients now being provided the option to receive treatment outside of Southern.

Para 11: *From the information received, it is evident that the issues faced by Te Whatu Ora Southern are also being faced by other regions across Aotearoa New Zealand, particularly in achieving Faster Cancer Treatment indicators, managing their own capacity and local demand, and addressing significant workforce shortages, particularly in radiation oncology.*

Para 12: *In my view urgent collaborative action and a coordinated programme of work is required nationally to address the workforce challenges faced by SCBS and other cancer centres around the country. It is encouraging to see the work currently being undertaken by Te Whatu Ora, including progress towards establishing a Radiation Oncology National Clinical Network and a National Clinical Cancer*

Network, focused efforts in regards to recruitment and retention of radiation oncologists and developing a consistent approach to engage the workforce in solutions. I recognise this aligns with the stated objective of the 2022 health system reforms which was to adopt a whole-of-country view to the planning and delivery of services, helping the health system to become more efficient and consistent.

We agree with your opinion as outlined in paragraphs 11 and 12. This is very much a national issue. We acknowledge the support that Southern has and continues to receive from the National Radiation Oncology community.

Performance and accountability framework.

Para 14: *My independent advisor considers there has been considerable progress made with respect to the design, implementation and embedding of an accountability and performance framework. However, he queried the continued reliance on raw waitlist data to assess performance noting that such data may not provide adequate information regarding potential patient harm. He noted that ideally clinicians should determine the dataset that provides the most appropriate measures of performance and risk.*

Para 15: *In response Te Whatu Ora Southern reported that performance data is being validated and reviewed, and that statistical process control charts have been introduced to monitor key performance indicators. Te Whatu Ora Southern note that this work will be further refined in consultation with its clinical team.*

Para 16: *However, feedback HDC has received from clinicians suggests that there has been little clinician involvement in the development of this framework to date. It is crucial that clinicians on the front-line are kept abreast of progress and involved in the development of performance indicators, and I urge Te Whatu Ora Southern to ensure clinicians are being adequately consulted.*

We acknowledge your opinion as outlined in paragraphs 14 to 16 and the point raised by the independent adviser on the use of '*raw waitlist data*'. We continue to engage closely with our clinicians to improve the service and monitoring the level of harm and risk. We have regular Faster Cancer Treatment Steering Group meetings involving our clinical oncology team, where we continue to refine our risk sensitive indicators with clinician input to strengthen our oncology risk management.

Para 17: *The feedback from clinicians also suggests that while communication with local management has improved since the publication of my report, the pathways for clinical risk escalation nationally and responsibility of management at a national level remain unclear.*

Para 18: *I have previously raised concerns with Te Whatu Ora about the need for a clear permanent national clinical governance system, including national clinical risk management and transparent escalation pathways. Such pathways are particularly important in the context of current workforce pressures and significant delays in care. I am pleased to see that some progress has been made towards the establishment of permanent governance structures, and I will continue to monitor work in this area.*

We are committed to instituting clear pathways for escalation of clinical risk nationally.

Para 19*: I also wish to touch on the work Te Whatu Ora Southern has undertaken to establish patient navigator roles for those awaiting First Specialist Assessment (FSA). It is pleasing to see that this service has become operational and that there is additional capacity for psychosocial support for patients.*

Para 20: *It is also positive that the service has reviewed the information it provides to patients in its referral receipt letters in consultation with its Community Health Council. The updated letter informs patients of expected wait times, provides a direct contact number for the patient navigator team with an explanation of the support they can offer and advises the patient to contact their GP for alternate options for accessing care, such as private options*.

Para 21: *Te Whatu Ora Southern advised that while the patient navigator team can offer advice around alternate options, they are unable to make referrals to private services, which needs to be made by the GP or the specialty. It considers that advising the patient to contact their GP for alternate options is a consistent approach across all specialties and a core role of general practice.*

Para 22: *However, I am concerned that referring patients to their GP for discussion of alternate options places both the administrative and financial burden back on the patient and primary care services. I acknowledge that this approach has been discussed with general practice in the Southern District. However, patients need to pay to see their GPs to discuss these management options, and this cost is a barrier for many patients.*

Para 23: *I am sympathetic to the fact that there are also very limited private options available, not just in Southern District but across Te Waipounamu (the South Island). This indicates to me that sending patients to their GP for alternate options may be of limited benefit. I suggest that Te Whatu Ora consider providing patients with written information about their options for private care across the country, which can be discussed further with patient navigators before a patient makes a decision to contact their GP to request a referral.*

We note but have no specific comment to make regarding the content of paragraphs 19 to 23.

Para 24: *After receiving Te Whatu Ora Southern's response to my recommendations I raised concerns that their review of patients on the harm register revealed that no ACC claims had been made, notwithstanding the patient harm that had been identified. I asked them to provide me with a detailed plan to remedy this.*

Para 25: *Te Whatu Ora Southern have advised that a retrospective assessment of harm will be undertaken of all cases listed on the Harm Registers, with ACC treatment injury claims made as appropriate, and it was committed to complete this work by the end of December 2023. It advised that additional resource will be allocated to this review and a methodological approach for it will be developed in conjunction with its clinicians, and all cases will be collated for review.*

We are continuing to complete the retrospective review of all the cases listed on the historical harm register. The Quality and Performance Manager is leading this with the SBCS clinical directors and senior medical staff input. A report on this will most likely be ready to share early 2024.

Para 26: *It is clear to me that Te Whatu Ora and Te Aho o Te Kahu | Cancer Control Agency have undertaken much work in an attempt to stabilise and improve cancer services in the Southern District. However, workforce constraints have significantly hindered progress, and the sustainability of the service remains at risk.*

Para 27: *The issues faced by cancer services in the Southern District are not isolated, and cancer services across the country are facing similar challenges with the provision of timely care. I acknowledge these complex issues do not necessarily have a quick fix, however, as stated above urgent collaborative action and a coordinated programme of work is required nationally to address the workforce challenges faced by SCBS and other cancer centres around the country. I am acutely aware that cancer outcomes are potentially compromised by a delay in treatment. For this reason, it is critically important that progress continues to be made, and that patient safety remains the focus of actions taken.*

Para 28: *In my opinion Te Whatu Ora and Te Aho o Te Kahu | Cancer Control Agency have met the recommendations outlined in my investigation of cancer service in the Southern region. However, as I remain concerned by the challenges faced by cancer services nationally, and the impact this has on people for whom care is time dependent I will continue to engage with Te Whatu Ora and Te Aho o Te Kahu |*

Cancer Control Agency in relation to steps being taken to address these issues and the issues I see in complaints.

We note your comments in paragraphs 26 to 28.

In general, we accept the comments made in the addendum and we appreciate your ongoing engagement with both us and Te Aho o Te Kahu regarding the improvement of non-surgical cancer service nationally.

Ngā mihi

Fepulea'i Margie Apa
Tumu Whakarae | Chief Executive
Health New Zealand – Te Whatu Ora