Waitemata District Health Board Referrals

A Report by the

Health and Disability Commissioner

(15HDC01667, 16HDC00035, and 16HDC00328)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Complaints and investigation

1. The Commissioner received three complaints about the services provided by Waitemata District Health Board (WDHB) to three consumers (Mr A, Mr B, and Ms C). All complaints concern WDHB's referral processes. While the complaints were investigated separately, given that they concern the same referral system, the Commissioner decided to address all three cases in this report.

2. The following issues were identified for investigation:

   - *Whether Waitemata District Health Board provided Mr A with an appropriate standard of care in 2013.*
   - *Whether Waitemata District Health Board provided Mr B with care of an appropriate standard between March 2014 and April 2015.*
   - *Whether Waitemata District Health Board provided Ms C with an appropriate standard of care between November 2014 and March 2016.*

3. The report addresses the facts of each case separately, and the care provided to each consumer separately. The Commissioner also makes general comments about the WDHB referral system, and recommendations that are relevant to all three cases.

4. Independent expert advice was obtained from a systems advisor, Dr Iwona Stolarek (**Appendix A**).

5. The following abbreviations are used in the report:

CT	Computed tomography scan
DHB	District Health Board
ED	Emergency Department
ESPI1	Elective service performance indicator (Ministry of Health)
FSA	First specialist appointment
GP	General practitioner
ICU	Intensive Care Unit
MDM	Multidisciplinary meeting
MRI	Magnetic resonance imaging scan
PIMS	Patient information management system
PSC	Patient Service Centre
WDHB	Waitemata District Health Board

Introduction — referral management

6. The PSC is an office that manages all elective and surgical referrals at WDHB. Patient information and referrals are managed in PIMS. Some WDHB services process referrals outside of the PSC, and have their own information system that is not linked to PIMS.

7. The Ministry of Health expects all referrals to be acknowledged appropriately and processed within 10 working days from receipt of referral.[1] The WDHB expectation is that within that time frame, all referrals will be logged in PIMS by a PSC referrals clerk, be printed out and given to a consultant for grading (prioritising), then be returned to the PSC for the PIMS referral status to be updated. If the referral is accepted, the PSC referrals clerk will send the referral to a booking clerk to waitlist the referral, then book the appointment.

8. GPs receive acknowledgement of receipt of patient referrals and other information, such as when an appointment has been scheduled, by an electronic message system.[2] Patients are sent a letter once their referral is accepted and they are placed on a waiting list, and once they receive an appointment date and time.

9. Prior to 2014, WDHB had in place a "Referrals management"[3] document and other associated documents[4] to guide staff on process in the PSC. In September 2014, the "Patient Service Centre Business Process Rules Working Document" was introduced.[5] The purpose of this document was to guide WDHB staff managing the patient administrative pathway, and to ensure that processes and Ministry of Health targets were adhered to. These rules were updated in December 2015 and are now called the "Patient Services Guidelines & Process Management for Scheduled Care".[6]

10. At the time of these events, internal referrals between WDHB specialties were processed according to the "Referrals management" document. Paper referrals were to be sent internally to the referrals clerk and processed as a new non-acute referral. Currently, WDHB staff refer to the 2016 "Patient Services Guidelines & Process Management for Scheduled Care" for internal referral guidance.

Information gathered during investigation — Mr A (16HDC00328)

11. On 19 April 2013, Mr A presented to his GP with a 1cm cyst underneath the skin of his right eyebrow associated with numbness.

12. On 28 April 2013, Mr A's GP made an electronic referral to WDHB, entitled "Skin Cancer Referral for Outpatient Appointment". The referral noted Mr A's past history of squamous cell carcinoma on his hand.

13. On 30 April 2013, the referral was logged in the PIMS by a WDHB PSC staff member.

14. On 1 May 2013, Mr A's GP received an acknowledgement of the referral. The referral was then sent for grading. This process involved printing out the electronic referral for the

[1] Ministry of Health — Guide to managing elective services patient flow indicators, March 2013.
[2] Called HL7 messaging.
[3] Issued April 2007.
[4] Including "Appointment life cycle and major steps" (issued April 2007), "Appointment creating" (issued April 2007) and "Waiting list management" (issued April 2012).
[5] Issued 26 September 2014. However, WDHB told HDC that this was in use in July/August 2014.
[6] The latest version was issued in April 2016.

grading clinician. On 6 May 2013, Mr A's referral was graded as priority one (to be seen urgently).

15. The WDHB document "Appointment life cycle and major steps" indicates that priority one patients would have an expected wait time of one week, and the "Appointment creating" document states that if it is not possible to fulfil an established referral priority, the referral is to be reviewed by the appropriate clinician. The "Referrals management" document states that all referrals returned after grading should have a priority status and wait time indicated. The "Waiting list management" document states that primary care guidelines and waiting times would be made readily available for those referring, and that for ESPI1 compliance, referrers would be provided waiting times.

16. At the time of these events, the Ministry of Health faster cancer treatment indicators defined best practice for management of a patient with a high suspicion of cancer as 14 days between receipt of referral and FSA, and 62 days between receipt of referral and commencement of definitive treatment.[7] However, at this time, the faster cancer treatment indicators did not apply to non-melanoma skin cancers.

17. On 9 May 2013, a PSC staff member updated PIMS to show the grading of priority one, and waitlisted Mr A for an FSA. Mr A was sent a generic referral acceptance letter that stated: "Waiting times vary according to the priority of the referral assessment. … Ministry of Health guidelines state an appointment will be offered within five months." This generic letter was sent for any accepted referral, regardless of priority.

18. On 10 May 2013, Mr A's GP received electronic notification of the grading of priority one from WDHB. The expected waiting time was listed as unknown. Mr A's GP told HDC:

> "My understanding of the waiting list grading system is that a [priority one] was considered to be a high priority and that an appointment would normally be available within a very short timeframe. I did not hear anything further from the hospital until [Mr A] phoned me [detailed below] … I had no reason to suspect [Mr A] may not be seen within the following four weeks."

19. On 10 July 2013, Mr A called his GP to ask why he had not yet received an appointment from WDHB. Mr A noted that his cyst was increasing in size and was painful. Mr A's GP told Mr A to come in for review if he had not received an appointment by the end of the month.

20. On 6 August 2013, an FSA was offered to Mr A, for 25 September 2013 (150 days, or four months and 28 days from the date of referral). WDHB told HDC that it was not until 6 August 2013 that an FSA for a non-melanoma skin cancer referral became available, according to the waiting list. It stated that, at this time, the average waiting time for an FSA for non-melanoma skin cancer priority one cases (including squamous cell cancers) at WDHB was 121 days. WDHB told HDC that the large volume of priority one non-melanoma referrals and limited resources available to meet this increasing demand meant that the volume of patients waiting for an FSA was large.

[7] Ministry of Health. Faster cancer treatment indicators: Data definitions and reporting for the indicators. March 2012. http://www.midlandcancernetwork.org.nz/file/fileid/44274 Accessed 15 February 2018.

21. On 9 August 2013, Mr A re-presented to his GP. At this time his GP had not been advised that an appointment had been offered for 25 September 2013. His GP sent a further electronic referral to WDHB the same day, entitled "General Surgery Other Referral for Priority Review". The referral noted that Mr A had been referred previously, but had not yet been seen. The referral requested a review of priority, as Mr A's lesion was larger, more painful, and causing more numbness. The medical history section of the referral noted that previously Mr A had had an invasive ulcerated squamous cell carcinoma excised from his right eyebrow (in 2009). This referral was acknowledged as being received in the PSC, but it was never logged in PIMS or graded. WDHB stated that it has been unable to determine what happened to it.

22. The "Patient Service Centre Business Process Rules Working Document" requires that if a further referral is received, within one working day of receipt the initial referral is to be located, the new referral is to be attached to the initial referral with a grading form and marked "upgrade request from referrer", PIMS is to be updated to show that an upgrade referral has been received, and then the documentation is to be sent for grading.

23. On 19 August 2013, Mr A's GP received notification that an appointment had been scheduled for 25 September 2013, 4 months and 28 days after the referral was received.

24. On 25 September 2013, Mr A had an appointment at an outpatient clinic at Hospital 2. Subsequently a CT scan was undertaken on 4 October 2013, which showed "extensive destruction of the superior orbital ridge and frontal bone, with recurrent [squamous cell carcinoma]".

25. On 9 October 2013, Mr A's case was reviewed in an MDM, and an MRI scan was arranged for 31 October 2013.

26. On 5 December 2013, Mr A underwent surgery to excise the squamous cell carcinoma, remove part of his skull, reconstruct his right brow and a free flap, and remove his eye. He then underwent radiotherapy.

27. Mr A had ongoing review with another district health board's (DHB2) head and neck service. He had further lesions removed from his nose and follow-up radiotherapy in 2015.

28. WDHB provided HDC with an ESPI compliance summary report from 2 August 2013, showing that it was aware that at that time, there were a large number of patients whose appointments were not compliant with the Ministry of Health's five-month timeframe. It told HDC that since 2013, a number of initiatives have been implemented to manage this, including:

    a) Electronic referrals and electronic triaging allowing for electronically tracked referral management.

    b) A single point of entry for referrals allowing for standardised grading across services.

    c) A GP skin lesion scheme, which has led to a reduction in patients waiting for an FSA. The effect of this is that the review of priority one patients has been more timely.

d) For non-melanoma skin cancer referrals, the referrals and FSA booking roles have been combined. The FSA booker now books the patient to the FSA directly after triaging, and contacts the clinician or peri-operative nurse coordinator if the 14-day timeframe is unable to be met.

e) Since 2013, increased general surgeon numbers has led to a reduction in patients waiting for an FSA for non-melanoma skin cancer, and review of priority one patients has been timelier. WDHB stated that at December 2016, the average waiting time was 27 days for patients referred to an FSA for non-melanoma skin cancer. For priority one patients, the average waiting time was 16 days.

Information gathered during investigation — Mr B (15HDC01667)

29. On 11 June 2014, Mr B presented to his GP with a mass over his right thyroid. The GP recorded in the clinical notes:

> "[Mr B] has for one week had a steadily swelling firm non tender mass over the right thyroid. This is now the dimension of a squashed squash ball. Whilst not sore it causes his throat to be sore, especially after the prolonged talking which he does in his job … There are no nodes. His throat is normal. He does not have difficulty with voice projection nor with breathing on his back at night."

30. That day, Mr B's GP sent a referral via fax to "Thyroid Surgery" at WDHB. The referral noted that Mr B had a thyroid mass that was increasing in size, and included the consultation note above. The referral was also copied to "Radiology" at Hospital 2 for an ultrasound.

31. Mr B's GP stated that, at that time, all faxes were sent from the medical centre with a covering letter that asks that the fax be returned if it is sent to the wrong person/department. He explained that the medical centre had daily confirmation sheets that identified documents not successfully sent via fax. At the time, these sheets were not retained once they had been checked. In June 2014, the medical centre had recently changed to a different information system that allowed electronic referrals to be made.

32. WDHB told HDC that this referral was never received in the PSC; however, it was received by the Radiology Service on 24 June 2014. WDHB stated that paper referrals to the Radiology Service are managed in a different electronic system than PIMS, and the Radiology Service would not usually follow up with surgery services regarding a referral, unless there were serious concerns raised within the referral. The Radiology Service electronic system was not visible to PSC staff.

33. On receipt of the faxed referral, the Radiology Service entered it into its electronic system and prioritised the referral as "routine" which, for an ultrasound, meant that the imaging was to be undertaken within six weeks. The ultrasound was outsourced to a private radiology service on 30 June 2014.

34. On 24 July 2014, Mr B had an ultrasound at the private radiology service, and the results were sent to Mr B's GP.

35. On 25 July 2014, Mr B's GP submitted an electronic referral to WDHB entitled "WDHB Thyroid/Parathyroid Referral for Specialist Advice". The reason for the referral was listed as "thyroid mass", and the referral stated: "[Mr B] has been referred. I am forwarding his [ultrasound] report to you as this is abnormal."

