

**Te Whatu Ora | Health New Zealand Southern
(formerly Southern District Health Board)**

**A Report by the
Health and Disability Commissioner**

(Case 22HDC01310)

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Executive summary

1. This report examines the delivery of Te Whatu Ora Southern's non-surgical cancer service, including delays in patients obtaining first specialist assessments (FSAs), over the period of 2016 to 2022.
2. This case is a salutary reminder of the detrimental outcomes, both physical and psychological, that can occur for patients, and the impact on their family/whānau when the system does not adequately provide for timely cancer care.

Findings

3. The Commissioner found that Te Whatu Ora Southern failed to recognise and respond to the clinical risk created by the lack of capacity within the Southern Blood and Cancer Service (SBCS).¹ This was due to poor overall clinical governance systems, including inadequacies in quality measures and indicators, and poor relationships between clinicians and executive management.
4. An effective accountability and performance framework where patients are the focus and patient safety concerns are signalled, acted upon and evaluated is a vital element of quality and risk management. The clinical governance systems at Te Whatu Ora Southern were poorly developed and not adequate to either delineate or minimise the risk across clinical services. Had they been adequate, the concerns regarding increasing patient harm from delays would have been more visible and could have been addressed much earlier.
5. Providers owe a duty of care to people waiting for resource-constrained specialist procedures, particularly when the intervention is time-critical. In this case, the Commissioner considered it clear that the care provided by Te Whatu Ora Southern was not adequate, and that patient harm was caused by capacity issues within the SBCS and prolonged delays for FSAs.
6. The Commissioner found that Te Whatu Ora|Health New Zealand failed to provide services to patients within the SBCS in a manner that minimised the potential harm to, and optimised the quality of life for, those patients, and therefore breached Right 4(4) of the Code.

Recommendations

7. The Commissioner recommended that:
 - Te Whatu Ora Southern consider establishing a system that provides a single point of contact for patients who are on the waiting list for FSA, with functions including continued assessment of patients on the wait list, keeping patients updated and informed about current wait times, and providing patients with all options available for accessing care and advice regarding the management of evolving symptoms.

¹ The SBCS includes the Medical Oncology, Radiation Oncology and Haematology services.

- Te Whatu Ora Southern provide a report on the implementation of the recommendations of two external reviews undertaken, in particular on progress with the design, implementation and embedding of an accountability and performance framework; the establishment of a clear clinical governance framework to address deficits in risk management and clinical governance; the cancer services recovery plan; implementation of a three-year workforce plan for the SBCS; and assessment of staff wellbeing.
 - Te Whatu Ora Southern 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.
 - Te Whatu Ora National Office provide HDC with an update on work underway to reduce the geographical disparities in patient access to cancer services across the country, in particular, ensuring timely access to services; considering the impact of the introduction of new technologies and new cancer medications on capacity; and considering the actions arising from the EY report² to better align SBCS workforce with other centres, and report back on FSA and treatment capacity issues in Southern and other centres.
 - Te Aho o Te Kahu provide HDC with an update on progress of its work with Te Whatu Ora Southern to address any cancer service delays.
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Complaint and investigation

8. In 2021 a patient advocate in the Otago/Southland region conveyed to the Health and Disability Commissioner (HDC) concerns about delays at the Southern District Health Board (SDHB) (now Te Whatu Ora Southern)³ non-surgical cancer service, including delays in patients obtaining first specialist assessments (FSAs).
9. In response to a request for information regarding the delays, Te Whatu Ora Southern provided HDC with two iterations of a “Harm Register”, which details information about patients identified as harmed by assessment and treatment delays (as at January 2021, and March/April 2021, respectively, with delays ranging from four to fifteen weeks), primarily within the Medical Oncology service. In January 2021, 24 patients were included in the register, and a further 18 patients were included in the March/April 2021 register.
10. A Commissioner-initiated investigation was commenced. The following issue was identified for investigation:

² See footnote 15.

³ On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora | Health New Zealand. All references in this report to SDHB now refer to Te Whatu Ora Southern.

- *The appropriateness of care provided by Te Whatu Ora|Health New Zealand (formerly Southern District Health Board) to consumers in the Medical Oncology, Radiation Oncology and Haematology Oncology Services from 1 January 2016 until 28 February 2022 (inclusive); specifically in relation to the delays in cancer treatment.*

11. SDHB/Te Whatu Ora Southern was directly involved in the investigation, and further information was received from:

Ms A	Patient advocate
Radiation oncologist and former SDHB Board member	
Dr B	Medical oncologist
Dr C	Medical oncologist
Mr D	Executive Director Specialist Services
Dr E	Radiation oncologist
Chief Executive of SDHB Manatū Hauora Ministry of Health Te Aho o Te Kahu Cancer Control Agency	

12. Independent advice was obtained from Dr Grant Pidgeon, who has extensive clinical governance experience within the New Zealand health system (Appendix A).

Information gathered during investigation

Introduction and overview

13. In late 2021, a patient advocate contacted HDC raising concerns about Te Whatu Ora Southern's cancer services, specifically delays in assessments and treatment in the non-surgical cancer services.
14. This report examines the delivery of the Medical Oncology, Radiation Oncology, and Haematology services (collectively the Southern Blood and Cancer Service (SBCS)). SBCS includes a variety of professional groups, including radiation oncologists, medical oncologists, and haematologists, and is one of only two cancer centres in New Zealand that has no direct access to local private radiation or haematology oncology facilities, and provides only limited private medical oncology care. Travel out of the region for private services is usually to Christchurch or Wellington.
15. SBCS is part of Te Whatu Ora Southern.

Increasing demand for cancer services

16. Currently cancer is Aotearoa New Zealand's leading cause of death, although survival rates are increasing. Cancer survival can depend on early diagnosis and timely treatment.

17. Demand and pressure on cancer services has increased because of a variety of factors, including population growth;⁴ a 23% increase in annual cancer registrations from 2010 to 2019;⁵ funding of new cancer medicines (which can require additional resources from the public healthcare system, including medical specialist time and nursing care);⁶ and new radiation therapy techniques, delivery technologies, and more personalised, tumour-specific care, which can involve greater staff input and time.⁷
18. This increase in demand is evident in the Southern region.⁸

Impact of demand on SBCS's performance against wait times

19. Aotearoa New Zealand has nationally prescribed measures⁹ for wait times for planned care, including cancer services.
20. Specifically, the Manatū Hauora|Ministry of Health Faster Cancer Treatment (FCT)¹⁰ indicators measure access to services across the whole cancer pathway, including the tests and investigations needed to confirm a diagnosis of cancer, as well as all forms of treatment. There are now two health system indicators (previously referred to as health targets):
 1. The 62-day indicator is that 90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and the triaging clinician believes the patient needs to be seen within two weeks to receive their first treatment (or other management) for cancer.
 2. The 31-day indicator is that 85% of patients receive their first cancer treatment (or other management) within 31 days from the date of the decision to treat.
21. According to data from Te Aho o Te Kahu for the year July 2020 to June 2021, Te Whatu Ora Southern's achievement for the 62-day measure was between 65% and 73% against a target of 90%. For the 31-day measure, Te Whatu Ora Southern's achievement was

⁴ The New Zealand Cancer Action Plan 2019–2029|Te Mahere mō te Mate Pukupuku o Aotearoa 2019–2029 (Wellington: Manatū Hauora|Ministry of Health) identifies that with population growth and aging, cancer diagnoses are increasing, placing growing demand on cancer treatment and post-treatment services.

⁵ <https://www.health.govt.nz/publication/new-cancer-registrations-2019>.

⁶ Te Aho o Te Kahu publication "Understanding the Gap: an analysis of the availability of cancer medicines in Aotearoa" (2022).

⁷ Manatū Hauora|Ministry of Health. The National Radiation Oncology Plan 2017 to 2021. Wellington (2017).

⁸ For example, the Clinical Directors of SBCS told HDC that there had been six new cancer drugs funded over the period 2020–2021, which also increased the workload for the service.

⁹ Patient Flow Indicators (or Elective Services Patient Flow Indicators (ESPis)) — these measured whether DHBs were meeting the required performance standard at a number of key decision or indicator points on the person's journey through the planned care system. The latest measures can be found at: https://nsfl.health.govt.nz/system/files/documents/pages/planned_care_2020.21_measurement_suite_technical_specifications_-_final.pdf.

¹⁰ FCT is a measurement used for all specialist services that provide care to cancer patients, not just oncology.

between 80% and 85% against a target of 85%. Te Whatu Ora Southern ranked 19¹¹ and 20¹² out of the 20 districts nationally during the 2020–2021 period for the 62-day measure.

22. Te Whatu Ora Southern also monitors its average wait time for FSA, and the number of people waiting for an FSA (number on the waiting list), as indicators of service performance.
23. The average wait times for people to see medical and radiation oncologists for FSA at Te Whatu Ora Southern steadily increased from 2016, with a marked further increase in Radiation Oncology wait times since 2020 and in Medical Oncology since 2021.¹³ From early 2021 there were prolonged delays for FSAs across Medical Oncology and Radiation Oncology services.