36. On 28 July 2014, the PSC general surgery administrative team acknowledged receipt and printed the referral. The referral was logged into PIMS and prepared for grading. It was graded on 30 July 2014 as priority two (to be seen by a specialist within eight weeks). It was not realised that a previous referral had been made on 11 June 2014, and so this referral was entered as a new first referral.

37. On 31 July 2014, Mr B's GP sent a second electronic referral, marked urgent, entitled "WDHB Thyroid/Parathyroid Referral for Priority Review". This referral stated that Mr B's thyroid mass was causing loss of voice and his job was voice dependent, and it noted that the ultrasound report had been sent previously. The referral was acknowledged as received and printed by the PSC. The referral and grading form were prepared, but the boxes stating "upgrade request from referrer" and "additional information received from referrer" were not ticked, as is the expected process outlined below. No comment was added to the initial electronic referral on PIMS stating that a subsequent referral had been received, as is the expected process. There is no evidence that the referral was received by a grading clinician.

38. The "Patient Service Centre Business Process Rules Working Document" requires that if a further referral is received, within one working day of receipt the initial referral is to be located, the new referral is to be attached to the initial referral with a grading form and marked "upgrade request from referrer", PIMS is to be updated to show that an upgrade referral has been received, and then the documentation is to be sent for grading.

39. WDHB stated that as the 25 July 2014 referral may not have been physically present in the PSC, this may have led to the process not being completed. However, it also acknowledged that information should have been added to PIMS. WDHB has now amended the PSC policy to state that if unable to locate the original referral within one day, then it is to be discussed with the nurse coordinator or medical administration manager.

40. On 4 August 2014, Mr B was placed on the waiting list, based on the referral of 25 July 2014, and a letter was sent to him acknowledging this. The letter stated that the wait time was unknown and that the referral was graded priority two, and an electronic message was sent to Mr B's GP stating the same.

41. The "Referrals management" document states that all referrals returned after grading should have a priority status and wait time indicated. The "Waiting list management" document states that primary care guidelines and waiting times would be made readily available for those referring, and that for ESPI1 compliance, referrers would be provided waiting times.

42. On 19 August 2014, Mr B's GP submitted a third electronic referral, entitled "WDHB Thyroid/Parathyroid Referral for Priority Review". The referral noted a three-month history of thyroid swelling. It stated that Mr B had been on the waiting list for 10 weeks (since the

first referral on 11 June 2014) and that he was distressed by discomfort when swallowing food, his voice became tired and broke, his job was being jeopardised, and he had tightness across the throat at all times. The referral requested that Mr B's position on the waiting list be reviewed. The referral was acknowledged as received and printed by the PSC. The referral and grading form were prepared, but again the boxes marked "upgrade request from referrer" and "Additional information received from referrer" were not ticked, and no comment was added to the initial electronic referral on PIMS stating that a subsequent referral had been received. There is no evidence that the referral was received by a grading clinician.

43. On 4 September 2014, Mr B was given an FSA, for 16 September 2014 (based on the referral of 25 July 2014) and a letter was sent to him advising of this. However, in the interim he presented acutely to the ED at Hospital 2 on 12 September 2014, and subsequently was diagnosed with thyroid cancer.

44. WDHB stated that the referral of 25 July 2014 was graded appropriately, but the priority should have been upgraded based on the subsequent referrals. It told HDC that it has been unable to determine why the subsequent referrals were not received and graded by a grader, as clerical staff do not recall any specific detail relating to the management of these referrals. However, WDHB stated that it is likely that the paper copy of the 25 July 2014 referral was with the grader when the second referral was received, and so could not be located by PSC. It told HDC that PSC staff did not follow approved processes for managing subsequent referrals.

Information gathered during investigation — Ms C (16HDC00035)

45. On 26 November 2014, Ms C was scheduled for surgery at Hospital 1 to remove her gallbladder. However, she had a severe allergic reaction to the anaesthetic medication suxamethonium, leading to a cardiac arrest. She was resuscitated and transferred to the ICU.

46. On 5 December 2014, an ICU registrar completed an internal paper referral form, requesting review for a cardiology outpatient appointment within one month (urgent priority). This was faxed to PSC and the original copy of the referral was retained in the clinical records.

47. Ms C was transferred from ICU to a surgical ward on 5 December 2014 and then discharged home on 16 December 2014. The electronic discharge plan recorded that Ms C was for anaesthetic allergy review in an outpatient clinic, cardiology follow-up in an outpatient clinic, and surgical follow-up in an outpatient clinic.

48. For general surgery outpatient appointment requests, the usual referrals process is that the referrer completes a section in the electronic discharge summary "WDHB General Surgery Follow up Request". These requests are sent electronically to the PSC for processing (wait listing and booking an appointment). The discharge summary was sent to the PSC for processing, and a general surgical outpatient appointment was booked for 12 February 2014.

49. For referrals to other services, the electronic discharge summary has a prompt under the "referrals to other services" field that tells referrers that they need to "complete a manual referral form(s) and record details here". The house officer completing the discharge summary recorded "Cardiology clinic follow-up" in the detail section. However, an internal paper referral was not completed on discharge because one had already been done on 5 December 2014.

50. WDHB told HDC that on 16 December 2014, a referral to cardiology was logged in PIMS. However, no action was taken on this referral until January 2016. As set out above, the Ministry of Health expectation is that referrals will be acknowledged and processed within 10 working days.

51. On 12 February 2015, Ms C attended the general surgical outpatient clinic at Hospital 1 and was seen by a senior surgical registrar. The registrar's documented plan was to refer Ms C to the outpatient Anaesthetic Clinic for risk assessment prior to surgery and then for Ms C to be reviewed again in the general surgical outpatient clinic.

52. The "Patient Service Centre Business Process Rules Working Document" states that at the end of a clinic there is to be a "cashing up" of all appointments to ensure that there is an outcome. The clinic outcome forms (filled in by the clinician) and the clinic list are to be collated together, then the outcome fields in PIMS updated with information such as whether a further appointment is required or the patient has been discharged.

53. The registrar told HDC that his usual practice was to handwrite an internal paper referral to the outpatient Anaesthetic Clinic and send this through the internal mail system to the Anaesthetic Department, with no copy kept in the patient notes. He also stated that it is standard practice to record on the clinic outcome form what follow-up arrangements are to be made. The form is then sent to clerical staff for processing, with no copy retained in the patient notes. The registrar told HDC that he would have ticked the box on the form to request that Ms C come back for a surgical outpatient appointment after Anaesthetic Clinic review. The registrar said that if the instructions on the clinic outcome form are unclear, the nurses are very careful to ask for clarification. There is no copy of the internal paper referral to the Anaesthetic Clinic, and no copy of the clinic outcome form requesting a further surgical outpatient appointment in Ms C's clinical records.

54. WDHB has been unable to determine why the anaesthetic and surgical referrals of 12 February 2015 were not received and actioned. It stated that the Anaesthetic Department keeps a log of requests made for outpatient assessment, and there is no log for receipt of a request relating to Ms C. There is also no record of the PSC receiving a request to waitlist and book an appointment for Ms C.

55. Ms C's GP told HDC that he contacted the Cardiology Clinic in March 2015 to query the fact that Ms C had not yet received an appointment. The GP's clinical records document that he left a message on 19 March 2015 asking to be called back about Ms C's cardiology outpatient appointment. The GP documented a telephone call with a booking clerk on 20 March 2015: "Stated it may be missed ? — will ask colleague … to book [appointment] for [patient] to be reviewed by specialist Monday." WDHB told HDC that there is no record of

any questions from Ms C's GP during 2015. It stated that staff do not recall a telephone call with the GP or discussing Ms C's cardiology referral.

56. Ms C told HDC that she called WDHB and left messages to follow up her anaesthetic and surgical appointments, but never received a response. WDHB told HDC that PSC staff do not recall receiving any messages from Ms C to follow up these appointments, and there is no record of this.

57. Ms C's GP documented that he followed up with WDHB about Ms C's cardiology outpatient appointment again on 23 December 2015. Before a response was received, Ms C was admitted to hospital with atrial fibrillation, on 3 January 2016. Ms C's GP made a further enquiry with WDHB on 5 January 2016, and Ms C was given a cardiology outpatient appointment, which she attended on 25 January 2016 (over a year after the referral was made on 5 December 2014). WDHB has been unable to identify the reason for the delay in the cardiology appointment (the referral was originally logged in PIMS on 16 December 2014). It stated that there is no electronic tracking of internal paper referrals (that had been loaded to PIMS), and it is most likely that the fax copy was lost.

58. Ms C also attended an anaesthetic review on 7 March 2016 and was seen in the general surgical outpatient clinic on 10 March 2016. These appointments took place over a year after the general surgical outpatient clinic on 12 February 2015.

59. The registrar stated that he now dictates internal referrals, which are copied into the notes.

60. WDHB stated that the internal paper referral form, whether faxed or internally posted to PSC, is a process step that creates a risk of the referral being misplaced.

Further information — Waitemata District Health Board

61. WDHB has made the following changes to its referral systems:

a) The operations manager and PSC team leaders for all specialties receive weekly electronic reports that flag overdue or un-booked follow-up appointments.

b) WDHB has provided refresher training on the "Patient Services Guidelines & Process Management for Scheduled Care" guidelines, and has developed detailed induction and knowledge review tools in relation to them.

c) WDHB is providing yearly refresher training on PIMS to PSC staff.

d) Until December 2015, WDHB did not have in place any policies for documenting telephone calls received at the PSC. The "Patient Services Guidelines & Process Management for Scheduled Care" now requires detailed documentation in the waitlist comments section regarding content of telephone calls.

e) A better reporting system has been introduced so that staff can track referrals and identify if and where in the referral process delays are occurring.

f) All patients referred to WDHB with information in the referral indicating a high suspicion of cancer have an alert placed on their file in PIMS at the time the referral is prioritised by the senior doctor. This highlights to booking staff which patients must have an FSA within 14 days.

g) Since September 2015, WDHB has updated its patient referral acceptance letter and HL7 electronic messages to referrers to include more information about estimated waiting times. It is considering additional steps to inform patients with referrals assigned priority one.

h) In September 2014, an audit schedule was developed to monitor internal referrals.

i) WDHB plans to introduce an integrated electronic system for internal referrals.

Responses to provisional opinion

62. Mr A, the family of Mr B, and Ms C were given an opportunity to comment on the respective "information gathered during investigation" sections of the provisional report. Each provided comments which have been considered.

63. WDHB was given an opportunity to respond to the provisional opinion. It provided updates on the work done in relation to the recommendations made in the provisional opinion. These are detailed further below in the recommendations section.

Opinion: Waitemata District Health Board referrals system — preliminary comment

64. WDHB has a responsibility to provide appropriate care to its consumers, and care that complies with relevant standards including the New Zealand Health and Disability Services (CORE) Standards,[8] which are designed to enable providers to be clear about their responsibilities for safe outcomes.

65. These three cases are concerning examples of information being available but not actioned appropriately within the WDHB system, and having a direct impact on the timeliness of the consumers receiving appropriate care.

66. My independent expert advisor, Dr Iwona Stolarek, who has extensive experience in health system governance and quality improvement, reviewed the care provided to all three consumers in the context of the WDHB referrals system. Dr Stolarek provided the following comments, which I consider are relevant to all of these cases:

> "Waiting list and appointment management problems are not unique to WDHB. With increasing demand, capacity needs to be monitored. Having mechanisms to monitor

[8] NZS 8134:2008.