Overview of response to demand in 2016 to 2022

Staffing numbers

24. Te Whatu Ora Southern told HDC that there were emerging concerns about wait lists within the SBCS as early as 2016.
25. SBCS did not increase its staff full-time equivalent (FTE) to meet the increase in demand and pressure on its services. The Clinical Directors for Radiation Oncology, Medical Oncology, and Haematology told HDC that from 2016 there had been increasing demand on all their services, without a corresponding increase in FTE staff. This is evident from the data; for the 10-year period 2010 to 2020, the SBCS service manager reported¹⁴ that for Medical Oncology there was a 0.3 increase in Senior Medical Officer (SMO) FTE, and for Radiation Oncology staff numbers had increased, but not overall FTE capacity, following a job-sizing exercise.
26. The EY¹⁵ Southern Blood and Cancer Service Action Plan also showed that SBCS had fewer FTE across clinical and technical positions relative to patient activity than most other cancer centres.

¹¹ During the six-month period July 2020 to December 2020.

¹² During the six-month period October 2020 to March 2021.

¹³ Te Whatu Ora Southern data provided to HDC.

¹⁴ Monthly Report to the Board October 2020.

¹⁵ Ernst & Young Global Limited (trade name EY) is a multinational professional services partnership. Te Whatu Ora Southern commissioned a report from EY, specifically to assist in development of a three-year action plan for SBCS. The Action Plan is contained in a February 2022 report.

Other strategies

27. As part of this investigation, HDC conducted interviews with Clinical Directors, senior medical staff, management staff, and a patient advocate. The Clinical Directors¹⁶ told HDC that they made multiple representations at all levels of the organisation for additional resourcing, and particularly increased staffing across the service. The Clinical Directors told HDC that the executive response to their concerns included “service redesign and locum staff intermittently employed to cover annual leave and sabbaticals”.
28. Dr C, a medical oncologist, commented on behalf of Te Whatu Ora Southern:
- “When we had melanoma drugs funded, we predicted very clearly over the course of one to two years how many new patients we’d need to treat and what new number of clinic appointments would be needed, how many new nurses would be needed, how many more scans would be needed ... and we said we need more staff to deal with this, because this is new work, and we were told ‘you have to manage within existing resource’. And so, that’s what happens repeatedly, when we make repeated business cases, make repeated presentations on the waiting list, and the staff FTE does not grow.”
29. The Clinical Directors told HDC that three main strategies were utilised. They stated that first, SBCS used service mapping to streamline process within the services. However, the Clinical Directors stated that this had minimal effect as it had already been undertaken and needed additional staffing to progress. Second, SBCS used a “do more with less” strategy by reducing non-clinical time in favour of direct clinical contact time and increasing the hours of clinicians to make up the shortfall. The Clinical Directors said that this had a negative impact on staff. Third, SBCS used locums. The Clinical Directors said that this reduced waiting times artificially, but delays reverted and there was a flow-on effect and increase in work for permanent staff when locums left.
30. Interviews conducted with medical staff also highlighted their perception that their concerns about capacity were attributed by the executive to outside influences, such as the impact of COVID-19 and decisions of Te Pātaka Whaioranga|Pharmac,¹⁷ which led to greater workload without commensurate funding.
31. The Clinical Directors further stated that “a sustained and sustainable intervention was not undertaken by the DHB” and that the strategies employed “left the service in a precarious deteriorating position with the mismatch of clinical resources versus the increasing expectation and demand leading to ever longer waiting lists”.

¹⁶ Clinical Directors are the senior medical officers providing clinical leadership and advice for each specialty.

¹⁷ Te Pātaka Whaioranga|Pharmac is the government agency that decides which medicines and related products are funded in Aotearoa New Zealand.

SAER reporting

32. The Serious Adverse Event Review (SAER) system¹⁸ was not being utilised to report the delays and subsequent harm. Te Whatu Ora Southern told HDC that SAER was available to any clinician to use at any time to report any patient safety incident, particularly where there were process or system errors requiring systems-based change.¹⁹ However, Te Whatu Ora Southern was unaware of any precedent in using the SAER system for reporting on harm to a patient due to waiting list delays.
33. Similarly, the SDHB review²⁰ (a report commissioned jointly by Manatū Hauora | Ministry of Health and Te Whatu Ora Southern in May 2021) identified that there appeared to be little discipline within departments around conducting mortality and morbidity reviews, and whilst a policy and process had been established, execution of the reviews was not embraced. Feedback from multiple clinicians at Te Whatu Ora Southern was that the SAER process was not utilised because there was limited faith that it would drive any change.

Clinical governance

34. The Clinical Council at Te Whatu Ora Southern was first established in 2016. The Clinical Council's stated purpose was to oversee "clinical quality and safety matters relating to care", and to provide "clinically-informed advice to the DHB Board and the ELT around clinical and patient risk".²¹
35. However, in the May 2020 Board meeting minutes, it was documented that "members expressed concerns about the Clinical Council's ability, in its current form, to usefully contribute to addressing the various clinical issues being reported to the Board".
36. The SDHB review²² similarly noted that the meeting minutes appeared to show that there was limited focus on the core issues of the DHB, and instead its focus spread across all operational aspects of the DHB. The SDHB review also noted that greater discipline was required over the management of action points, with many remaining outstanding for up to eight months.
37. The SDHB review also identified that the lack of clinical governance was contributing significantly to its crisis state, with key risks and issues not being governed or managed

¹⁸ In Aotearoa New Zealand, reporting of adverse events is guided by the Health Quality & Safety Commission (HQSC) document "National Adverse Events Reporting Policy" (2017). This policy supports learning from adverse events and near misses that occur in health and disability services. Te Whatu Ora Southern told HDC that only three patients were found to meet the SAC 1, 2 or 3 adverse event criteria, and of these, two were classified as SAC 3, so a formal full investigation documentation report was not prepared. The third was classified as SAC 2 on 28 May 2021, but as at August 2022 the SAER had not been completed, and the report was in draft.

¹⁹ Te Whatu Ora Southern's "Adverse Event Management Policy v6" (2021) defines an adverse event as an event with negative or unfavourable reactions or results that are unintended, unexpected or unplanned (also referred to as an "incident" or "reportable event").

²⁰ "Southern District Health Board Review" (May 2021).

²¹ <https://www.southernhealth.nz/about-us/about-southern-dhb/clinical-council>.

²² "Southern District Health Board Review" (May 2021).

effectively, and resources being deployed to areas that “want[ed] them” as opposed to where the need was most required. The review noted that the crisis state cost the organisation significantly in short-term thinking, decision-making, and reduced staff morale.

38. The SDHB review also noted that there was evidence of a clinical/corporate divide, with the managers within the provider arm focused only on ESPI compliance and financial management, and a notable absence in quality and safety monitoring and forward planning.
39. Lastly, the SDHB review highlighted the absence of an effective accountability and performance framework at Te Whatu Ora Southern. The report also found the following:
 - a) A focus on financial results and ESPI compliance rather than key clinical and quality indicators.
 - b) Ad hoc review of quality data.
 - c) Key risks and issues not effectively governed or managed.
 - d) Low maturity around risk identification and mitigation.²³
 - e) Evidence of a clinical/corporate divide.
 - f) The hospital was not meeting its compliance targets and there were considerable wait times for FSAs and follow-ups.
 - g) There was no recovery plan available to improve cancer treatment times.
40. In the CEO Report to the Board (Public Excluded) November 2020,²⁴ the Chief Executive Officer (CEO) of SDHB at the time of events noted the ways in which the waiting lists in SBCS might be managed, discounting further use of locums as difficult and outsourcing to an out-of-district hospital as expensive.

Relationship between management and clinicians

41. The SDHB review noted that interviews with staff highlighted “a concerning level of low staff morale, clinical and non-clinical staff felt a clinical/corporate divide and a frustration around reactive decision making and changing demands and messages”.
42. The interviews conducted by HDC also highlighted a theme of perceived dysfunction within clinical staffing groups, and, as a result, that their concerns were not taken seriously. For example:

²³ It was highlighted that a Risk Manager was appointed only in 2020, that the systems around risk identification and reporting were manual and paper-based, and there was selective reporting of high and extreme risks to the Board, the Finance, Audit and Risk Committee (FARC), and the Clinical Council. This meant that some risks reported as extreme were not being escalated to the relevant committee. At the time, the risk register was also incomplete, with many risks not validated by the risk owner and mitigation not provided, and with several extreme and high-rated risks not showing any action or mitigation against them.

²⁴ Prepared for the Board meeting on 8 December 2020.

- a) Dr B stated that there was a “disconnect” between the executive management and the senior clinicians, and no “easy direct reporting lines and feedback [loop]”. Dr B told HDC that clinicians “know what is going on but are not listened to”.
- b) Dr C told HDC that Medical Oncology had produced a number of business cases in response to increasing demand associated with new treatments, and that these were sent to the ELT by the Clinical Director. However, the ELT did not seem to understand the clinical risk to patients caused by the increasing waiting times.
- c) Dr E stated that the executive management were unhelpful in their focus on the financial deficit. I note that at the time of events, Te Whatu Ora Southern was working in a deficit funded environment.²⁵
- d) Dr E also stated that their (SMOs’) frequent written correspondence to the executive about the impact of inadequate SMO staffing was like “charting the course of the Titanic”, in that actions were not taken to change the trajectory toward increasing wait times and patient harm.