> wait times and make these transparent to both the public and to referrers is key. Transparency allows referrers to provide additional clinical information to improve the prioritisation and triage process, and for alternative provider options to be sought. Organisations also need to consider initiatives such as different models of care to reduce the gap between capacity and demand …
>
> Referral systems are complex with many stages from initial referral through grading/triage to the appointment, whether for first specialist appointment or follow-ups. There are different transition points and handovers between staff. Further the system is a mix of electronic and paper systems as well as faxes. Paper and faxes can be lost or are left not actioned. Although processes to monitor or flag steps or priorities have been developed to mitigate these they are not completely failsafe.
>
> Many organisations are trying to address and improve this complex system. Often the approach in many organisations has been a fixing of problems as they arise. Often the needs of different areas are not similar so solutions need to be tailored to different work practices and flows.
>
> Although much is now electronic there are still manual processes at some steps dependent on people. As such people are vulnerable to distractions, interruptions, and a noisy environment. They also need good induction and orientation programmes, with supporting policies and guidelines."

67. Dr Stolarek stated that given this context, these events could likely occur in other organisations and, as such, may not be unexpected when viewed by her peers.

68. WDHB has made changes to address many of the issues that have arisen in these cases. This includes detailed induction and knowledge review tools in relation to the "Patient Services Guidelines & Process Management for Scheduled Care" guidelines. It has improved its capabilities for recognising delays within the referral system, and it is looking to move to a fully electronic internal referral system. I consider that these changes, and the ones outlined above, are necessary and appropriate in the circumstances.

69. Dr Stolarek noted that WDHB has made changes to its referral systems. She stated:

> "The information that the Chief Medical Officer has provided shows an ongoing commitment by the DHB to addressing and improving the referral and appointment management system and addressing issues that have arisen from the above cases."

Opinion: Waitemata District Health Board — care of Mr A

Waiting time for FSA

70. On 28 April 2013, Mr A's GP sent an electronic referral to WDHB for a skin cancer outpatient appointment. The referral was logged in PIMS, graded priority one (to be seen urgently), and acknowledged within 10 days. The "Appointment life cycle and major steps"

document indicates that priority one patients would have an expected wait time of one week, and the Ministry of Health faster cancer treatment indicators defined best practice for management of a patient with a high suspicion of cancer as 14 days between receipt of referral and FSA, although these did not apply to non-melanoma skin cancers. The "Appointment creating" document states that if it is not possible to fulfil an established referral priority, the referral is to be reviewed by the appropriate clinician. This did not occur.

71. Neither Mr A nor his GP were given an indication of wait time for an FSA other than Mr A being sent a generic letter stating that an appointment would be offered within five months (152 days). This generic letter was sent for any accepted referral, regardless of priority. On 10 May 2013, Mr A's GP was advised that the referral had been graded priority one, and the expected waiting list time was unknown. He stated: "I had no reason to suspect [Mr A] may not be seen within the following four weeks." Mr A's GP was not informed by WDHB that, at that time, the average waiting time for an FSA for non-melanoma skin cancer priority one cases at WDHB was 121 days.

72. The "Waiting list management" document states that waiting times would be made readily available for those referring, and that for ESPI1 compliance, referrers would be provided waiting times. I agree with my expert advisor's view that had the GP been informed of the average waiting time, it would have given the GP the opportunity to provide further information, or advise Mr A to consider seeking alternative assessment elsewhere. Dr Stolarek also advised that, in this respect, WDHB did not meet the New Zealand Health and Disability Services (CORE) continuum of service delivery standard 3.1.1, as "[a]ccess processes and entry criteria were not clearly documented and communicated to consumers … and referral agencies". Although I acknowledge that Mr A was provided with the generic Ministry of Health specified timeframe of five months, I do not consider that this was sufficient information for Mr A or his GP, especially given that the referral had been graded priority one. I consider that they should have been informed that the average wait time was 121 days, and in my view, patients should receive clear information when waiting for resource-constrained specialist appointments when levels of uncertainty and anxiety may be high.

73. Mr A was not given an FSA until 25 September 2013, 150 days after the first referral. WDHB said that this was the first available appointment. WDHB told HDC that the large volume of priority one non-melanoma referrals and limited resources available to meet this increasing demand meant that the volume of patients waiting for an FSA was large. Dr Stolarek advised that, accordingly, WDHB did not meet the CORE standards 3.1, as the "[c]onsumer's entry into services was not facilitated in a competent equitable timely and respectful manner when their need for services was identified", and 3.3.3, as "[a]ssessment was not provided within time frames that safely met the needs of the consumer".

74. I accept that 25 September 2013 was the first available FSA following the initial referral, and I note that this was within the generic five-month Ministry timeframe for any accepted referral. While I am concerned at the time taken for Mr A to receive an FSA, I accept the DHB's advice that this was the first available FSA.

75. However, I am highly critical that neither Mr A nor his GP were given an indication that the waiting time for an FSA would be significantly longer than the waiting times specified by the WDHB "Appointment life cycle and major steps" document and Ministry of Health faster cancer treatment indicators (one week or 14 days respectively). I am concerned that this information was not provided and, in my view, this meant that the opportunity was missed for Mr A to be able to discuss other treatment options with his GP and make an informed decision about the next steps in his care.

76. While I acknowledge that the faster cancer treatment indicators did not specifically apply to non-melanoma skin cancers, as a result of this case, and to manage the long waiting time for non-melanoma skin cancer FSAs, WDHB made two changes to its processes acknowledging the importance of the 14-day timeframe. Namely, an alert is now placed on file where there is information indicating a high suspicion of cancer, highlighting those patients needing an FSA within 14 days, and the FSA booking clerk now contacts the clinician or peri-operative nurse coordinator if the 14-day timeframe is unable to be met.

Management of further referral

77. During the time waiting for an FSA, Mr A's GP also sent a further electronic referral on 9 August 2013, noting that Mr A's symptoms were getting worse. Despite being received by the PSC, this referral was never loaded onto PIMS, and WDHB is unable to explain what happened to it.

78. The "Patient Service Centre Business Process Rules Working Document" requires that if a further referral is received, within one working day of receipt the initial referral is to be located, the new referral is to be attached to the initial referral with a grading form and marked "upgrade request from referrer", PIMS is to be updated to show that an upgrade referral has been received, and then the documentation is to be sent for grading. This did not occur.

79. I am particularly concerned that the second referral, while acknowledged as being received by the PSC, was not loaded onto PIMS or actioned appropriately in accordance with the above process. I acknowledge that the initial referral may already have been given the highest priority (priority one, urgent). However, I consider that this process should have been followed so that the GP's additional concerns could have been brought to the grading clinician's attention and dealt with appropriately. For example, this could have prompted WDHB to advise that there would still be a six-week wait until the FSA.

Conclusion

80. Overall, Dr Stolarek advised that she considers that the care provided to Mr A in relation to WDHB referrals was a moderate departure from accepted standards. I accept this advice. I am critical that neither Mr A nor his GP were given an indication that the waiting time for an FSA would be significantly longer than specified by WDHB internal policy and Ministry of Health best practice guidelines, and that the second referral was not loaded onto PIMS or actioned appropriately in accordance with WDHB processes. Right 4(2) of the Code of Health and Disability Services Consumers' Rights states that every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards. I do not consider that the care Mr A received in respect of the referrals complied

with WDHB's own internal policies, or the CORE standards. Accordingly, I find that WDHB breached Right 4(2) of the Code.

Other comment

81. I note that there has been significant work undertaken since these events to reduce the average wait time to 27 days to FSA for patients referred for non-melanoma skin cancer, and, for priority one patients, to reduce the average wait time to 16 days.

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82. Mr B had a thyroid mass and on 11 June 2014 was referred by his GP for both a scan and an FSA. The faxed referral was received by the Radiology Service but not by the PSC. The GP sent a subsequent electronic referral to the PSC on 25 July 2014 once Mr B had had the scan, and the results returned abnormal. This referral was processed as a new referral and was given a grading of priority two (to be seen by a specialist within eight weeks). Subsequently, Mr B's GP made two more electronic referrals (31 July and 19 August 2014) with additional information to potentially upgrade the priority status. These were both received by the PSC but were not loaded onto PIMS or given to the grading clinicians.

83. On 4 September 2014, Mr B was given an FSA for 16 September 2014, but he had an emergency presentation to hospital in the interim and subsequently was diagnosed with thyroid cancer.

First referral not received

84. I am particularly concerned that the initial faxed referral was apparently not received by the PSC, or was not actioned appropriately if it was received by the PSC. I am satisfied that the fax was sent appropriately by the GP, as it was received by the WDHB Radiology Service, and the medical centre had systems in place to detect unsent faxes. I acknowledge that at the time of these events it was not unusual to use fax as a means of sending a referral, but consider it appropriate that, overall, electronic referrals are the norm.

Waiting times not specified

85. The "Referrals management" document states that all referrals returned after grading should have a priority status and wait time indicated. The "Waiting list management" document states that primary care guidelines and waiting times would be made readily available for those referring, and that for ESPI1 compliance, referrers would be provided waiting times. Based on the referral of 25 July 2014, Mr B was placed on the waiting list. A letter was sent to Mr B stating that the wait time was unknown and that the referral had been graded priority two, and an electronic message was sent to Mr B's GP stating the same.

86. Dr Stolarek advised that WDHB did not meet the New Zealand Health and Disability Services (CORE) continuum of service delivery standard 3.1.1, as "[a]ccess processes and entry criteria were not clearly documented and communicated to consumers".

87. I am critical that neither Mr B nor his GP were given an indication of the approximate wait time for an FSA in accordance with WDHB process and the CORE standard. In my view, patients should receive clear information when waiting for resource-constrained specialist appointments when levels of uncertainty and anxiety may be high.

Additional referrals not managed appropriately

88. The subsequent referrals sent on 31 July and 19 August 2014 were received by PSC but not loaded onto PIMS or actioned. WDHB stated that the priority of Mr B's referral should have been upgraded based on the subsequent referrals, and that PSC staff did not follow approved processes for managing subsequent referrals. WDHB has been unable to determine why the subsequent referrals were not received and acted upon. It stated that it is likely that the paper copy of the 25 July 2014 referral was with the grader when the second referral was received, and so could not be located by PSC.

89. I note that the 25 July 2014 referral was loaded onto PIMS, so this would have been available to view electronically and be printed off if necessary. I am highly concerned that PSC staff did not follow the processes for upgrade requests as outlined in the "Patient Service Centre Business Process Rules Working Document", and that the referrals were not given to the grader for review, and, as a result, the priority of Mr B's initial referral was not able to be reconsidered in light of his GP's concerns. I consider that the system of printing a paper copy of the referral for grading potentially contributed to the additional referrals not being actioned.

90. Dr Stolarek advised that, accordingly, WDHB did not meet the following CORE standards: "3.1 Consumer's entry into services was not facilitated in a competent equitable timely and respectful manner when their need for services was identified" and "3.3.3 Assessment was not provided within time frames that safely met the needs of the consumer." I accept this advice.

Conclusion

91. Dr Stolarek advised that, overall, she considers that the care provided to Mr B in relation to WDHB referrals was a moderate departure from accepted standards. I accept this advice. I am critical that Mr B's initial faxed referral was apparently not received by the PSC or, if received, was not actioned appropriately, that neither Mr B nor his GP were given an indication of the approximate wait time for an FSA, and that two opportunities to reconsider Mr B's priority in light of his GP's concerns were missed. Right 4(2) of the Code of Health and Disability Services Consumers' Rights states that every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards. I do not consider that the care Mr B received in respect of the referrals complied with WDHB's own internal policies, or the CORE standards. Accordingly, I find that WDHB breached Right 4(2) of the Code.

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Delay in actioning first cardiology referral

92. On 5 December 2014, a paper referral for an urgent cardiology outpatient appointment was faxed internally to the PSC. WDHB told HDC that on 16 December 2014, a referral to cardiology was logged in PIMS. However, no action was taken on this referral until 5 January 2016, over a year later, when Ms C was given an appointment for 25 January 2016. WDHB said that it has been unable to identify the reason for the delay. It stated that it is most likely that the faxed referral was lost.