2019–2020

43. According to Te Whatu Ora Southern’s data, by 2019 the Radiation Oncology waiting list was significantly greater than its capacity for management, and there were also increasing wait lists in Medical Oncology and Haematology. In June 2019, Te Whatu Ora Southern developed a recovery plan for Radiation Oncology, which outlined actions for ensuring that Radiation Oncology wait times met Manatū Hauora|Ministry of Health performance indicators. Key strategies identified to manage clinical risk and patient experience included regular reassessment of the wait list with clinical teams prioritising patients, weekly service meetings to assess current workload, and updating of wait-list letters informing patients of current wait times and how to seek advice if there were any concerns or changes in their condition.
44. Between March and September 2020, executive reporting to the Board²⁶ identified wait times outside the service capacity and/or national guidelines:
 - In March, the wait list for Radiation Oncology was significantly greater than capacity.
 - In April, urgent cancer service patients (across all services) were being seen within “clinically indicated timeframes”, but in less urgent cases they were being seen in 7–8 weeks rather than the clinically indicated four weeks.
 - In June and July, following the first COVID-19 lockdown (March and April 2020), there had been a small reduction in referrals for Radiation Oncology, but more patients were seen because SMO annual leave was not taken. Radiation Oncology FSA performance improved markedly and the wait list reduced.

²⁵ The SDHB review noted that the DHB had maintained a deficit financial position for “many years” (as at 2021), and a \$15 million deficit was forecast for the 2020/21 financial year.

²⁶ Bi-monthly Executive Director Specialist Services report to the Health Advisory Committee and CEO’s monthly report to the Board.

45. In September 2020, the Radiation Oncology wait list had again increased well beyond capacity for patients waiting for an FSA.
46. Actions taken to reduce the wait list at that time included employing additional registrars and SMOs to run regular weekend follow-up clinics. Whilst Te Whatu Ora Southern supported a Radiation Oncology Fellowship as additional senior medical workforce, this was not achieved due to recruitment issues.

October 2020–March 2021

47. The October SBCS Service Manager's²⁷ report to the Directorate Leadership Team²⁸ identified capacity and demand issues becoming critical across SBCS and growing wait lists that could result in poor patient experience and harmful outcomes for patients. Modelling suggested further increases by the end of March 2021.
48. The actions taken in response to this included recruitment of a radiation oncologist and registrar (which would not begin until February/March 2021) and locum recruitment underway providing short-term relief, continuing weekend SMO clinics, and nursing initiatives in Haematology and Radiation Oncology.
49. The November 2020 report²⁹ to the Hospital Advisory Committee (HAC)³⁰ did not raise cancer services waiting lists as an issue, and mentioned cancer services only in regard to performance against the 31-day target having dropped slightly compared to the previous month.
50. However, the November 2020 HAC meeting minutes³¹ record that concerns regarding waiting times were raised. The response to this by the CEO³² was that the radiation oncology waiting list had stabilised, and that more information would be provided to the HAC around effectiveness of the whole of cancer services, including performance against the 31-day and 62-day targets and a comparison against other DHBs.
51. In December 2020, HAC was advised³³ that in response to this issue there was a plan to use unbudgeted funding for further locums.
52. At its March 2021 meeting, the Board³⁴ was advised that the 62-day FCT target achieved was only 65% (against a target of 90%) across all cancer services.
53. In the HAC meeting of March 2021, they focused on the 31-day FCT target in oncology, but also looked at the increasing waiting lists across SBCS. It is recorded in the minutes that

²⁷ SBCS Service Manager responsible for Radiation Oncology, Medical Oncology, and Haematology services.

²⁸ SBCS Report to the Executive Director Specialist Services.

²⁹ The Executive Director Specialist Services Report ahead of the November 2020 HAC meeting.

³⁰ The HAC monitors the financial and operational performance of hospital services.

³¹ Meeting minutes included in the HAC Agenda for December 2020.

³² As recorded in the November 2020 HAC meeting minutes.

³³ In the Executive Director of Specialist Services Report ahead of the December 2020 HAC meeting.

³⁴ Southern District Health Board.

coding anomalies were identified as one of the causes of poor FCT performance,³⁵ but that even adjusting for this, performance was still below the target, and HAC was considering what measures could be taken to improve this.

54. Te Whatu Ora Southern's Organisational Risk Register also identified risks from March 2021 relating to delays in cancer care, and highlighted the potential for patient harm. The Register contained the following entries:

- 1 March 2021: "Delayed care: ... Faster Cancer Treatment (FCT) has 0.5 FTE for the entire SDHB. This is a vulnerable service. Any loss of staffing due to unplanned absence would make delivery of the service impossible."
- 1 March 2021: "Delayed care: Oncology — [area]. The high patient numbers and low nursing staff are causing treatment delays in oncology care at [the public hospital]. Possible delay in treatment and unsustainable working practice."

55. The initiatives to improve the Radiation Oncology wait times in response included recruitment for additional staff and outsourcing to a private hospital in another region to bring the wait list down.

Harm register — March 2021

56. In March 2021 the SBCS Clinical Directors wrote to the CEO outlining the ongoing issues with Medical Oncology's lack of capacity, and enclosed a harm register with a stated purpose of enabling the ELT to understand the harm to individual patients caused by prolonged wait times for cancer care/medical oncology in Te Whatu Ora Southern. Harm was defined as physical harm to the patient or financial harm to the DHB, and did not include psychological harm.

57. The Harm Register was produced on two occasions (a snap shot in time) covering the period January/February 2021 and March/April 2021 (the latter presented to ELT in May 2021), listing patients exceeding the recommended wait times and describing the subsequent harm. During this four-month period, there were 42 patients who in the clinical judgement of the oncologists were harmed by prolonged waits for FSA and treatment. In the letter accompanying the first Harm Register, the Clinical Directors noted that delays from diagnosis to treatment of greater than eight weeks were known to result in reduced survival in common cancers.³⁶ Descriptions of the harm to patients included ongoing weight loss, functional decline, and progressive disease while awaiting investigation, limiting treatment options.

58. Dr B told HDC:

³⁵ It was noted that HAC believed that the manner in which performance was being recorded was inconsistent with other DHBs, and HAC undertook an exercise of replicating another DHB's logic for calculating the 62-day target. It was anticipated that its own performance might lift if it were to calculate more consistently with other DHBs.

³⁶ Hanna TP, King WD, Thibodeau S, et al. Mortality due to cancer treatment delay: systematic review and meta-analysis. *BMJ*. 4 Nov 2020.

“[We thought that] if we personalised it to some degree and mentioned a list of patients that we believed were disadvantaged by the wait lists, this might focus their thinking.”

59. The CEO stated: “[T]he Harm Register was the catalyst, a big incentive for us all ... [I]t drove the right culture ... created awareness and interest from multitudes of sources.”
60. Updated Harm Registers were intended to be forwarded to relevant parties on a regular basis throughout 2021 with the hope that it would inform decision-making by the ELT and the Board. However, this did not occur.
61. The CEO told HDC that the reason for this was that once the concerns (outlined by the Harm Register) were highlighted and Te Aho o Te Kahu|Cancer Control Agency became involved (see next section), weekly reporting to the CEO and Board was put in place to monitor progress.

Te Aho o Te Kahu — March 2021

62. In March 2021, a presentation was delivered by the Clinical Council on behalf of SBCS to Te Aho o Te Kahu Chief Executive, the Executive Leadership at the DHB, Manatū Hauora|Ministry of Health DHB Performance Monitoring Deputy Director General, and Manatū Hauora|Ministry of Health Chief Medical Officer, to bring to their attention Te Whatu Ora Southern’s oncology patient wait-list challenges. The presentation highlighted that delays in cancer care at Te Whatu Ora Southern were leading to poor outcomes for consumers, including increased mortality.
63. From the time of the March presentation and throughout 2021, Te Aho o Te Kahu worked with Te Whatu Ora Southern to help stabilise and strengthen its non-surgical cancer services.

Actions taken after Harm Register — April 2021 to February 2022

64. Following presentation and circulation of the Harm Register, SDHB’s CEO, Board, and Clinical Directors of SBCS discussed and engaged in initiatives to address the wait times. The issue of delay also received more attention at a governance level. For example:
 - a) SBCS began working with Te Aho o Te Kahu and Manatū Hauora|Ministry of Health on development of a short-term recovery plan for Radiation Oncology, and a 10-year strategic plan (to be developed over the course of 2021 with key Te Aho o Te Kahu input) for oncology services.
 - b) In April 2021, the Clinical Council provided the Board with an update advising that its focus was changing from being representative to one based on operational clinical leadership.
 - c) In May 2021, the SDHB review report was completed.
 - d) In June 2021, the Clinical Council’s (on behalf of the Clinical Directors) presentation to the Board identified that for the 62-day FCT measure, Te Whatu Ora Southern was the

worst performing DHB in the country, and conveyed its concern of “failure across the cancer pathway” and highlighted a need for a significant FTE capacity increase.

- e) The Board approved \$2m of unbudgeted funding for the 2021/22 financial year to assist with increasing the staffing levels of all oncology services.
- f) In June 2021, an action plan³⁷ was developed in collaboration with Te Aho o Te Kahu to address the current waiting list and service planning challenges. The plan included monitoring waiting lists, weekly updates on risk and harm mitigation strategies, formalising outsourcing, and recruitment. The action plan was finalised in July 2021.
- g) The organisational risk register was also updated in July 2021 with the risk of “Delayed care: Increased demand for Oncology” marked as “extreme”.
- h) There was also significant investment from the Board to mitigate the oncology treatment delays, and Radiation Oncology was outsourced to reduce the waiting list.

Results of initiatives undertaken

- 65. The initiatives undertaken appeared to assist in addressing the issues of delay. For example, at the Board meeting in September 2021, the CEO advised that the Radiation Oncology wait list had reduced as a result of outsourcing and SMO clinics in weekends; in October 2021 the risk of “Delayed care: Increased demand for Oncology” first entered in July 2021 was lowered from “extreme” to “high” risk (where it remained as at April 2022); and in November 2021 the CEO reported to the Board that oncology wait times in all three services remained stable.
- 66. In February 2022, the SBCS Service Manager reported to the executive that the Radiation Oncology wait list had continued to improve but that recruitment was ongoing for a sixth radiation oncologist.
- 67. In the same report, the SBCS Service Manager highlighted that Medical Oncology wait times had deteriorated, and service capacity remained at risk in the short term due to parental leave and difficulty finding a locum. Two permanent Medical Oncology SMOs (1.6 FTE) had started. The Haematology Oncology service continued to have SMO capacity issues with a 0.5 FTE SMO vacancy and locum recruiting processes going through five cycles without interest, as well as upcoming parental leave. Increasing wait lists were at risk of increasing further.
- 68. Lastly, Te Whatu Ora Southern commissioned a report from EY, specifically to assist in development of a three-year action plan for SBCS. An integral part of the EY work was to benchmark SBCS with other centres in New Zealand in relation to workforce and service delivery, with recommendations for action in 2022–2024 to address any material gaps.

³⁷ Programme Plan for Southern Blood and Cancer Service Planning July 2021.

69. In its summary of all recommendations, EY found:

“[T]here is prima facie evidence that increased workforce resourcing, beyond the approved \$2m of unbudgeted funding for the 2021–22 financial year to assist with increasing the staffing levels of all oncology services, is needed to better align SBCS with other centres. While the budgeted uplifts in some roles in 2022 begins to achieve this, there remains some material differences, particularly when the service delivery context of the DHB is considered.”

70. The Board approved and adopted the EY SBCS Action Plan report,³⁸ and requested that “management draw attention to this when engaging with Te Whatu Ora on the 2022/23 budget for the region”.

71. Te Whatu Ora Southern told HDC that as at July 2022, the action from the EY recommendations had focused on nursing 2.0 FTE and additional administration resource of 4.0 FTE, and recruitment for these roles was nearing completion. It noted that there has been some discussion about the recommendations and whether they are achievable or can be progressed now that it is no longer a district health board and is part of Te Whatu Ora|Health New Zealand.

72. The CEO told HDC that in the last 18 months (2021–2022) the Clinical Council had gone from “a mediocre effective group to something that is very effective”, due to the right configuration of leadership and engagement. The CEO credited this group with flagging the unacceptable waiting list harm and the need to take action.

Impact of treatment delays on patients

Psychological impact of delays on patients

73. The New Zealand Cancer Society³⁹ notes that “the uncertainty and anxiety of waiting [for specialist assessment or treatment with a cancer diagnosis] can be physically, mentally and emotionally exhausting”.

74. Four complaints were received by Te Whatu Ora Southern from whānau of patients on the Medical Oncology Harm Register regarding the delays in cancer care. The complaints all related to the delays in FSA and subsequent delays in treatment, and noted undue mental distress and anxiety, missing out on time that could have been spent with loved ones, and planning end-of-life care. In one case, the patient allegedly missed out on potentially curative care.

75. Dr C, medical oncologist, told HDC that it is hard to capture the harm of human distress caused by waiting following a diagnosis of cancer, especially an eight-week delay to be seen. He stated that the “trauma of that wait can[no]t be understated”. Dr C told HDC that

³⁸ EY report February 2022.

³⁹ The Cancer Society of New Zealand is a non-government organisation dedicated to reducing the incidence and impact of cancer and ensuring cancer care for everyone in New Zealand.

“[t]he thing which remains impossible to convey is the distress that that waiting time causes at one of the most vulnerable times”.

76. Ms A, a patient advocate, told HDC that in 2018, her family were given an expected timeframe of 12 weeks for her husband to be seen by an oncologist, after he was informed that he had approximately six to eight weeks to live. She stated: “[T]hat situation had a catastrophic impact on our family.” The patient advocate said that they were told that her husband was dying but he was not being seen urgently, which “really caused [them] a lot of harm”.
77. The patient advocate told HDC that people are harmed because of under resourcing and consequent waiting lists, and “not just [by] cancer harm, mental harm”.
78. Dr C told HDC:
- “[P]eople’s acceptance and stoicism around being inside a system that deals with them in a certain way is absolutely and utterly mind-blowingly accepting of that situation ... [T]hey are so stoic and so gracious in that circumstance.”
79. Dr C stated that “as a provider, you know [the system at Te Whatu Ora Southern] doesn’t have to be that way”.

Information provided to patients about delays

80. Te Whatu Ora Southern told HDC that patient referrals are triaged by the appropriate oncologist at the SBCS, and a letter is then sent to the patient and the general practitioner (GP) with the current or actual wait time for FSA compared to the Manatū Hauora | Ministry of Health guidelines. Each oncology specialty has prioritisation criteria guidelines⁴⁰ that outline triage categories and wait times of between one day and four weeks (except for Haematology, where “routine” patients are seen within four months, aligning with the national ESPIs). The letter to the patient also notes the options of going back to their GP or going to a private care provider.
81. Te Whatu Ora Southern provided HDC with 10 letters sent to cancer patients in 2021 following triage, where actual wait times were estimated to be between 6 to 12 weeks. Nine⁴¹ of these letters were for radiation oncology patients, where the guidelines

⁴⁰ Radiation Oncology:

<https://nsfl.health.govt.nz/system/files/documents/pages/radiationoncologyprioritisationguidelines-final.doc>

Medical Oncology:

<https://nsfl.health.govt.nz/system/files/documents/pages/medicaloncologyprioritisationcriteriaoct2012.doc>

Haematology:

<https://nsfl.health.govt.nz/system/files/documents/pages/haemprioritisationcriteriajuly2011.doc>

⁴¹ The tenth letter was for a medical oncology patient expected to be seen in approximately seven weeks’ time — the letter did not state the recommended timeframe within which the patient had been categorised to be seen in accordance with the Ministry of Health guidelines, and therefore the length of delay is not known.

recommend being seen within four weeks.⁴² The letters do not provide a contact number or name for SBSCS.

82. The patient advocate told HDC:

“[P]eople have this horrendous news that they are dealing with, they know that they’ve got cancer and they can’t get care in a timely way and they get a letter that says I’m really sorry but we’re operating outside of the [Manatū Hauora] Ministry of Health’s recommendations.”

83. The patient advocate said that in her opinion, information provided to patients around wait times is lacking. She stated that Te Whatu Ora Southern “is notorious just for not replying to people in a timely manner or not replying at all”.

84. Clinicians confirmed that there is no further communication from Te Whatu Ora Southern to the patient until notification of the appointment time, which could be up to 12 weeks later. Dr B told HDC that “until such time as they’re seen by a member of our team we do not have an overview of their care”.

Open disclosure about possible harm

85. Te Whatu Ora Southern’s “Open Disclosure Guidelines” (2018) describe when and how open disclosure⁴³ should occur, including when a patient has suffered harm when receiving health care, or has been exposed to possible harm from a system error. The guidelines note that the level of response is dependent on the severity of the incident.

86. Te Whatu Ora Southern told HDC that several of the harms described on the Harm Register were the need for repeat diagnostic tests due to a time lapse between the initial test and FSA, and the patient’s clinical condition deteriorating while waiting. In such cases, the clinician would discuss the delay “sensitively and in a patient centred manner” at the time they saw the patient.

87. Te Whatu Ora Southern told HDC that at no time nor in any way were the harms experienced by patients or the relationship of that harm to waiting times concealed or hidden from patients. All such cases were managed as sensitively as possible by clinicians working in a resource-constrained environment.

88. Dr C stated that where a delay to an appointment has resulted in a reduced chance of cure, “a more nuanced discussion” is required, as harm is often more potential harm (as opposed to actual harm). Dr C noted that it is difficult to establish for an individual patient whether that patient personally was harmed, but it can be demonstrated at a population level. Dr C told HDC that a report on wait times and its impact seems an appropriate way to capture this group-level harm, which is more difficult to discern at an individual patient level.

⁴² See footnote 40 — Radiation Oncology.

⁴³ Open disclosure is an open communication with a patient about an incident(s) that resulted in harm while they were receiving health care.

Further information

89. Mr D, Executive Director Specialist Services, told HDC:

“I think it’s really important to note that once we saw [the wait list] starting to grow there was a lot of work done in terms of putting in an improvement programme around services and there was willingness from the Board to invest, we spent a considerable sum of unbudgeted funding with the CEO and Board endorsement to outsource to [a private hospital in another region] to manage the wait-list volumes and that work programme did translate into the wait-list coming back down to where it needed to be. So ... we didn’t allow the situation to continue and deteriorate further, we put in the investment, even though it wasn’t planned for in our budget process.”

90. Dr B said that since these events, the most recent general manager had been very helpful, and the relationships between clinicians and senior management had improved considerably with the new executive team, and they now felt listened to.

91. However, the Clinical Directors told HDC that unfortunately, the very conservative recommendations within the EY report have not translated into significant action, with only a few of the recommendations being implemented. They said that (as at July 2022):

“[C]urrently services are underpinned by goodwill, excessive work hours and in the case of radiation oncology expensive outsourcing and insourcing which is unsustainable. The wait lists are now rising back to unacceptable levels and currently there is no plan in place to bring them back under control.”