93. The Ministry of Health expectation is that referrals will be acknowledged and processed within 10 working days. At the time of these events, internal referrals were processed according to the "Referrals management" document. Paper referrals were to be sent internally to the referrals clerk and processed as a new non-acute referral. Despite the PSC receiving the referral, it was not processed as a new referral at the time. I am highly critical that not only was the referral not processed within the 10-day timeframe, but there was a significant delay of over a year before the referral was processed.

Internal referral for Anaesthetic Clinic not received

94. On 12 February 2015, Ms C attended a general surgical outpatient clinic. The registrar's plan was to refer Ms C to the Anaesthetic Clinic and then for Ms C to be reviewed again in the general surgical outpatient clinic. The registrar said that his usual practice would be to handwrite an internal paper referral to the Anaesthetic Department and send this through the internal mail system, and record the follow-up arrangements on the clinic outcome form. The registrar told HDC that he would have ticked the box on the clinic outcome form to request that Ms C come back for a surgical outpatient appointment after the Anaesthetic Clinic review. There are no copies of either the internal paper referral or the clinic outcome form in the clinical notes. No appointments were booked at the time for Ms C, and WDHB has been unable to determine why these referrals were not actioned.

95. The "Patient Service Centre Business Process Rules Working Document" states that at the end of a clinic there is to be a "cashing up" of all appointments to ensure that there is an outcome for every patient seen. The clinic outcome forms and the clinic list are to be collated together, then the outcome fields in PIMS updated with information such as whether a further appointment is required or the patient has been discharged. The registrar said that if the instructions on the clinic outcome form are unclear, the nurses are very careful to ask for clarification.

96. In the absence of supporting documentation, I am unable to make a finding that the internal paper referral to the Anaesthetic Clinic was filled in and sent, and that a request for a further general surgical outpatient appointment was made on the clinic outcome form. However, WDHB had in place a "cashing up" system to ensure that there was an outcome recorded for each patient in the clinic. I am concerned that this system did not work to ensure that an appropriate outcome was arranged for Ms C. Furthermore, if the internal paper referral for the Anaesthetic Clinic appointment was made, I am concerned that this was apparently lost, as it was not received by the Anaesthetic Department. I agree with WDHB's statement that the internal paper referral form, whether faxed or internally posted to PSC, is a process step that creates a risk of the referral being misplaced.

97. I am critical that the planned follow-up appointments were not booked for Ms C in a timely manner after the general surgical outpatient clinic.

Telephone contact not recorded or acted upon

98. Ms C and Ms C's GP said that they followed up with telephone calls to WDHB about the delayed appointments, and Ms C's GP made contemporaneous clinical records on 19 and 20 March 2015, 23 December 2015, and 5 January 2016 of his follow-up contacts to WDHB. WDHB stated that it has no record of these conversations, and that PSC staff do not recall these discussions.

99. Given the contemporaneous records, I consider it is more likely than not that these follow-up telephone calls did occur. I am concerned that, at the time of these events, WDHB did not have in place a requirement for staff to document telephone calls, and that despite follow-up calls being made by the GP in March 2015, these were not acted upon and it was not until the following year that Ms C received follow-up outpatient clinic appointments.

Conclusion

100. Dr Stolarek advised that WDHB did not meet the New Zealand Health and Disability Services (CORE) continuum of service delivery standard 3.10.1 that "[c]onsumers experience a planned and coordinated transition, exit, discharge or transfer from services". Dr Stolarek considers that the care provided to Ms C in relation to WDHB referrals was a moderate departure from acceptable standards.

101. I accept Dr Stolarek's advice, and I am concerned that following Ms C's discharge from hospital on 16 December 2014, some of her follow-up appointments were not planned or coordinated appropriately. In particular:

- The internal referral for a cardiology outpatient clinic appointment was not processed as a new referral in accordance with the WDHB policy or within 10 days as per the Ministry of Health expectation;
- The clinic "cashing up" system outlined in WDHB's policy did not work to ensure that an appropriate outcome was arranged for Ms C in respect of her anaesthetic and general surgical outpatient clinic appointments; and
- Telephone contacts from Ms C's GP were not recorded and acted upon.

102. Right 4(2) of the Code of Health and Disability Services Consumers' Rights states that every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards. I do not consider that the care Ms C received in respect of the referrals complied with Ministry of Health expectations, WDHB's own internal policies, or the CORE standards. Accordingly, I find that WDHB breached Right 4(2) of the Code.

Recommendations

103. I recommend that, within three weeks of the date of this report, WDHB provide a written apology to Mr A, Mr B's family, and Ms C, for the failings identified in this report.

104. In the provisional opinion, I recommended that WDHB:

a) Provide HDC with an update on its progress to move to a fully electronic internal referral system.

- WDHB advised that the regional DHB elective electronic referral system went live in March 2018. This is to be used for referring patients for elective care within the northern region within the same hospital, and between hospitals and DHBs (Auckland, Counties Manukau, and Waitemata).

b) Ensure that there is a clear procedure for ensuring that referrals, once received in the PSC (internally, via fax, or electronically) are loaded onto PIMS and actioned, and confirm to HDC that this is in place.

- WDHB confirmed that the process for the management of referrals is clearly documented in the "Patient Services Guidelines & Process Management for Scheduled Care", electronic referrals training guide, and PIMS instructions.

c) Provide HDC with an update on the current wait times for FSA for non-melanoma skin cancer referrals.

- WDHB advised that over the past three months, this has been 26 days.

d) For future updates of the PSC Guidelines and process management for scheduled care, consider stating the key changes that have been made within the new version of the document.

- WDHB advised that fundamental changes to key steps in the "Patient Services Guidelines & Process Management for Scheduled Care" are communicated across users with "key tip" posters and by updating the refresher training guide and quiz yearly.

e) Consider moving away from a system that requires printing of the electronic referrals for grading, and update HDC on the outcome of this consideration.

- WDHB stated that since January 2018, online grading has been in place for all services except radiology and maternity. Radiology is excluded as the referrals require scanning into the separate radiology system, and maternity is excluded because there are very few referrals from GPs and the different nature of referrals vs birth notifications.

105. I am satisfied that the recommendations set out in paragraph 104 are now met.

Follow-up action

106. A copy of the final report with details identifying the parties removed, except the expert who advised on this case and Waitemata DHB, will be sent to the Health Quality & Safety Commission New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent systems advice to the Commissioner

The following expert advice was obtained from Dr Iwona Stolarek:

> "1. I have been asked to provide an opinion to the Commissioner on case references 15HDC01667 ([Mr A]), 16HDC00035 ([Mr B]), and 16HDC00328 ([Ms C]).
>
> 2. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> 3. My qualifications are as follows MBChB, MMEd, PGDipHSM, MRCP (UK), FRACP, FRACMA.
>
> 4. I have over 30 years of clinical experience both in the United Kingdom and New Zealand. My training and experience relative to the area of expertise called upon reflects my 5 years as Chief Medical Officer, a role that focused on clinical governance matters at a district health board level, my RACMA training, and my two years as Medical Director at the Health Quality & Safety Commission New Zealand. I have also completed a quality improvement advisor course.
>
> …
>
> 6. My instructions from the Commissioner were to provide expert advice regarding:
>
> The adequacy of WDHB's referrals systems from a systems perspective, at the time of the three case referrals in relation to:
>
> a) The management of waiting lists.
> b) The checks in place to ensure subsequent referrals/requests for update of priority were logged, graded and actioned.
> c) The Radiology Service having a different electronic system for referrals, with no cross-referencing.
> d) Electronic referrals being printed in order to be graded.
> e) Internal referrals being paper rather than electronic.
> f) The tracking of internal referrals to ensure they are logged, graded and actioned.
> g) The tracking of follow-up outpatient appointments listed on discharge summaries.
> h) The process for following up when pre-op questionnaires were not completed.
> i) The tracking of clinic outcome forms to ensure they were logged, graded and actioned.
> j) Patient Services Centre (PSC) staff recording and actioning communication with it.
> k) Any other comment I may wish to make about WDHB's referral systems.

7. The adequacy of WDHB's current referral systems.

8. Whether I consider the care provided to [Mr A], in relation to his referrals, was reasonable in the circumstances and why.

9. Whether I consider the care provided to [Mr B], in relation to his referrals, was reasonable in the circumstances and why.

10. Whether I consider the care provided to [Ms C], in relation to her referrals, was reasonable in the circumstances and why.

11. Any other comments.

12. For each question I have been asked to advise

a) What is the standard of care/accepted practice?

b) If there has been a departure from the standard of care or accepted practice how significant a departure do I consider this to be?

c) How would it be viewed by my peers?

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

13. In considering these cases I have received documentation from the Commissioner as follows:

14. Case 1 ([Mr A])

a) Complaint from [Mr A] dated [date].

b) WDHB's response dated 12 May 2016, including attachments.

c) WDHB's response dated 13 October 2016, including attachments.

d) Email from [Mr A's] medical centre dated 21 March 2016, including attachments.

e) [Mr A's] medical centre's response dated 28 September 2016, including attachments.

f) [Mr A's] medical centre's response received 21 November 2016.

15. Case 2 ([Mr B])

a) Complaint from [Mr B's] relative dated [date].

b) WDHB's response dated 26 February 2016, including attachments.

c) WDHB's response dated 13 May 2016, including attachments.

d) WDHB's response dated 10 June 2016.

e) WDHB's response dated 14 October 2016.

f) [Mr B's] medical centre's response dated 7 December 2015, including attachments.

g) [Mr B's] medical centre's response dated 27 July 2016.

16. Case 3 ([Ms C])

a) Complaint from [Ms C] dated [date].

b) WDHB's response dated 11 March 2016, including attachments.

c) WDHB's response dated 24 June 2016, including attachments.

d) [Ms C's] medical centre's response received by HDC 14 March 2016, including attachments.

e) [Ms C's] medical centre's response received by HDC 23 May 2016, including attachments.

17. List of all attachments received:

a) Appointment life cycle and major steps 2007

b) Referrals management 2007

c) Appointment creating 2007

d) Appointment management 2007

e) Planned appointments 2007

f) 'Repetoire' data integrity reports and spreadsheets 2007

g) Appointment reminder 2007

h) Did not attend (DNA) management 2007

i) Clinic outcome 2 management 2007

j) Theatre & procedures bookings 2007

k) Waiting list management April 2012

l) Patient Service Centre Business Process Rules (working document v1.1 issued 26 Sept 2014).

m) Standards of service provision for thyroid cancer patients in New Zealand (provisional) published by the Ministry of Health December 2013.

n) Patient Services — Guidelines and process management for scheduled care v1 issue date Dec 2015.

o) Patient Services — Guidelines and process management for scheduled care issued April 2016.

p) Patient Services guidelines and process management for scheduled care Referral Clerk review quiz date unknown.

q) Patient Services guidelines and process management for scheduled care knowledge review updated 13 July 2016.

r) Patient Services Centre induction and patient services guidelines and process management for scheduled care (business rules) training date unknown.

s) Patient Services guidelines and process management for scheduled care review quiz medical and surgical services section date unknown.

t) Patient Services guidelines and process management for scheduled care refresher training date unknown.

Case 1 [Mr A]

19. To note there is slight variation in dates between patient statements and that of DHB and these are noted in the timeline summary (appendix 1) but do not affect the overall comments made.

20. Documents provided that are relevant to this case are:

a) Appointment life cycle and major steps 2007

b) Referrals management 2007

c) Appointment creating 2007

d) Planned appointments 2007

e) 'Repetoire' data integrity reports and spreadsheets 2007

f) Appointment reminder 2007

g) DNA management 2007

h) Clinic outcome 2 management 2007

i) Waiting list management April 2012

21. It is assumed that all the 2007 and 2012 documents provided coexisted and were part of the Outpatient/Booking and Scheduling A–Z. The total number of documents in this A–Z is not clear. It is not clear what induction materials were present in 2013.