92. Recommendations for immediate action from the EY report included a further 0.3 FTE haematologist and consideration of a further 1 FTE medical oncologist from new funding, as well as the prioritisation of the 1.3 FTE radiation oncologist approved within the \$2m of unbudgeted funding for the 2021/22 financial year.⁴⁴

93. Te Whatu Ora Southern told HDC that to date the action from the EY recommendations has focused on nursing and additional administration resource FTE, and recruitment for those roles was nearing completion (as at July 2022). Te Whatu Ora Southern also stated that there had been some discussion about whether the recommendations are achievable or can be progressed following the health reforms and disestablishment of DHBs.

Responses to provisional opinion

94. Te Whatu Ora Southern was given an opportunity to respond to the provisional opinion, and its feedback has been incorporated where relevant.

⁴⁴ In June 2021, Te Whatu Ora Southern approved 16 FTE positions across the three specialties, including senior medical staff, registrars, nurses, and allied health staff.

95. Te Whatu Ora Southern stated that following the SHDB review⁴⁵ a performance and accountability structure has been put in place, and this is supported by a clinical governance system that promotes assurance of the safety and quality of its delivery.

96. Te Whatu Ora Southern told HDC that the focus on fiscal targets continues to be a very complex aspect of governance and clinical governance within health care. It stated:

“We feel that to state ‘Southern’s executive leadership failed to act on the valid concerns raised by its senior clinicians and ensure that actions were taken to address the clinical risk being caused by the lack of capacity’ underplays the very real problems and fiscal pressures that the Commissioner,⁴⁶ the Board, and the Executive faced across this time.

Inequities in funding have led to variations within healthcare delivery across Aotearoa and we sincerely hope that the new model of healthcare under Pae Ora (Healthy Futures) Act 2022, together with our further efforts to improve our clinical governance systems, will improve the situation.

The Southern Blood and Cancer Service acknowledges the immense challenges highlighted in this report and, although a lot of excellent work has been done recently, the ongoing challenges with recruitment, especially senior doctors, have continued to be significant.

Southern does not underestimate the impact this has on our staff and our communities when we are unable to fill key vacancies. With such a small service dependent on individual tumour stream specialists, this has added to the vulnerability of the service over the years.

Te Whatu Ora is currently working on a national and regional recovery and support plan to improve access to oncology treatment and ensure equity of access to radiotherapy. A significant part of this recovery and support plan is looking at how we collectively work regionally and nationally on implementing pathways to access cancer treatment regardless of who you are or where you live.”

97. Dr B stated that some of the statements from former members of ELT highlighted in this report imply that Te Whatu Ora Southern ELT were unaware of issues facing SBCS until the Clinical Council drew it to their attention in 2020–2021, following which action was taken swiftly. He noted that issues facing SBCS had been raised from 2016 onwards.

98. Ms A, the patient advocate, was given an opportunity to comment on the full provisional report. She stated (among other things):

“The findings of the report sadly confirm what many of us already knew, that patients in Southland and Otago suffered significant harm due to clinically unsafe lengthy waits

⁴⁵ See footnote 20.

⁴⁶ Between June 2015 and December 2019, the Board of SDHB was replaced by a Commissioner.

and that the care provided by Southern District Health Board was a severe departure from the accepted standard of care.

I was particularly heartened to see that the report also acknowledged the immense pressure that oncology professionals were under, and that they had tried numerous times to get the resources they needed to treat their patients appropriately.

I was pleased to see the report also highlighted the psychological impacts that patients and their families have had to endure, which is often overlooked in discussions about cancer care.”

99. However, Ms A expressed concern about a deterioration in the service post-investigation, and the inaction to address such deterioration. She would like inadequate resourcing of the Southern Cancer Service urgently addressed so as to prevent harm to cancer patients in the Otago and Southland region.

Opinion: Te Whatu Ora | Health New Zealand Southern — breach

Introduction

100. Healthcare providers have a responsibility to provide patients with an appropriate standard of care that minimises the potential harm to, and optimises the quality of life of, that consumer (Right 4(4) of the Code of Health and Disability Services Consumers’ Rights (the Code)). This includes patients who have been accepted onto a waiting list for specialist services.
101. Demographic trends, as well as the introduction of new technologies and treatments, have driven an increase in demand for cancer services across Aotearoa New Zealand. However, timely treatment can be particularly important for reducing morbidity and mortality for cancer patients, as it can often be a key factor in survivability. As highlighted in this report, cancer care delays can also have a significant psychological impact on patients. In a significantly resource-constrained environment, healthcare providers have a responsibility for prioritising resources to those services that are life-preserving.
102. By October 2020, there were significant delays for SBCS patients to be seen or to be assessed by a specialist, resulting in significant clinical risk and harm. This included functional decline and progression of the disease while awaiting investigation, limiting treatment options and leading to psychological harm.
103. In my view, since at least 2016, Te Whatu Ora Southern did not recognise and respond appropriately to the degree of clinical risk to patients as a result of increasing delays in patient FSAs and treatment. Te Whatu Ora is responsible for the operation of the clinical services it provides, and is responsible for any service failures.

104. I note that SDHB was subject to previous reviews⁴⁷ relevant to the issues under investigation, and HDC's investigation builds on those.

Cause of delays

105. My independent advisor, Dr Grant Pidgeon, stated that the delays in patient assessments identified in the Harm Registers were predominantly due to capacity issues within the SBCS. He noted that by October 2020, clinicians were already working to the limits of their capacity and were unable to absorb any increasing demand.
106. Dr Pidgeon noted (and the data provided by Te Aho o Te Kahu confirms with respect to cancer registrations) that oncology volumes at Te Whatu Ora Southern had increased over the preceding 10 years, with associated increased complexity of patient care, but that staffing levels had changed minimally in the same time period.
107. I accept this advice. Simply put, demand exceeded capacity and insufficient attention was given to addressing this significant clinical risk to patients. At the start of October 2020, the SBCS was under considerable strain with regard to its staffing resource. This is evidenced by the fact that in October 2020 the Service Manager raised concerns about critical capacity versus demand issues, and flagged the potential harm and distress for patients subject to delays. Te Whatu Ora Southern noted the growing radiation waiting list in late 2020.
108. The Radiation Oncology SMO headcount increased minimally following a job-size exercise, but not to the levels needed to respond to the increasing demand. Medical Oncology staffing also changed minimally (by only 0.3 FTE) over the 10-year period. The EY report completed in 2022 noted that SBCS had fewer FTE across clinical and technical positions relative to patient activity than most other cancer centres, and that increased workforce resourcing was clearly required.

Executive management's response to clinical risk caused by delay

109. Te Whatu Ora Southern told HDC that it was aware of concern about wait-list delays as early as 2016. That the service was under pressure is also evident from SBCS performance reporting, which shows an increasing reduction in compliance with Manatū Hauora | Ministry of Health expectations for timely cancer treatment from 2016, with a marked further increase in Radiation Oncology wait times since 2020 and Medical Oncology since 2021.
110. Dr Pidgeon advised that Te Whatu Ora Southern's focus on fiscal targets and the lack of key quality indicators obscured the clinical risk to patients. His view is that in the deficit-funded environment, performance focus was very much on reducing costs rather than the avoidance of patient harm.
111. Dr Pidgeon advised that capacity issues can be addressed in only two ways — by increasing capacity through increasing staffing and throughput, or by reducing demand.⁴⁸

⁴⁷ The "Southern District Health Board Review" (May 2021), and the EY report (February 2022).

112. Te Whatu Ora Southern considered restricting its services but did not action this. It also considered outsourcing and locums. However, up to June 2021, although there was some use of locums and outsourcing, this was largely piecemeal, and no other increase in FTE was actioned.
113. Dr Pidgeon stated:
- “The pressure on the waiting times had been alluded to since 2016 with descriptions in the service report in late 2020 of a ‘looming crisis’. Therefore, the adequacy and timeliness of the response [by Te Whatu Ora Southern] was very poor in that nothing was done to address these issues until March 2021 and only then following the publication of the Harm Register. The previous four to five years was an opportunity to enhance capacity through the services, and manage the referrals and waiting lists appropriately, but it would appear that very little was done during this time other than continued focus on service improvement work.”
114. Dr Pidgeon also noted that locums are a “poor answer” to demand pressures as they are very much a temporary fix usually focused on FSAs, and subsequently adds to the follow-up and treatment burden on permanent staff, including re-work because locums are not fully aligned to the SBCS model of care.
115. In addition, Dr Pidgeon’s view is that the management response to the deteriorating FCT target achievement was to focus on data anomalies rather than potential patient harm.
116. I accept this advice. It is clear that since at least 2016 demand outstripped capacity in SBCS, creating a significant risk to patient safety. This is evidenced by the fact that at its March 2021 meeting, the Board was advised that the 62-day FCT target achieved was only 65% (against a target of 90%) across all cancer services. However, the response from Te Whatu Ora Southern, at least until March 2021, was inadequate in that although some actions (such as regular weekend follow-up clinics, attempts to seek greater efficiencies through service improvement, ad hoc outsourcing, and locums) were employed, these were piecemeal, unsustainable, and had a minimal impact on the waiting list delays. The primary strategy seemed to be considerable reliance on existing workforce, which in my view was inadequate.
117. As this Office has highlighted previously,⁴⁹ provider accountability is not removed by the existence of systemic pressures. Increasing demand and risk to patients was apparent since at least 2016, but was not planned for.

⁴⁸ Dr Pidgeon noted that the latter was considered by the CEO at the time, but not followed through on, and that it also would have been an extreme response leading to considerable inequity of service delivery compared to the rest of the country, and significant patient harm.