22. Personal summary of timeline from notes (appendix 1).

23. Case summary:

This patient waited 150 days from first referral in April 2013 to their first specialist appointment (FSA). WDHB state that at this time the average wait time for Priority 1 cases for non-melanoma skin cancers including squamous cell cancers (SCC) was 121 days as resources were not able to meet the demand, and the volume on the wait list for a FSA was large. This appointment in September was the first FSA becoming available for a non-melanoma skin cancer.

24. In response as to whether I consider the care provided to [Mr A], in relation to WDHB referrals, was reasonable in the circumstances and why, and

a) What is the standard of care/accepted practice?

b) If there has been a departure from the standard of care or accepted practice how significant a departure do I consider this to be?

c) How would it be viewed by my peers?

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

25. In addressing the question of standard of care I have compared the standard of referral service delivery against that described in the DHB's own policies and procedures, and with the New Zealand Standard Health and Disability Services (CORE) Standards (NZS 8134: 2008) and guidance. The relevant sections of the New Zealand standards are:

26. NZS 8134.1.3 continuum of service delivery with outcome 3 being that consumers receive timely assessment, followed by services that are planned, coordinated and delivered in an appropriate manner. The following subsections apply:

27. Standard 3.1: consumer's entry into services is facilitated in a competent equitable timely and respectful manner when their need for services has been identified. The criteria include the organisation ensuring

28. Standard 3.1.1: access processes and entry criteria are clearly documented and are communicated to consumers their family/whānau of choice and where appropriate local communities and referral agencies: this may include priorities process, referral processes, entry criteria.

29. Standard 3.3.3: each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. This may include but is not limited to:

(a) service provision time frames are documented in order to meet consumer needs in line with time frames specified in

i. clinical pathways/desired clinical outcomes,

ii. the organisational policies/procedures

(b) a monitoring process to ensure time frames are met and

(c) a process to identify and respond to variance/trends.

30. Standard 3.3.4: the service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

31. Standard 3.10.1: consumers experience a planned and coordinated transition, exit, discharge or transfer from services.

32. I consider the care provided to Case 1 [Mr A], in relation to WDHB referrals, fell below acceptable standards and was a moderate departure from acceptable standards for the following reasons:

33. At the time of this case the Appointment life cycle and major steps document April 2007 indicates that Priority 1 patients would have had an expected wait time of 1 week (page 10, appendix 4). The grading form used by the clinician is dated September 2012. This 2012 form has priority status but not expected wait times which is different than the 2007 grading form. Page 8 of the Referrals management document 2007 states that all referrals returned after grading should have a priority status and wait time indicated. The grading form used by the clinician has priority 1 status but no wait time indicated or place to indicate this. Page 10 of the Referrals management document 2007 document states that priority 1 referrals are then passed to the clinic coordinators for scheduling and the first appointment available is booked.

34. Waiting list management document issued April 2012 highlighted changes for wait times for FSAs with the patient and GP being advised within 10 days whether or not assessment or treatment would be offered, and that they would be dealt with in terms of priority of need with a maximum wait time for FSA of 5 months by July 2013.

35. WDHB state that at this time the average wait time for Priority 1 cases for non-melanoma skin cancers including SCC was 121 days as resources were not able to meet demand and the volume on the wait list for a FSA was large. The appointment in September was the first FSA that had become available for a non-melanoma skin cancer as stated by the DHB. Page 3 of the Appointment creating document 2007 states that if it is not possible to fulfil an established referral priority the referral is to be reviewed by the appropriate clinician. It is not clear from the DHB letter if this happened. Waiting list management document issued April 2012 indicates on page 10 that the specialty operations managers should monitor demand and capacity and implement initiatives to reduce the variation between demand and capacity. The DHB were aware of the long wait list for non-melanoma skin cancers but it is not clear if this was recognised as an organisational risk, and what risk mitigation had been undertaken at that time.

36. The first GP referral was acknowledged and processed within the 10 working days and letters sent to the patient and GP. No indication of the wait times was given. Page 8 and 9 of Waiting list management document issued April 2012 states that primary care guidelines and waiting times would be made readily available for those referring and that for ESPI1 compliance, referrers would be provided with referral guidelines, access thresholds and waiting times. It is not clear if WDHB had let the GP in this case know of the wait time for non-melanoma cases. If the GP had known that wait times for Priority 1 patients were on average 120 days this would have been an opportunity for them to provide further additional information, or advise the patient to consider seeking alternative assessment in the private sector.

37. Waiting list management document issued April 2012 page 17 in reference to the audit tool indicates that the primary care guidelines, access criteria for a FSA and patient waiting times information were to be readily available to members of the public. How this information was shared is not clear in the document and was not referred to in the sample patient letter provided by the DHB. [Mr A] has not indicated the availability of this public information. Again if he had known that wait times for Priority 1 patients

were on average 120 days this would have been an opportunity for him to have considered seeking alternative providers.

38. The GP did re-refer in August 2013, asking for a review of priority and although the e-referral was received on 9 August 2013 it was not logged into Patient Information Management System (PIMS). The DHB has been unable to say what happened to this second referral. It was date stamped as having been received by the referrals office on 9 August 2013. If it had been logged, then a second referral should have been given to the grading clinician for review according to DHB policy.

39. The DHB have acknowledged that at the time (2013) their capacity was not able to meet demand for the management of non-melanoma skin cancers. ESPI 5-month compliance report provided by the DHB showed that on 2 Aug 2013, [Mr A's] referral for FSA was non-compliant with the ESPI 5-month time and also showed 23 other priority 1 patients, awaiting outpatient skin cancer appointments for non-melanoma skin cancers that were not compliant with ESPI timeframes.

40. The DHB have also not met the NZS 8134.1.3 continuum of service delivery standards 3.1, 3.1.1, and 3.3.3 as:

a) Consumer's entry into services was not facilitated in a competent equitable timely and respectful manner when their need for services was identified.
b) Access processes and entry criteria were not clearly documented and communicated to consumers.
c) Assessment was not provided within time frames that safely met the needs of the consumer.

41. In response as to whether I consider the care provided to [Mr A], in relation to WDHB referrals, was reasonable in the circumstances and why, and

a) How would it be viewed by my peers?

Systems for consumer/patient appointments were noted in the Health Quality and Safety Commission's (the Commission) Learning from Adverse Events publication in December 2016. Events resulting from issues in appointment systems were reported from a variety of settings. Follow-up appointments in one speciality accounted for 18% of the total clinical management events reported.

Waiting list and appointment management problems are not unique to WDHB. With increasing demand, capacity needs to be monitored. Having mechanisms to monitor wait times and make these transparent to both the public and to referrers is key. Transparency allows referrers to provide additional clinical information to improve the prioritisation and triage process, and for alternative provider options to be sought. Organisations also need to consider initiatives such as different models of care to reduce the gap between capacity and demand.

Patient management systems in primary and secondary care have usually developed independently. In secondary settings this can be further complicated with different patient management systems for individual services. Much work has been done over

the past years to try and allow greater visibility of information across the continuum of care settings. Patient portals are also being rolled out which give patients better access to their health information.

Referral systems are complex with many stages from initial referral through grading/triage to the appointment, whether for first specialist appointment or follow-ups. There are different transition points and handovers between staff. Further the system is a mix of electronic and paper systems as well as faxes. Paper and faxes can be lost or are left not actioned. Although processes to monitor or flag steps or priorities have been developed to mitigate these they are not completely failsafe.

Many organisations are trying to address and improve this complex system. Often the approach in many organisations has been a fixing of problems as they arise. Often the needs of different areas are not similar so solutions need to be tailored to different work practices and flows.

Although much is now electronic there are still manual processes at some steps dependent on people. As such people are vulnerable to distractions, interruptions, and a noisy environment. They also need good induction and orientation programmes, with supporting policies and guidelines.

Given this context this event could likely occur in other organisations and as such may not be unexpected when viewed by my peers.

b) Recommendations for improvement that may help to prevent a similar occurrence in future.

I have addressed this part later in the document (points 76–105), as many are common to the three cases.

Case 2 [Mr B]

42. Documents provided that are relevant to this case are:

a) Standards of service provision for thyroid cancer patients in New Zealand (provisional) published by the Ministry of Health December 2013

b) Appointment life cycle and major steps 2007

c) Referrals management 2007

d) Appointment creating 2007

e) Planned appointments 2007

f) ‘Repetoire’ data integrity reports and spreadsheets 2007

g) Appointment reminder 2007

h) DNA management 2007

i) Clinic outcome 2 management 2007

j) Waiting list management April 2012

k) Patient Service Centre Business Process Rules (working document v1.1 issued 26 Sept 2014). Page 9 of this document lists services covered by this document and those excluded.

The DHB has indicated in their response that this last document was used at the time period covering both July and August 2014. To note the issue date of the document is September 2014.The newer versions of this 2014 document are now supported by induction materials and quizzes (undated but from DHB information in May 2016, would suggest were used from September 2015). It is not clear what induction materials were present in 2014.

43. Personal summary of timeline from notes (appendix 2).

44. Case summary:

This patient with a thyroid mass was referred by their GP for both a scan and FSA. The faxed paper referral was received by radiology but not by PSC. A subsequent electronic referral from the GP with the abnormal scan result was received by the PSC and processed with an appointment made as priority 2. Subsequently two electronic referrals from the GP with additional information to potentially upgrade the priority status were received by PSC but were not received by the grading clinicians. The DHB have been unable to say why this occurred. The opportunity to be seen at an earlier date thus did not arise. There was a delay from initial GP referral in mid June 2014 until the clinic appointment of 16 September 2014, with diagnosis precipitated by an emergency admission on 12 September 2014.

45. In response as to whether I consider the care provided to Case 2 [Mr B] in relation to WDHB referrals, was reasonable in the circumstances and why, and

a) What is the standard of care/accepted practice?

b) If there has been a departure from the standard of care or accepted practice how significant a departure do I consider this to be?

c) How would it be viewed by my peers?

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

46. In addressing the question of standard of care I have compared the standard of referral service delivery against that described in the DHB's own policies and procedures, and with the New Zealand Standard Health and Disability Services (CORE) Standards (NZS 8134: 2008) and guidance. The relevant sections of the New Zealand standards are noted in points 26–31.

47. I consider the care provided to [Mr B], in relation to WDHB referrals, fell below acceptable standards and was a moderate departure from acceptable standards for the following reasons:

48. The problem in case 2 is twofold. The initial faxed referral from the GP to PSC was not received. The subsequent two e-referrals with additional clinical information were

not managed as per Patient Service Centre Business Process Rules (working document v1.1 issued 26 September 2014 page 12–14, which the DHB acknowledge.

49. The Waiting list management document issued April 2012 highlighted changes for wait times for FSAs with patients and GPs being advised within 10 days of a referral receipt whether or not assessment or treatment would be offered. A lack of acknowledgement could have prompted the GP to ring or chase the faxed referral. It is not clear how well known these timeframes were in primary care.

50. Following the second GP referral of 25 July 2014 (electronic) a letter was sent to the GP and patient indicating a priority 2 grading but with no indication of the wait times for priority 2. Page 8 and 9 of the Waiting list management document issued April 2012 document states that primary care guidelines and waiting times would be made readily available for those referring and that for ESPI1 compliance, referrers would be provided waiting times. Nevertheless, the GP did re refer a fortnight later again electronically. It is not clear if WDHB had let the GP and patient know of the wait time for priority 2 status.

51. WDHB acknowledges that their own processes were not followed as the priority status should have been reconsidered and clinical staff state the priority status would have been upgraded. The DHB state that it is likely the paper copy of 25 July 2014 (e-referrals are printed out for grading) was with the clinician for grading when the second referral of 31 July 2014 was received and so could not be located. However, as the 25 July 2014 referral was an electronic one it would have been visible in PIMS. This would have allowed for additional information to be added.