⁴⁹ See Opinion 16HDC01010 (12 March 2018).

Clinical governance systems at Te Whatu Ora Southern

118. An effective accountability and performance framework where patients are the focus and patient safety concerns are signalled, acted upon and evaluated is a vital element of quality and risk management. Dr Pidgeon advised that the clinical governance systems were poorly developed and not adequate to either delineate or minimise the risk across clinical services, and, had they been adequate, then the concerns regarding increasing patient harm from delays would have been more visible and addressed much earlier.

Quality measures

119. In my view, Te Whatu Ora Southern's quality measures and systems were inadequate for the purpose of ensuring safe patient care. The quality measures reported to the Hospital Advisory Committee (HAC) and Board were not adequate to identify the extent of the problems, or to illustrate the potential patient harm that was occurring.
120. Dr Pidgeon advised that waiting list data was an inadequate representation of potential harm within the cancer services, and the focus on this data suggested that cancer services were seen as no different to other planned care services. He noted:

“Hospital management staff are used to thinking about waiting times for surgical procedures such as hip replacements, where delay in the provision of the service might increase morbidity, but rarely influences mortality. The difference in cancer services is that there is good data that indicates that delay in first assessment leads to significant differences in outcomes, particularly mortality, following a diagnosis of cancer.”

121. Further, Dr Pigeon noted that the FCT targets involve only a small fraction of total patients with cancer and address only a fraction of the workload of the SBCS, and therefore underestimated the potential patient harm caused by delay in assessment.
122. In addition, it is evident that the Clinical Council was not functioning adequately in its clinical governance and safety role until its change in focus in 2021. Dr Pidgeon noted that the SDHB review indicated that it was not working well from a clinical governance perspective, and was not capable of dealing with the issues raised in the cancer services, as evidenced by meeting minutes in late 2020.
123. Further, the SAC/SAER reporting system — a key element of capturing patient harm and improving service quality — was not used by clinicians, who had lost trust in its ability to contribute to quality improvement.

Relationship between clinicians and executive management

124. From at least 2016, senior clinicians attempted to communicate their concerns to Te Whatu Ora Southern's executive management regarding the growing lack of capacity of SBCS to meet demand. Clinicians considered that their concerns were largely discounted (due to perceived dysfunction within clinical staffing groups) by executive management or attributed to outside influences, such as the impact of COVID-19 and decisions of Te

Pātaka Whaioranga|Pharmac that led to greater workload without commensurate funding.

125. The multiple representations by clinicians for additional resources, especially staffing across the service, resulted in ineffective and temporary relief action such as the use of locums, but not an increase in FTEs.
126. For example, as noted in paragraph 28 above, Dr C noted:
- “[W]hen we had melanoma drugs funded, we predicted very clearly over the course of one to two years how many new patients we’d need to treat and what new number of clinic appointments would be needed, how many new nurses would be needed, how many more scans would be needed ... and we said we need more staff to deal with this, because this is new work, and we were told ‘you have to manage within existing resource’. And so, that’s what happens repeatedly, when we make repeated business cases, make repeated presentations on the waiting list, and the staff FTE does not grow.”
127. Dr Pidgeon advised that while there may have been issues relating to outside influences, there was inadequate recognition of the pressures on staff and a lack of support for them in this regard. He also noted that while there may have been dysfunction within some staffing groups, there does not appear to have been any recognition of the significant workload of these groups.
128. In my view there was a disregard for, and lack of trust in, clinicians’ knowledge of clinical risk. The partnership between management and clinicians is reliant upon mutual trust and respect. Until the submission of the Harm Register in March 2021, Te Whatu Ora Southern’s executive leadership failed to act on the valid concerns raised by its senior clinicians, and ensure that actions were taken to address the clinical risk being caused by the lack of capacity.

Conclusion

129. Providers owe a duty of care to people waiting for resource-constrained specialist procedures. In this case, it is clear that the care provided by Te Whatu Ora Southern was not adequate, and patient harm was caused by capacity issues within the SBCS and prolonged delays for FSAs. I note that the SDHB review and the EY report concluded or stated the same.
130. My advisor considers this to have been a severe departure from accepted standards of care, and I accept his advice.
131. As this Office has noted in previous decisions,⁵⁰ it is essential that providers assess, plan, adapt and respond effectively to the foreseeable impacts that changing demographics and

⁵⁰ See Opinion 16HDC01010 (12 March 2018), and Opinion 17HDC01491, 17HDC01385, 17HDC01700, 17HDC02066, 18HDC00326 (21 August 2019).

new technology will have on systems and demand. It is also incumbent on providers to have in place strong clinical governance frameworks that allow them to proactively identify and manage clinical risk in order to prevent patient harm.

132. This case is a salutary reminder of the detrimental outcomes, both physical and psychological, that can occur for patients when the system does not adequately provide for timely cancer care. As I stated earlier, in my opinion Te Whatu Ora Southern had a responsibility for prioritising resources to those services that were life-preserving, and this did not happen.
133. Due to poor overall clinical governance systems, including inadequacies in quality measures and indicators and poor relationships between clinicians and executive management, Te Whatu Ora Southern failed to recognise and respond to the clinical risk created by the lack of capacity within the SBCS. These issues developed gradually over a number of years, due predominantly to a lack of investment in staffing resource to cope with the increasing demand on the services.
134. Dr Pidgeon noted that this lack of investment stemmed largely from the deficit status of the DHB, which in his view led to a focus on fiscal management rather than avoidance of patient harm. He considered that this was contributed to by a significant disconnect between management and clinical staff, and clinical governance and risk management systems were not adequate to raise concerns sufficiently regarding the developing patient harm.
135. The concerns raised by clinicians and by service managers were, in the view of the clinicians, largely discounted or attributed to outside influences, with no meaningful intervention until the presentation of the Harm Register in March 2021, which was an initiative of the clinical staff, and reflects inadequacy of established clinical governance systems at the time. Once the degree of patient harm was recognised, there was a reasonably rapid response with a significant injection of funds for enhancing staffing resource. However, this is of little comfort to those on the Harm Registers or their families and whānau.
136. In my view, Te Whatu Ora Southern failed to provide services to patients within the Southern Blood and Cancer Service in a manner that minimised the potential harm to, and optimised the quality of life for, those patients. Accordingly, I find that Te Whatu Ora | Health New Zealand breached Right 4(4) of the Code.

Patient support — adverse comment

137. While this investigation has focused on Te Whatu Ora Southern's systems with respect to cancer services, sight should not be lost of the real people whose lives were affected by Te Whatu Ora Southern's inaction on growing concerns about the cancer services' ability and capacity to care for the people of its region.
138. There is no dispute that for consumers, waiting for an FSA or treatment can be distressing and can have a psychological impact. Dr Pidgeon noted that delayed assessment increases

anxiety in patients who, having received a cancer diagnosis, are already incredibly vulnerable. This was echoed by clinicians from the service, and by the patient advocate, who spoke of the significant psychological harm caused to patients by the long delays. The patient advocate's comments were born of personal experience.

139. Patients on the waiting list received a letter informing them of their wait time in relation to Manatū Hauora | Ministry of Health guidelines, as well as their option to seek private care (which was very limited in the region) and to discuss any concerns with their GP. However, no further communication from Te Whatu Ora Southern occurred until an FSA date was sent — in some cases up to 12 weeks later.
140. Dr Pidgeon noted that the options of seeking private care or discussing with their GP any concerns would have been at increased cost to the patient. He considered that it would have been preferable for greater support to have been provided to patients while awaiting their FSA.
141. In my view, patients would have benefited from a more consumer-centred, humanised approach, including a clinical navigator service or point of contact within the district, and the offer of subsidised GP visits if their circumstances changed.

Current status of oncology services — other comment

142. I accept that once the Harm Register was presented, there was initially a timely response by management to address the issues within the service, and that progress has been made to improve the delivery of cancer services at Te Whatu Ora Southern.
143. However, I note that Dr Pidgeon has identified that progress has slowed recently. He commented:
- “The gains in clinical performance over the last 6 months of 2021 are at risk of being eroded ... It is imperative that a Cancer Service recovery plan is developed that plans for adequate services and staffing to deal with continued increasing demand. It is important that this includes the development and reporting of more appropriate clinical indicators than just the presentation of numbers of patients on the waiting list.”
144. Subsequently, and during my preparation of this report, it has been reported that due to specialist workforce shortages, Te Whatu Ora Southern are currently unable to provide some cancer services, and there are ongoing delays in patients receiving FSAs. I am also mindful of Ms A's concerns in this respect noting her most recent feedback that she has “been told by a number of credible sources that the oncology department is in a worse state today than it was at the time of the investigation”.
145. I encourage Te Whatu Ora to act on this information to ensure people in the Southern region receive timely cancer treatment, and I will be following up on the actions taken.

Recommendations

146. I recommend that within three months of the date of this report, Te Whatu Ora Southern:
- a) Consider establishing a system that provides a single point of contact (for example, a patient navigator service) for patients who are on the waiting list for FSA. The functions of this system could include:
 - i. continued assessment of patients on the wait list;
 - ii. keeping patients updated and informed about current wait times, including when wait times are outside current recommendations;
 - iii. providing patients with all options available for accessing care, including available supports (whether they be clinical, psychological or social); and
 - iv. providing patients with advice regarding the management of evolving symptoms.
 - b) Provide a report on the implementation of the recommendations of the Southern District Health Board Review 2021 and the EY report of 2022, in particular:
 - i. progress with the design, implementation and embedding of an accountability and performance framework;
 - 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;
 - iii. the cancer services recovery plan;
 - iv. implementation of a three-year workforce plan for the SBCS, incorporating the recommendations from the EY SBCS Action Plan and taking into account the work capacity of each FTE and the geographical demands of the area, and allowing for the non-clinical duties of clinicians; and
 - v. the assessment of staff wellbeing, particularly with regard to current hours of work, non-clinical duties, capacity for leave, and planning of sabbaticals across the three oncology services.
 - c) 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.
147. I recommend 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;
 - ii. consider the impact of the introduction of new technologies and new cancer medications on capacity; and

- 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.
148. I recommend that Te Aho o Te Kahu provide HDC with an update on progress of its work with Te Whatu Ora Southern to address any cancer service delays, within three months of the date of this report.
149. In response to the provisional opinion, Te Whatu Ora Southern advised that in relation to recommendation a), it agrees that improvements can be made to its systems in this area, and although it considers that a patient navigator system may not be possible within current resources, it will look into the use of the current referral nursing teams to offer patient updates and care until FSA in oncology has been delivered.
150. In relation to recommendation b), Te Whatu Ora Southern advised that it accepts the recommendation and plans to utilise its Quality and Clinical Governance Solutions team to support achieving this recommendation.

Follow-up actions

151. A copy of this report with details identifying the parties removed, except SDHB/Te Whatu Ora | Health New Zealand Southern and the advisor on this case, will be sent to the Director General of Health, the Chief Medical Officer at Manatū Hauora, the Chief Executive of Te Aho o Te Kahu, the Health Quality & Safety Commission, and the Chief Executive of Te Aka Whai Ora, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.
152. In addition, pursuant to section 59(4) of the Health and Disability Commissioner Act 1994, I have written to Manatū Hauora alerting them to the feedback provided by Ms A regarding the current status of oncology services at Te Whatu Ora Southern.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from an internal medicine specialist, Dr Grant Pidgeon:

“Expert Advice Report re: Commissioner Initiated Investigation of Southern District Health Board Cancer Services October 2020 to February 2022

Dr Grant Pidgeon, Renal Physician, Wellington Hospital

I have been asked to provide expert advice regarding the care provided to patients of the Southern Blood and Cancer Service (SBCS) between October 2020 and February 2022, in light of a complaint to the HDC by a member of the public regarding treatment delays at Southern DHB’s Oncology Service. As a consequence of this complaint the HDC received copies of a Harm Register that had been developed by the Oncology Services and presented to the Board. This Harm Register detailed a number of incidences of harm caused by delays in the assessment and treatment of patients by the Medical Oncology, Radiation Oncology, and Haematology Services. The Commissioner initiated investigation is aimed at assessing whether the Southern DHB at the time acted appropriately to identify and respond to the delays in treatment during the relevant time period.

Timeline

October 2020 — the monthly report of the SBCS detailed increasing numbers on the wait list for radiation oncology and medical oncology, indicating a looming crisis with modelling suggesting further increases by the end of March 2021.

November 2020 — the Hospital Advisory Committee (HAC) report fails to raise the cancer services waiting lists as an issue, only mentioning cancer services with regard to the faster cancer treatment (FCT) 31 day target, indicating that it has dropped slightly. The HAC meeting minutes from the 2nd November 2020 however indicated that the Committee had raised concerns regarding waiting times. The response from the CEO advised that the Radiation Oncology waiting list had stabilised and that more information would be provided.

December 2020 — the report to the HAC from the Executive Director, Subspecialty Services mentions issues with Radiation Oncology and Medical Oncology with regard to outpatient waiting times, with a plan to use unbudgeted funding for further locums. Attention is drawn to the FCT 31 and 62 day targets suggesting slight deterioration only. The report indicates significant data issues with regard to the 62 day target and the need for further analysis.

January 2021 — a letter written to the CEO by the Medical Oncology clinical leader details a list of patients suffering harm due to delays in assessment, in the first iteration of the Harm Register. Some 27 patients were listed, thirteen with prolonged

delays in assessment, nine requiring additional tests due to delays, two requiring admission for complications while awaiting assessment, and three patients who deteriorated while waiting and were no longer eligible for treatment.

March 2021 — the Medical Services HAC report again mentions oncology but focusses mainly on the 31 day FCT target. This report does however include information on the increasing waiting lists across the three subspecialty areas and mentions the consideration of outsourcing of radiation oncology treatment to [another region].

March 2021 — the presentation to the Clinical Council by the clinical leaders of the Oncology Subspecialties focusses on the deteriorating FCT data, increasing waiting lists and includes a list of patients who were exposed to avoidable harm through delays in assessment and treatment (Harm Register).

March 2021 — presentation of the Cancer Care executive summary again portraying the impact of delays on outcomes and listing current wait times across the subspecialty areas.

March/April 2021 — further presentation of the updated Harm Register.

April 2021 — Engagement with the Cancer Control Agency.

May 2021 — Cancer Control Agency visit by the [region] manager.

June 2021 — Board presentation undertaken by the clinical leads of the oncology specialties.

July 2021 — Development of a Southern Blood and Cancer Service programme plan.

July 2021 — Presentation of the Cancer Control Agency summary and recommendations.

August 2021 — further presentation to the Board by the subspecialty clinical leads with subsequent approval of \$2 million budgeted for immediate staffing increases, medical, nursing, and administrative.

September 2021 — Ernst Young commissioned to undertake benchmarking exercise.

October 2021 — contract signed with [a private hospital in another region] for outsourcing of radiation oncology volumes.

February 2022 — presentation of the Ernst Young report recommending a three year plan of further improvements across the services.

Background

Although the investigation focusses on the time period of October 2020 through to February 2022 it is clear from the documents submitted to the HDC that the delays in provision of cancer services by SBCS had been developing for some years prior to this time period. Submissions by the clinical leads of the oncology subspecialties indicate that from 2016 onward there were major issues with regard to the staffing of these services, impacting on increasing wait lists and reducing compliance with the Ministry of Health acceptable waiting times. [Te Whatu Ora] also indicates that management were aware of emerging concerns about wait lists as early as 2016. Over those years the clinical leads discussed their concerns with management on many occasions but made little traction in their request for additional staffing. Data suggests that oncology volumes had increased 100% over the preceding ten years with associated increased complexity of patient care, but that staffing levels had changed minimally in the same time period. Radiation Oncology staffing had increased following a job size exercise but not to the levels needed to cope with increasing demand. Medical Oncology staffing had changed minimally, by only 0.3 FTE, over the ten year period.

The submissions from the clinical leads indicate that the management response to the increasing demands on the services was to seek greater efficiencies through service improvement, and to offer temporary locum support to address waiting list issues. Locums are a poor answer to demand pressures as they are very much a temporary fix usually focussed on first specialist assessment. Subsequently these patients add to the follow up and treatment burden on the permanent staff and there is also often a need for rework due to locum staff not being fully aligned with the model of care used by the SBCS.

At the start of the time period of the investigation i.e. October 2020, all three services within the SBCS were under considerable strain with regard to their staffing resource. The senior medical officers (SMOs) were working excessive hours with reduced capacity for non-clinical duties. They were unsupported by sufficient numbers of RMOs. There was inadequate succession planning particularly in the Radiation Oncology service and there were high levels of staff dissatisfaction and burnout.

What caused the delays as outlined on the Harm Register?

The delays to the timing of patient assessment as indicated on the Harm Register were predominantly due to capacity issues within the individual services. Each SMO within a service has a certain capacity to see new patients for assessment and determination of appropriate treatment. Already by October 2020 the SMOs were working excessive hours without sufficient non-clinical time or time for annual and CME leave. As the referral demand increased there was no capacity within the system to see the increasing number of patients and as such the waiting lists grew and continued to grow. Some of the issues on the Harm Register were also contributed to by delays in imaging, either CT or MRI, or in surgical management of patients, but predominantly the issues were with those of wait list increases due to capacity in the cancer services.

Such capacity issues can only really be addressed in two ways:

1. By increasing capacity through increasing staffing and throughput
2. Reducing demand. Board minutes indicate that this was considered by the CEO at the time, but never followed through on. This would have been an extreme response and would have led to considerable inequity of service delivery, compared to the rest of the country, and significant patient harm.

The adequacy and timeliness of the response by Southern DHB.

The pressure on the waiting times had been alluded to since 2016 with descriptions in the service report in late 2020 of a 'looming crisis'. Therefore, the adequacy and timeliness of the response was very poor in that nothing was done to address these issues until March 2021 and only then following the publication of the Harm Register. The previous four to five years was an opportunity to enhance capacity through the services, and manage the referrals and waiting lists appropriately, but it would appear that very little was done during this time other than continued focus on service improvement work. The engagement with the Cancer Control Agency from April 2021 provided further stimulus to a more timely response, focussed particularly on permanent staff recruitment.

Once the Harm Register was presented, revealing the concerns with regard to individual patient harm, there was a reasonably timely response to address these issues. The response initially was to outsource radiation oncology volumes to reduce the waiting list, and the EDSS Director [Mr D] indicates that this was ramped up over the first six months of 2021 with resultant impact on reducing the waiting list. However, the formal contract with [the private hospital in another region] was only signed in October 2021, some six months following presentation of the Harm Register.

The other major response to the delays was to use non-budgeted funds for enhanced locum support, although as noted above this is very much a temporary fix and can contribute to greater workload on existing staff. It is not a sustainable solution to capacity issues within a service and is usually more expensive than investing in more permanent solutions.