52. The DHB have not met NZS 8134.1.3 continuum of service delivery standards 3.1, 3.1.1, and 3.3.3 in that

a) Consumer's entry into services was not facilitated in a competent equitable timely and respectful manner when their need for services was identified.

b) Access processes and entry criteria were not clearly documented and communicated to consumers.

c) Assessment was not provided within time frames that safely met the needs of the consumer.

53. In response as to whether I consider the care provided to [Mr B], in relation to WDHB referrals, was reasonable in the circumstances and why, and

a) How would it be viewed by my peers?

Referral and appointment management problems are not unique to WDHB. Referral systems are complex with many stages from initial referral through grading/triage to the appointment, whether for first specialist appointment or follow-ups. There are different transition points and handovers between staff. Further the system is a mix of electronic and paper systems as well as faxes. Paper and faxes can be lost or are left not actioned.

Many organisations are trying to address and improve this complex system. Often the approach in many organisations has been a fixing of problems as they arise. Often the needs of different areas are not similar so solutions need to be tailored to different work practices and flows.

Although much is now electronic there are still manual processes at some steps dependent on people. As such people are vulnerable to distractions, interruptions, and a noisy environment. They also need good induction and orientation programmes, with supporting policies and guidelines.

Patient management systems in primary and secondary care have usually developed independently of each other. In secondary settings this can be further complicated with different service based patient management systems. Much work has been done over the past years to try and allow greater visibility of information across the continuum of care settings. Patient portals are also being rolled out which give patients better access to their health information.

Work has been carried out in many organisations on alerts and flags internally for staff but also messaging back to referrers to indicate that requests had been received and actioned at different stages of the process. Although processes to flag steps or priorities and then monitor these have been developed, they are not completely failsafe.

Given this context this event could likely occur in other organisations and as such may not be unexpected when viewed by my peers.

b) Recommendations for improvement that may help to prevent a similar occurrence in future.

I have addressed these questions later in the document (points 76–105), as many are common to the three cases.

Case 3 [Ms C]

55. Documents provided that are relevant to this case:

a) Patient Service Centre Business Process Rules working document v1.1 issued 26 Sept 2014. Page 9 of this document lists services covered by this document and those excluded. The document does not cover inpatient referrals. It is not clear if there is an equivalent inpatient referral guidance.

b) Patient Services — Guidelines and process management for scheduled care vi issue date Dec 2015. As the exact date in December is unknown, it is unlikely this document would have applied so comments are made in reference to the 2014 guide.

56. Personal summary of timeline from notes (Appendix 3).

57. Case 3 timeline summary

Follow-up appointments for cardiology after an inpatient episode did not occur in a timely manner although surgical and anaesthetic allergy clinics appointments did.

Further an anaesthetic risk assessment clinic follow-up and a repeat surgical clinic follow-up did not occur after the surgical clinic appointment. Phone calls made by the patient and their GP were not documented or acted upon. A year elapsed before the appointments occurred.

58. In response as to whether I consider the care provided to [Ms C], in relation to WDHB referrals, was reasonable in the circumstances and why and

a) What is the standard of care/accepted practice?

b) If there has been a departure from the standard of care or accepted practice how significant a departure do I consider this to be?

c) How would it be viewed by my peers?

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

59. In addressing the question of standard of care I have compared the standard of referral service delivery against that described in the DHB's own policies and procedures, and with the New Zealand Standard Health and Disability Services (CORE) Standards (NZS 8134: 2008) and guidance. The relevant sections of the New Zealand standards are noted in points 26–31.

60. I consider the care provided to [Ms C], in relation to WDHB internal referrals, fell below acceptable standards and was a moderate departure from acceptable standards for the following reasons:

61. To note there is a slight discrepancy in that the DHB letter 24 June 2016 which states that the faxed cardiology outpatient referral sent to PSC (from ICU) was not logged into the PIMS system until January 2016 following the patient's complaint. This is at odds with their earlier statement of March 2016. The March letter states that the cardiology investigation showed the cardiology outpatient referral was logged in PIMS under the General Surgical consultant's name on 16 December 2014, however no further activity happened, with no booking of an appointment until January 2016. The DHB state that it is likely the faxed paper referral was lost after logging. The faxed paper system is not trackable electronically so the DHB cannot determine what happened after this point. It is not clear what audits were being run at this time to monitor internal referrals. If the internal referral had been logged in PIMS this log with no further activity may have been audited in a reporting process.

62. Patient Service Centre Business Process Rules working document v1.1 issued 26 Sept 2014, page 28–29 states that at the end of a clinic there is a 'cashing up' of all appointments to ensure there is an outcome. All the blue clinic outcome forms (filled in by the clinician) and the clinic list are collated together. The outcome fields in the PIMS should be updated with information such as a further appointment or discharge. This system relies on the clinician filling in the blue form, handing it to the clinic clerk and then transcription into PIMS. Follow-up appointments are booked by different rules depending on the DHB clinic site and at times the speciality. The surgical clinic would

appear to have taken place at [Hospital 1]. If a follow-up appointment had been planned in less than 4 weeks the patient should have received an appointment before they left the clinic. If greater than 4 weeks a planned appointment and request for the required timeframe should have been noted in PIMS. There should have also been a check that the outcome forms matched the clinic list to ensure that all patients and their outcomes had been captured. It does not appear that this process was followed.

63. The anaesthetic department do not have a log of a request for a clinic follow-up and the DHB have been unable to find a referral for an anaesthetic follow-up after the surgical appointment. The referral would have either been dictated or hand written. The clinician indicates their usual method is a hand written yellow form of referral to anaesthetics sent via internal mail so no copy is kept in the notes. The Patient Service Centre Business Process Rules working document v1.1 issued 26 Sept 2014, page 51 state that the process of booking such an appointment would be to phone the patient to organise a pre-admit following the triage process. As no request was logged no triage or phone call occurred. Again as the paper system is not trackable the DHB cannot determine what happened.

64. The PSC business rules have no guide on phone calls and their documentation by PSC staff. This may be covered by a separate WDHB policy. Calls were made direct to PSC by the patient and to the cardiology clinic by the GP. No documentation of the cardiology phone call has been found.

65. The DHB acknowledge in their letter of March 2016 that the PSC staff did not follow the approved processes resulting in the delays and have made changes as a result.

66. The DHB have also not met the NZS 8134.1.3 continuum of service delivery standard 3.10.1: consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

67. In response as to whether I consider the care provided to [Ms C], in relation to WDHB referrals, was reasonable in the circumstances and why and

a) How would it be viewed by my peers?

Referral and appointment management problems are not unique to WDHB. Referral systems are complex with many stages from initial referral through grading/triage to the appointment, whether for first specialist appointment or follow-ups. There are different transition points and handovers between staff. Further the system is a mix of electronic and paper systems as well as faxes. Paper and faxes can be lost or are left not actioned.

Many organisations are trying to address and improve this complex system. Often the approach in many organisations has been a fixing of problems as they arise. Often the needs of different areas are not similar so solutions need to be tailored to different work practices and flows.

Although much is now electronic there are still manual processes at some steps dependent on people. As such people are vulnerable to distractions, interruptions, and a

noisy environment. They also need good induction and orientation programmes, with supporting policies and guidelines.

Patient management systems in primary and secondary care have usually developed independently of each other. In secondary settings this can be further complicated with different service based patient management systems. Much work has been done over the past years to try and allow greater visibility of information across the continuum of care settings. Patient portals are also being rolled out which give patients better access to their health information.

Work has been carried out in many organisations on alerts and flags internally for staff but also messaging back to referrers to indicate that requests had been received and actioned at different stages of the process. Although processes to flag steps or priorities and then monitor these have been developed, they are not completely failsafe.

Clinic outcomes and failure to follow up are not unique to this organisation and adverse events have been reported to the Commission related to these types of problems. Follow-ups often rely on information to be transferred to booking staff by a clinician in paper-based format. As it is handwritten there can be issues with legibility. Booking systems do not always allow for appointments to be booked many months ahead.

Clinics can be busy places with multiple interruptions and distractions during the booking process. Clinic and booking staff may have to handover to a colleague. This is another potential step for the system to fail.

The main backup in these processes is often a general practitioner and patient receiving a letter with a follow-up plan outlined. Patients are not always routinely copied into letters in many organisations, though this is increasing. Greater transparency and the involvement of patients in this process, with a clear indication of timeframes in clinic letters for a follow-up is helpful in creating a safety net. GP access to secondary systems and messaging back to indicate that requests have been received and actioned at different stages of the process also help. Although processes to flag steps or priorities and then monitor these have been developed, they are not completely failsafe.

Given this context this event could likely occur in other organisations and as such may not be unexpected when viewed by my peers.

b) Recommendations for improvement that may help to prevent a similar occurrence in future.

I have addressed these questions later in the document (points 76–105), as many are common to the three cases.

68. In response to question 6 from the Commissioner regarding the adequacy of WDHB's referrals systems from a systems perspective, at the time of the three case referrals in relation to the management of waiting lists:

WDHB state that at this time the average wait time for Priority 1 cases for non-melanoma skin cancers including SCC was 121 days as resources were not able to meet

demand and the volume on the wait list for a FSA was large. The DHB were aware of the long wait list for non-melanoma skin cancers. It is not clear if this was recognised as an organisational risk, and what risk mitigation had been undertaken at the time. The Waiting list management document issued April 2012 indicates on page 10 that the specialty operations managers should have been monitoring demand and capacity and implementing initiatives to reduce the variation between demand and capacity. It is not clear what steps had been taken at that time towards this. No indication of the wait times was given to GP or the patient. From a systems view greater visibility to primary care and patients of wait times allows for additional clinical information to be provided to expedite the appointment, or to allow the patient to consider seeking alternative assessment.

69. In response to question 6 regarding the adequacy of WDHB's referrals systems from a systems perspective, at the time of the three case referrals in relation to the checks in place to ensure subsequent referrals/requests for update of priority were logged, graded and actioned:

At the time no electronic flags existed that could have alerted booking and scheduling staff between referral receipt, and booking an appointment, nor when additional information had been received. Staff could not track referrals to see where in the process delays were occurring. There were no alerts for patients with a high suspicion of cancer. There were no electronic responses to e-referrals to inform GPs that a referral had been received, a referral status had changed, or a waiting list priority had changed. GPs also could not access PIMS themselves so did not have visibility of the key stages and timeframes of the referral process. The process was and remains a largely manual process dependent on people and as such vulnerable to distractions, interruptions, a noisy environment and rely on good induction and orientation etc. Although there were some mitigating audits in place these have been subsequently strengthened.

70. In response to question 6 regarding the adequacy of WDHB's referrals systems from a systems perspective, at the time of the three case referrals in relation to The Radiology Service having a different electronic system for referrals, with no cross-referencing:

The presence of a single electronic referral system so that all patient information is visible in one system did not exist. This is probably no different than other organisations where separate electronic systems have developed over time in different parts of the organisation and are not visible to all users. A means of tracking and linking diagnostics and specialty referrals did not exist. It is not clear if this is being worked on.

71. In response to question 6 regarding the adequacy of WDHB's referrals systems from a systems perspective, at the time of the three case referrals in relation to Electronic referrals being printed in order to be graded:

The referral process was a mix of electronic referrals (on the whole) with printing of e-referrals for grading. Paper printouts are difficult to trace unlike electronic documents.

Further printing, risks paper copies being lost, misfiled, or stapled to another referral. From a systems point of view a fully electronic system for both internal and external referrals would be the aim, with key stages trackable, visible to referrers and auditable. Electronic grading did not exist at the time and it is unclear if this has since been implemented.