Authority to appoint new permanent staff to positions in the services was only given in July 2021 following a further presentation to the Board by the clinical leads of the Cancer Services. Following that authority however, there was reasonably rapid filling of vacancies across the services, other than in Radiation Oncology which continues to struggle with recruitment of permanent SMOs. It is worth noting however, that the two SMO appointments to the Medical Oncology service were only filled in March 2022, illustrating the very long lag phase to appoint to permanent appointments.

It is also noteworthy that when interviewed, the previous CEO indicated that he thought that the funds provided for the new appointments across the services were indiscriminately applied, indicating dissatisfaction with the process, despite the

subsequent endorsement of this by the Ernst Young team. This is illustrative of the disconnect between management and the clinical teams.

Adequacy of the clinical governance systems in place at Te Whatu Ora Southern

As noted in the [Southern District Health Board Review] report from 2021, clinical governance processes across the Southern DHB at that time were poorly developed and not adequate to either delineate or minimise the risk across clinical services. Had they been adequate then the concerns regarding increasing patient harm from delays would have been more visible and addressed much earlier.

The quality measures reported to the Hospital Advisory Committee (HAC) and Board were not adequate to portray the concerns within the services, or to illustrate the potential patient harm that was occurring. That this only became appreciated by the CEO and HAC through the reporting of the Harm Register, initiated by the clinical staff within the services, reflects that the existing mechanisms were inadequate.

The reporting that was done through the monthly service reports focussed predominantly on the Faster Cancer Treatment (FCT) targets and the waiting list data. The FCT data involves only a small fraction of total patients with cancer, and the management response to the deteriorating target achievement was to focus on data anomalies rather than potential patient harm.

Waiting list data was an inadequate representation of potential harm within the cancer services. The focus on the number of patients awaiting their first specialist appointment suggests that cancer services are seen as no different to other services where patients queue for assessment. Hospital management staff are used to thinking about waiting times for surgical procedures such as hip replacements, where delay in the provision of the service might increase morbidity, but rarely influences mortality. The difference in cancer services is that there is good data that indicates that delay in first assessment leads to significant differences in outcomes, particularly mortality, following a diagnosis of cancer. For this reason, the Ministry of Health (MOH) has provided guidance on appropriate waiting times for different presentations, the minimum standard being that patients should be assessed within 4 weeks of triage. During this period within the Southern DHB, patients were routinely being told that their waiting time would likely be 7–8 weeks. It is likely therefore that compliance with the MOH waiting time targets would have been very low and this would have been a far stronger indicator of service provision than the number of patients awaiting assessment. Similarly reliance on the FCT targets, which only included a fraction of patients with cancer diagnoses, under-estimated the potential patient harm caused by delayed assessment, and led to arguments regarding the integrity of the data.

Other standard means of delineating patient harm such as SAC reviews, similarly did not adequately capture the degree of risk and patient harm. Interviews with the clinical leads indicate a lack of trust in the SAC reporting mechanism. Many clinicians find SAC reviews to be very time consuming with significant delays in output leading

to disconnect and distrust in the process as a means of enacting sustainable service improvement.

The minutes of the Clinical Council from late 2020 indicate that it was not working well from a clinical governance perspective and was not capable of dealing with the issues raised in the Cancer Services. That it took a service derived Harm Register, developed by the clinical leads, to illustrate the impact of the delays in treatment indicates that the clinical governance structures in the DHB were inadequate for purpose.

Other matters that require consideration

Relationship between management and clinicians

The Southern DHB at that time was working in a deficit funded environment of some \$15 million per annum. As such, performance focus was very much on reducing costs and in such circumstances demonstration of staffing deficits are always difficult to progress. It is clear from the submissions of various staff, both service management and clinical, that there was significant distrust in executive management's support of the services. It would appear that staff felt that the management response to the issues was for them to work harder and longer.

Interview responses from management staff at the time suggest that the wait list concerns were attributed to the impact of COVID, and to decisions of Pharmac that led to greater workload without commensurate funding. Various interview statements also indicate a concern that there was a degree of dysfunction within the clinical staffing groups, particularly Radiation Oncology, suggesting a disinclination to take their concerns seriously.

Although there may have been issues relating to the impact of COVID and insufficient funding of services following more permissive decisions from PHARMAC, there was inadequate recognition of the pressures on staff and a lack of support for them in this regard. Similarly, although there may well have been dysfunction within some of the staffing groups, there never appears to have been recognition of the significant workload of these staff and the very real risk of burnout and staff harm. The [Southern District Health Board Review] report also highlights very significant dysfunction across the levels of the DHB at that time.

Patient support

Patients with a diagnosis of cancer are incredibly vulnerable and anxious. Once referred they expect prompt assessment and rapid initiation of appropriate therapy. Delayed assessment increases anxiety considerably and as noted previously impacts subsequent outcomes. In response to the increasing waiting times for first assessment SBCS developed letters that were sent to patients informing them of the delay in assessment. These letters suggested that any change in circumstance should be discussed with their GP or that they could consider private medical review. Such actions would have been at increased cost to the patient through no fault of their own

and knowledge of the likely delay in assessment would have added considerably to their anxiety at such a stressful time.

It would have been preferable for the DHB to have provided greater support to patients while waiting for their first assessment. This could have included the use of nurse led triage to provide continued assessment of patients or provision of free GP assessment if their clinical situation changed.

Quality measures of Cancer Service performance

There has been a predominant focus on the waiting list pressures across the Cancer Services and the potential and avoidable harm attributed to the increased waiting lists. It is clear however that the harm is directly attributable to the time between referral and then first assessment and subsequent initiation of treatment. Many secondary care services use waiting lists and managers are very used to managing these. However, the impact of burgeoning waiting lists on cancer patients is much greater than those for patients with non-malignant disease and therefore requires a different approach. Similarly, the faster cancer treatment 31 day and 62 day targets are not ideal for measuring overall performance in the Cancer Services as they only address a fraction of the workload. It would be preferable to consider the presentation of waiting list data as a percentage of patients who are seen within Ministry of Health waiting list targets i.e. one, two and four weeks from referral.

Current status of the Cancer services

The time period of this review was through until February 2022 during the management of the Southern DHB. In July 2022 the Southern DHB ceased to exist and all services came under Te Whatu Ora|Health New Zealand. Following the presentation of the Harm Register in March 2021 much progress was made to improve the cancer services of the Southern DHB, predominantly through increased staffing resource, and waiting times for first specialist assessment were improved. However continued improvement was slowed due to the pending transfer to Te Whatu Ora and uncertainty regarding future funding. Consequently further staffing developments, in line with the recommendations of the Ernst Young report, have been delayed and clinical staff are concerned that waiting times are again increasing with further potential for patient harm. It is imperative that the improvements undertaken since July 2021 continue to be progressed, to prevent deterioration in service delivery.

It is noteworthy that the [Southern District Health Board Review] report raised concerns that there was no evidence of a cancer service recovery plan. In the absence of such a plan it is likely that progress will be piecemeal and reactive, and will not lead to sustained improvement in service delivery or adequate future proofing of services.

Summary

It is clear that there was significant patient harm caused by the burgeoning waiting lists and prolonged waiting times for patients to be assessed by specialists across the Cancer Services throughout the time period of this investigation. The care provided by the Southern DHB was not adequate and led to significant patient harm and is a severe departure from the accepted standard of care.

The issues that led to this did not arise overnight but developed gradually over a number of years due predominantly to a lack of investment in staffing resource to cope with the increasing demand on the services.

This lack of investment stemmed largely from the deficit status of the DHB leading to a focus on fiscal management rather than avoidance of patient harm, and was contributed to by a significant disconnect between management and clinical staff. Clinical governance and risk management systems were not adequate to sufficiently raise concerns regarding the developing patient harm.

The concerns raised by clinicians and by service managers were largely discounted or attributed to outside influences, with no meaningful intervention until the presentation of the Harm Register in March 2021, which was an initiative of the clinical staff, and reflects inadequacy of established clinical governance systems at the time. Once the degree of patient harm was recognised there was a reasonably rapid response with a significant injection of funds for enhancing staffing resource, however there was an inevitable delay in recruiting the necessary staff, and this continues for Radiation Oncology.

The gains in clinical performance over the last 6 months of 2021 are at risk of being eroded following the transfer of services to Te Whatu Ora. It is imperative that a Cancer Service recovery plan is developed that plans for adequate services and staffing to deal with continued increasing demand. It is important that this includes the development and reporting of more appropriate clinical indicators than just the presentation of numbers of patients on the waiting list.

Recommendations

1. Develop a high trust model of clinical leadership reporting to line management.
2. Develop a cancer services recovery plan.
3. Focus on the three year recommendations of work force planning from the Ernst Young report.
4. Develop a Southern workforce plan that considers the work capacity of each FTE, the geographical demands of the area, and allows for adequate non-clinical duties of clinicians.

5. Assess staff wellbeing particularly with regard to current hours of work, non-clinical duties, capacity for leave and planning of sabbaticals across the three oncology services.
6. Focus on the development of improved clinical governance including appropriate quality and performance KPIs of the services with improved reporting mechanisms through to the Clinical Council. Develop reporting on the compliance with MOH triage recommendations.
7. Address deficits in risk management and clinical governance as highlighted in the [Southern District Health Board Review] report.
8. Address deficiencies in patient support during periods of increased waiting times.”