72. In response to question 6 regarding the adequacy of WDHB's referrals systems from a systems perspective, at the time of the three case referrals in relation to Internal referrals being paper rather than electronic, the tracking of internal referrals to ensure they are logged, graded and actioned, and the tracking of follow-up outpatient appointments listed on discharge summaries:

The referral process was a mix of mainly paper referrals which were faxed to PSC for follow-up appointments. Some referrals were able to be processed electronically (surgical follow-up appointments via the Electronic Discharge Summary (EDS)). Internal inpatient referrals for inpatient assessment were logged in a separate cardiology system that was different than the outpatient appointment PIMS (see case 3 timeline appendix 3). Paper printouts are difficult to trace unlike electronic documents. Confirmation of fax sent and received could occur but once printed out. Paper copies risked being lost, misfiled, or stapled to another referral. Although at the time a mix of systems existed the EDS did prompt staff for follow-up appointment methods so was a good forcing function. This meant staff (who were often rotating through DHB in their training) did not need to rely on memory and were prompted on the WDHB system. At the time there were no audits or tracking of follow-up appointments listed on EDS.

73. In response to question 6 regarding the adequacy of WDHB's referrals systems from a systems perspective, at the time of the three case referrals in relation to: The process for following up when pre-op questionnaires were not completed:

The DHB PSC documentation Waiting list management April 2012 and Patient Service Centre Business Process Rules working document v1.1 issued 26 Sept 2014 do not make this process clear to the reader. It would appear that the patient health questionnaire is sent out to patients after anaesthetic triaging and can be completed by phone, or is sent to the patient as part of their 'patient packet' along with the wait list, and copy of the last clinic letter (page 51) of 2014 document. It would also appear that on page 29 these are collected after a clinic as part of the outcome process. I am not clear if the patient health questionnaire is sent out to patients as part of their information sheets and brochures (page 28).

74. In response to question 6 regarding the adequacy of WDHB's referrals systems from a systems perspective, at the time of the three case referrals in relation to the tracking of clinic outcome forms to ensure they were logged, graded and actioned:

At the time at the end of a clinic there was a cashing up of all appointments to ensure there was an outcome for each patient that attended. All the blue clinic outcome forms (filled in by the clinician) and the clinic list were collated together. The outcome fields in the PIMS were updated with information such as a further appointment or discharge. This system relied on the clinician filling in the blue form, handing it to the clinic clerk

and then the clerk transcribing into PIMS. Further follow-up appointments were booked by different rules depending on the DHB clinic site and at times the specialty. This system was reliant on people and paper with risks of paper copies being lost, misfiled, or stapled to another referral. There was a potential risk that information on the blue form was not transcribed into PIMS or incorrectly done. Checks were in place that all clinic attendees had an outcome recorded. It is not clear if this was electronic or manual tracking. From a systems point of view, a fully electronic system would be the aim, with key stages trackable and auditable though safety risks remain even with fully electronic systems.

75. In response to question 6 regarding the adequacy of WDHB's referrals systems from a systems perspective, at the time of the three case referrals in relation to PSC staff recording and actioning communication with it:

There appeared to be no policy in the PSC materials to guide staff in documenting phone calls though it may have been covered by other DHB policies and guidelines. At the time the PIMS did not allow for adding and flagging of this additional information which would have made it trackable. From a systems point of view both these steps may have helped in closing the loop and following up on the information provided in the phone calls. There was also no apparent indication to patients or GPs in the letters sent who to contact if calling. Calls were made both to the PSC and to the specialty cardiology clinic.

76. In response to question 2 regarding the adequacy of WDHB's current referral systems:

The time span covering the 3 cases is from April 2013 through to January 2016. Over this time changes have occurred following event investigations that have improved aspects of the system above.

77. Systems Improvements made after event review by the DHB as per letters from DHB in 2014–2016:

78. WDHB undertook an adverse events investigation of case 1 in October 2014 and May 2016, regarding the management of non-melanoma skin cancers including SCC, and the referral processes coordinated by the PSC.

79. In October 2014 the DHB agreed the delay in this case was unacceptable and should not have happened but could not determine why there had been a delay from time of receiving the referral (28 April 2013) to an appointment being sent (6 August 2013). They have now introduced an electronic flag that alerts booking and scheduling staff to a delay between referral receipt and booking an appointment. Staff can track referrals to see where in the process delays are occurring and all patients with a high suspicion of cancer have an alert that highlights to booking and scheduling staff that a FSA must occur within 14 days.

80. The DHB has introduced that all non-melanoma skin cancer referrals are now dealt with by a specialty clerk who manages all aspects from logging a referral, to wait-listing after triage, and booking patients into a priority 1 dedicated clinic slot. If the

wait time is longer then 6 weeks for a priority 1 case it is discussed with the nurse coordinator. There are new grading forms with high suspicion of cancer and confirmed cancer flags and priority time frames. A priority 1 referral is now seen within 2 weeks. Whilst an improvement this still remains a person dependant process and remains at risk of human error from noisy environments, distractions and interruptions etc.

81. The FSA grading forms now have high suspicion and confirmed cancer flags and priority timeframes e.g. priority 1 = 2 weeks.

82. Although Faster Cancer treatment times (FCT) have been introduced with indicators for assessment and treatment times, it would appear that some cancers such as non-melanoma are not captured so remain in ESPI times of FSA within 4 months. As such referrer and public visibility of FSA guidelines, access criteria and wait times indications would allow additional information to be provided for potential reprioritisation or alternate treatment providers sought. The DHB are now treating non-melanoma skin cancers in the same way as FCT.

83. The DHB have since taken steps to reduce wait times and the management of non-melanoma skin cancers. As a result a reduction in wait times started in early 2014 to an average wait of 20–40 days in 2016.

84. Since 2016 primary care now can send photos of skin lesions to improve the process of triage (GP case 1 statement).

85. Electronic responses to e-referrals have now been introduced to inform GPs that a referral has been received, a referral is accepted or declined, a referral status has changed, a referral is added to a wait list, a waiting list priority has changed, an appointment is booked, a patient does not attend their appointment and when the patient is discharged from the service as a result of a referral. This gives GPs better visibility of the key stages of the referral process and could alert them if a referral is not acted on as with the second e-referral in this case.

86. From GP correspondence in case 2, it would appear that the GP's practice system now allows them to enter the DHB referral system and request a review of priority status and give additional information (GP statement case 2). This is not mentioned in the latest PSC business rules Patient Services — Guidelines and process management for scheduled care issued April 2016 but may be covered in other DHB documents. It is also not clear if this is available to all GP practices.

87. GPs often refer a patient to a few linked services e.g. diagnostic testing and a clinic done simultaneously to expedite the process for the patient. It is challenging for referrers to have to fill out different forms paper and electronic, duplicating information when time is constrained. Electronic referrals to all services would streamline this and could allow a means of tracking and linking diagnostics and specialty referrals.

88. It is not clear if radiology still has a separate patient information management system. It is not clear if a single DHB wide PIMS so that all patient information is visible in one system is being considered.

89. Following event investigation in case 2, the DHB clinical staff have streamlined the thyroid nodule clinic so that patients are seen by an endocrinologist and a surgeon on the same day.

90. There has been work with the DHB's information technology service to develop a flag so that when extra information e.g. a phone call is added to the PIMS this is alerted and that this information is processed in a timely manner within 10 working days. The changes also allow for recording of the outcome of a clinical review of the additional information and ensures via reports that the additional clinical information is processed in a timely manner. In case 2 the DHB indicated in correspondence from April 2016 this was being piloted, with a second pilot starting in October 2016 following feedback. It is not clear if this has now been fully implemented and this information should be sought.

91. The referral process remains a mix of paper and electronic with printing of e-referrals for grading. Paper or fax referrals are difficult to trace unlike e-referrals which can be acknowledged to GPs. Printing of e-referrals and the risks of paper copies being lost, misfiled, or stapled to another referral remain. This is a problem as organisations transition from a paper to a fully electronic system. From case 3 the DHB are taking measures to move to a fully electronic system both for external primary care referrals as well as internal referrals. However if some services within a DHB prefer to deal with paper and fax rather than e-referrals then these problems will continue. Of note the GP statement (in case 2) states in July 2016 that there were still areas of the DHB that prefer faxed referrals e.g. sterilisation. It would be prudent for the DHB to move towards an electronic process for all specialty referrals. In the meantime all faxed referrals are now acknowledged by the DHB and the GP is also able to track referrals via the PIMS system.

92. The DHB state in June 2016 that they were planning to introduce an integrated electronic system for internal referrals as part of a fully electronic system. It was planned that this would go live in January to March 2017 with 50% completion by April–June (letter states 2016 but this may be a typo). An electronic internal referral system mitigates faxes/paper referrals not being delivered, printed faxes being lost etc. It would be important to see if HL7 messaging to GPs will be part of this system and if GPs will be able to track the internal referrals for follow-up appointments in the same way they can for their outpatient referrals. The ability for GPs to add additional information to request a reprioritisation of a follow-up appointment would be useful. Audit of internal e-referrals will need to be built in to the new fully electronic system in the same way as has occurred for external referrals. All faxed external referrals are now acknowledged by the DHB but it is not clear if a similar system exists for acknowledgement of faxed internal referrals.

93. In terms of internal referral for follow-up appointments, the new EDS planned follow-up appointments audit (document of February 2016) is a start. At the time such an audit would only have picked up the surgical appointment (as it was the only service where follow-up appointments could be done via EDS). All follow-up appointments on discharge should be done via the EDS system. It is not clear if this is planned.

94. Until internal referrals are fully electronic, a paper and fax system continues to be subject to issues previously highlighted and mitigations should be considered. Perhaps all internal referrals from clinics are dictated so this information is captured electronically and if all follow-up appointments on discharge are done via the EDS system. All faxed external referrals are now acknowledged by the DHB and the GP is also able to track referrals via the PIMS system (see case 1 and 2). It is not clear if a similar system exists for acknowledgement of faxed internal referrals.

95. The DHB has introduced sending copies of clinic letters to patients. In March 2016 this was being rolled out across services. Confirmation that this is in place should be sought as visibility of follow-up plans to the patient helps in the safety net of ensuring these occur. If again timelines were made clear in the letter, then patients and GPs could chase the appointments up if not done within expected timeframes.

96. Perhaps thought needs to be given to help patients and their GPs know who to contact or have a single point of entry for all enquiries or phone calls. Logging this additional information into PIMS similar to a second referral or additional information may be helpful as it would also help monitor follow-up actions.

97. It is not clear if the DHB's EDS system pulls in future appointments and populates this in the EDS (this happens in some DHB systems). This can provide the opportunity for a patient and GP to see upcoming appointments and prompt enquiry if expected appointments are not listed.

98. The 2007 Referral for appointment management guidance documents were put in place to improve leave cover, ensure best use of resources, and standardise practice. The documents were relevant to the elective services team for FSA and follow-up appointments.

99. Many of these early documents have subsequently been further standardised in the documents provided dated from 2014 onwards, which have made the process clearer, having brought the separate documents of 2007 and the individual components of the receipt of referrals through to booking and follow-up into one overarching document. This is now supported by induction materials and quizzes (undated but from DHB information would suggest were used from September 2015). Several iterations and changes have been made to the PSC business rules with refresher training. Following new guidance issued in December 2015, all PSC staff have received refresher training and yearly update training is scheduled.

100. I have reviewed the two later documents provided by the DHB:

a) the PSC Guidelines and process management for scheduled care v1 issue date Dec 2015, and

b) Patient Services — Guidelines and process management for scheduled care issued April 2016.

101. The PSC Guidelines and process management for scheduled care v1 issue date Dec 2015 had the following changes from the Patient Service Centre Business Process Rules working document v1.1 issued 26 Sept 2014 document:

- Grading clinician now to return forms on Day 5 in ESPI1 timeline
- Specialities now are responsible for maintaining ESPI1 compliance
- GP automated HL7 messages now include
    - When a new referral is received
    - When referral status is changed
    - When waitlist priority is changed
    - When an appointment is booked rather than within 7 days of the appointment.
- Format is better with numbered steps in each section.
- The document has lost information on perioperative nurse steps on facilitating high suspicion of cancer (HSC) and confirmed cancer referrals for grading, though this may now be in other documentation.
- There is better clarity in the document regarding which staff need detailed understanding versus broader overview (e.g. medical staff) of the guidelines.
- Services covered by PSC show that oncology no longer appears on the list and this may reflect a change in services provision. It is not clear where primary care should refer oncology patients to.
- It is clearer what performance and processes in the document are audited.
- Priority 1, HSC and cancer patients are in a separate section and it is clearer that patient focused booking does not apply to the priority 1, HSC, and cancer group.
- In outcoming clinics there is now a line to cash up the clinic and ensure all on list have an outcome at all sites.
- EDS follow-up appointments is a new section.
- There is more detail on patient health questionnaire and follow up.
- Anaesthetic triage key requirements.
- Separate ACC patients section.

In the Patient Services — Guidelines and process management for scheduled care issued April 2016 it is not clear what changes have been made but it would appear after comparing the two documents that the authorisation name change in the footnote is the only change. An enhancement the DHB may wish to consider is stating what key changes have been made in a new version within the document. This may have occurred in covering documentation such as an email when the updates were released.

102. A quality assurance reporting and audit schedule document was updated in February 2016 and monitors key stages in the process. Some of these appear to still be

'work in progress' and were being updated at the time of the DHB letter in October 2016. There are a large number of audits which monitor what remain largely manual processes. Operations managers and general manager receive daily runs of ESPI 1 and 2 (completed FSA) compliance, and monitor a live list of wait-listed patients by priority and time waiting. There is also a requirement of daily monitoring by each specialty nurse coordinator and referrals clerk, and weekly this is reviewed with the specialty operations manager. There is also audit of correct practice and following up with services when processes are not followed (examples provided).

103. Team leaders have been appointed to the PSC to support staff and ensure that the Business Process rules are being followed consistently. The newer versions of the PSC business rules are now supported by induction materials and quizzes.

104. The DHB has made great changes to their referral systems over the time from 2013 till last reported in 2016.They are taking steps to move to a fully electronic referral system for both external referrers that will allow great visibility to them and the ability to track progress, and add further clinical information to help with reprioritisation. The DHB are also now moving to a fully electronic internal referral system. The move to a full electronic system has its own inherent patient safety risks and needs to be tested and rolled out gradually to ensure it works in different services and follows work practices. In the meantime, the DHB have put in place mitigations that allow greater tracking and monitoring. There will always remain steps in the process that are manual and dependent on people and as such vulnerable to distractions, interruptions or a noisy environment. The DHB should be aware of these human factors and work to mitigate them.

105. In addition to the electronic referral system there remains the need for a GP or patient to be able to ring and speak to a service. The ease and documentation of the calls and information provided needs to be considered by the DHB.

Appendix 1

Case 1 [Mr A] timeline summary

- 28.4.13 (patient) 19.4.13 (General Practitioner (GP) statement) [Mr A] presents to the GP with a painful 1cm lesion right eyebrow which had been present for more than 6 months. Past history (PH) of Squamous cell cancer (SCC) on the hand was noted in GP e-referral but not the previous PH excision of SCC from right eyebrow in 2009. This latter history was only stated in the second GP e-referral of 9.8.13. GP states that as the original eyebrow SCC lesion had been excised completely, and thus they had not mentioned in the original referral, and were reassured when patient was given a Priority 1 status.
- 28.4.13 GP makes 'e referral' to WDHB 'skin cancer for outpatients' as urgent priority 1 which the patient understood was to be seen within 14 days.
- 30.4.13 referral logged into Patient information management system (PIMS) by Patient Service Centre (PSC).

- 1.5.13 referral receipt acknowledged to GP (HL7 messaging) and referral sent for grading. This process involves printing out of the e-referral for the grading clinician. Graded as Priority 1 urgent.
- 9.5.13 PIMS upgraded to show Priority 1 and waitlisted for first specialist appointment (FSA). This referral is sent by the referrals clerk to the booking clerk to waitlist the referral and then book a FSA.
- Patient sent letter regarding referral. A generic letter example from WDHB states that wait times vary depending on priority, but an appointment within 5 months.
- 10.5.13 GP notified of priority 1 but wait time listed as 'unknown' (letter provided by GP).
- 11.7.13 patient rang GP as no appointment had been received and right eyebrow cyst was larger and more painful. GP asked them to come in if no appointment received by end of month.
- 6.8.13 FSA given for 25.9.13 (150 days from referral). WDHB state that at this time the average wait time for Priority 1 cases for non melanoma skin cancers including SCC was 121 days as resources were not able to meet the demand, and the volume on the wait list for a FSA was large. This appointment in September was the first FSA becoming available for a non-melanoma skin cancer as stated by the DHB.
- 9.8.13 saw GP who sent second e-referral to general surgery (first referral was to the skin cancer service) noting previous SCC removed from right eyebrow in 2009, and although patient had been referred still not seen. GP asked for a review of priority.
- 19.8.13 GP notified of 25.9.13 appointment.
- 25.9. 13 Seen in clinic by registrar discussed with consultant for CT scan to look for metastases and deeper invasion. For urgent scan and review in clinic.
- 4.10.13 CT done showing invasive lesion of bone, recurrent SCC needing surgery, plastics for reconstruction for enucleation and removal of part of skull, and follow-up radiotherapy (RXY).
- 9.10.13 reviewed in Multi-Disciplinary Meeting (MDM) with MRI arranged for 31.10.13.
- Patient underwent reconstructive surgery with 6 weeks follow-up RXY.
- Ongoing review from [DHB2] head and neck service with further lesions removed from nose and follow-up RXY in 2015.

Appendix 2

Case 2 [Mr B] timeline summary

- 11.6.14 [Mr B] presents to their GP with a non-tender, thyroid mass.
- GP refers to WDHB thyroid clinic (paper referral faxed to speed dial number) and referred at same time to WDHB radiology for ultrasound (done by paper as radiology at the time did not receive electronic referrals). Fax had a cover letter to

notify if received by another department to notify the referrer. The referrer's practice ran confirmation of fax delivery reports but have not kept copies. (Now keep for 3 years.)

- WDHB state that the paper referral for the thyroid clinic was not received by PSC.
- 24.6.14 copy of paper referral received by radiology and entered into their electronic system and prioritised as 'routine' which for an ultrasound meant within six weeks. The ultrasound was outsourced to The Radiology Group (TRG) on 30 June. The radiology patient information management system is a different system from the main hospital one, and therefore not visible to PSC staff.
- 4.7.14 TRG tried to contact patient for appointment.
- 24.7.14 US done and results sent to the GP.
- 25.7.14 GP refers electronically to DHB thyroid clinic for specialist advice with information from the US showing abnormality, stating that already referred but updating with US report abnormality.
- 28.7.14 This e-referral received by PSC and acknowledged, printed and sent for grading. As the radiology system is not visible then this referral was entered as a new first referral.
- 30.7.14 Graded as P2 (see within 8 weeks). This form did have boxes to tick if high suspicion of cancer or confirmed cancer but not ticked as radiology report suggested adenoma.
- Logged into PIMS but it was not realised that a previous referral was not received as information from radiology system not visible to PIMS used by PSC.
- 31.7.14 GP sends second e-referral marked urgent with additional information that the thyroid mass was causing loss of voice and that the patient's job was voice dependant. Referral was acknowledged as received, date stamped 1.8.14, printed and forms prepared but upgrade of priority and re grade boxes were not ticked on form, and no additional information added to PIMS that a re-referral had been received as would be expected in the policy. There is no evidence these forms were received by the grading clinician. The GP referrer did receive electronic confirmation of receipt. The DHB state that as the original referral may have not been physically present in the PSC this may have led to the process not being completed, however also acknowledge that information should have been added to PIMS. They have now amended the PSC policy to state that if unable to locate the original referral within 1 day then discuss with the nurse coordinator or medical administration manager.
- 4.8.14 placed on waiting list and a letter sent to patient and GP with wait time unknown and Priority 2. As the patient was not a priority 1 or high suspicion of cancer or confirmed cancer by the policy they did not require a phone call, and the patient focused booking process was followed with a letter to the patient.
- 19.8.14 Third e-referral sent by GP following a further phone call from the patient for thyroid specialist review. GP gave further information stating patient waiting 10 weeks (since first referral date) in June, and symptoms progressing and now

discomfort on swallowing. Position on waitlist was asked to be reviewed. Referral was acknowledged and printed and re-referral and grading form prepared and again the upgrade box was not ticked and no comment was added to initial e-referral on PIMS.

- 12.9.14 presented acutely as emergency before appointment.
- Further timeline not detailed in these notes but reviewed.

Appendix 3

Case 3 [Ms C] timeline

- 23.11.14 [Ms C] presents to the Emergency Department WDHB with gallstones. Prepared for theatre but has anaphylaxis to suxamethonium, is resuscitated and admitted to ICU (raised troponins and mild LVH).
- 5.12.14 ICU faxed an urgent referral (paper) for cardiology outpatient follow-up to be seen one month. This is loaded onto CVDIS (this is separate from the PIMS and does not connect the information. It is used for inpatient referrals which the patient had had). As the intention was for a cardiology outpatient (OP) follow-up appointment then following discussion a yellow internal OP appointment form was done by ICU registrar and faxed to PSC. There was good written transfer of information across specialties when the patient was discharged from ICU to the surgical ward prior to their discharge. Although the transfer form does not detail any outstanding referrals that are awaited, the cardiology outpatient referral was noted in the electronic discharge summary (EDS) from surgery.
- 16.12.14 discharged from the surgical ward for follow-up at anaesthetic allergy clinic ([DHB2]), cardiology and surgical outpatients (at WDHB). EDS states that surgical, cardiology outpatient appointments were planned. The surgery outpatient appointment was booked directly by PSC as this can be done electronically from the EDS (a section in EDS is completed), but other services need a manual referral form (EDS has prompts for staff). As the ICU registrar had completed the yellow form for cardiology (in the patient notes provided) this was not repeated.
- 20.1.15 Patient seen in anaesthetic allergy clinic ([DHB2]).
- 12.2.15 Patient seen in WDHB surgical clinic. The clinic plan was for a referral for anaesthetic assessment at WDHB to assess repeat surgery and then to be seen again in surgical outpatients following this. To note the DHB have been unable to find a referral for further anaesthetic assessment and or further surgical follow-up. The doctor cannot recall the specifics of the clinic visit but states they would have either dictated or hand written a referral. The clinic letter indicates this plan. The doctor indicates their usual method is a hand written yellow form of referral to anaesthetics sent via internal mail so no copy is kept in notes. The doctor now dictates internal referrals which are copied into notes.
- 19.3.15 phone call to the cardiology clinic from GP asking to be called back as no appointment had been received for cardiology follow-up. GP notes state they left message. Call was not to the PSC.

- 20.3.15 the above phone call with a booking clerk is documented by the GP and indicates that they were told appt is to be booked by a colleague on 23.3.15 asking for a review by specialist on Monday. No telephone call recalled by PSC staff though it would appear that the call was made to the cardiology clinic.
- Patient states they rang and left messages with PSC re anaesthetic and surgical appointments but no response back. DHB state that staff do not recall any messages and no record exists of documentation.
- Dec 2015 GP followed up cardiology appointment. Before the appointment was received the patient was admitted to [hospital]. Appointment sent for 5.1.16 but the patient attended in 25.1.16.
- An anaesthetic review and surgical appointment have taken place since."

The following further advice was received from Dr Stolarek on 18 January 2018:

> "Many thanks for sending through a letter from the Chief Medical Officer in response to some of the questions I raised in my report of 6th April 2017. I also received the supporting DHB policy a copy of which I had already seen earlier.
>
> The information that the Chief Medical Officer has provided shows an ongoing commitment by the DHB to addressing and improving the referral and appointment management system and addressing issues that have arisen from the above cases.
>
> You have asked me to consider this information and whether this changes my original opinion. In reading the materials I have not changed the opinion provided in the report of April 2017 but I do commend the DHB on continuing to make further improvements and mitigations for their referral and appointment management system."