Decision 23HDC02667
27 August 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

# Loss of sight in right eye caused by delay in appointment for injection

## Complaint background

1. In early 2020 Mr A was diagnosed with wet AMD[1] by Dr B, a consultant ophthalmologist and vitreoretinal specialist at a private hospital, following a referral from an optometrist. Dr B treated Mr A's wet AMD, as well as a submacular haemorrhage[2] and an inferior retinal detachment,[3] and Mr A was transferred to an eye clinic (Health New Zealand|Te Whatu Ora (Health NZ) Waitaha Canterbury) to receive regular 'Eylea injections[4]'.

2. On 23 March 2022, following a consultation with Dr C, an ophthalmologist, Mr A was told that his monthly injections would be changed to three monthly, as a trial. The clinical notes made by Dr C state to 'stop injections' and to 'Book [clinic follow-up] in 3 months'. Mr A said that instead of giving him an appointment when he was at the clinic in March 2022, he was told that the clinic would contact him prior to the due date for his next three-monthly appointment (ie, June 2022).

3. On 12 September 2022 (some six months later) Mr A emailed the eye clinic to find out when his appointment would be, as he had noticed a change in his eyesight and had yet to receive an appointment. Mr A described having a 'non-committal response from them that said nothing'.

4. HDC was provided with an email sent to Mr A from Health NZ, which stated that it was facing unprecedented demand on its services and, as such, it was experiencing significant delays in its waitlists. The email informed Mr A that Health NZ had not forgotten about him, and he would be sent an appointment as soon as one was available. The email suggested that if Mr A experienced any worsening symptoms, a GP or optometrist could send the clinic updated clinical information to help with reassessing him on the waitlist, or he could be put through to the nursing team to discuss his symptoms.

5. On 16 February 2023 Mr A visited an optometrist for a routine eye examination following their reminder to book his regular two-yearly eyesight check-up. At this appointment, the eye specialist raised concerns that he could not see into the back of Mr A's eye and recommended that Mr A either see an eye specialist at the eye clinic or return to see Dr B.

[1] An eye condition that causes blurred vision or reduced central vision. Blood vessels leak blood or fluid into the macula and damage areas essential for vision. Also called advanced neovascular age-related macular degeneration 'nAMD'.
[2] Bleeding under the retina in the macular region.
[3] An emergency situation in which a thin layer of tissue (the retina) at the back of the eye pulls away from the layer of blood vessels that provides it with oxygen and nutrients.
[4] A drug injected into the eye to block the growth of abnormal blood vessels in the back of the eye and slow vision loss in people who have wet AMD.

Mr A stated that he opted for the latter, as he had lost faith in the public health system. The optometrist made a referral to Dr B on this date.

6. Mr A saw Dr B on 17 April 2023. Mr A said that Dr B was 'horrified that [Mr A's] macular had completely blown and was now irreparable'. Dr B informed Mr A that this had been caused by the delay in him getting the required injections. Mr A stated that if he had received the injections, it is likely he would still be able to see out of his right eye. This was confirmed by Dr B in a letter to the optometrist dated 13 June 2023 and in correspondence to HDC on 1 November 2023. Dr B stated: 'This is an end-stage age-related macular degeneration finding and represents gross and irreversible structural damage to the highly sensitive foveal[5] region of the macula.'

7. On 30 August 2023, as a result of the information from Dr B, Mr A met with Dr C, who informed Mr A that the blindness in his right eye was as a direct result of the delayed treatment and advised him to make a complaint to Health NZ, which he did.

8. On 15 September 2023, in a letter to Mr A's GP, Dr C acknowledged that there had been delays in follow-up appointments in their eye department and 'missed opportunities to monitor' Mr A's vision and, as a result, Mr A had developed a 'massive exudative maculopathy[6] with poor central vision and no prospect of any improvement with treatment'. Dr C also stated that he had told Mr A to initiate a complaint.

9. On 25 September 2023 Health NZ Waitaha Canterbury sent Mr A an apology letter in response to his complaint. Health NZ acknowledged that the delay in the hospital seeing him had caused his 'macula to blow out' and stated that due to a variety of reasons beyond its control, it had not been able to meet the demand for its follow-up appointments. Health NZ confirmed that this was due to workforce shortages and staff illness, and it apologised for this.

10. Due to the concerns raised, on 9 October 2023 I made a referral to Health NZ's national office raising concerns about the delays in provision of outpatient ophthalmology services at Health NZ Waitaha Canterbury.

**Health NZ (national office and Waitaha Canterbury) responses to HDC**

11. On 27 November 2023 Health NZ's national office confirmed that 43% of Health NZ Waitaha Canterbury's total wait list of 14,728 patients were waiting more than 10% longer than the clinically requested timeframe, and it recognised capacity constraints. Health NZ also advised of the actions taken to monitor the impact on patients. The actions include asking patients waiting to be seen to advise their general practitioner if their condition deteriorates; reviewing the acuity of patients waiting for time-critical treatment by putting measures in place such as checks to ensure that the overall waiting list is managed by the greatest need and longest wait; and intense monitoring for time-critical procedures.

[5] The central portion of the macula, responsible for central vision.
[6] Uncontrolled growth of new vessels that leak fluid under the retina.

12. Health NZ also recognised and acknowledged the pressure on staff and the health system across the country, and all the hard work being done to ensure that it can deliver planned care. However, Health NZ stated:

> '[N]ationally, planned care elective surgical inpatient delivery across all services is being impacted by several factors including:
>
> i) increasing acute demand displacing planned elective surgery,
> ii) workforce vacancies, and
> iii) capacity restrictions across wards and Intensive Care Units.'

13. Health NZ told HDC that due to these factors, it is implementing national reviews of waitlists each week and standardising clinical thresholds to ensure that there is equal access across the country.

14. On 12 April 2024 Health NZ Waitaha Canterbury told HDC the following:

a) Mr A was classed as a priority 4, which meant that he was classed as semi-urgent (to be seen within 100 days) within its booking system (SIPICS[7]). As Mr A was no longer having the injections, and patients who did were given priority, he sat in the general queue for follow-up.

b) The staff had been flagging the increased demand on the ophthalmology service with senior management since 2016. This included stating that there was avoidable harm to patients. Health NZ said that a range of initiatives was introduced, but the overall risk remained.

15. On 27 September 2024 Health NZ Waitaha Canterbury told HDC that whilst changes have been made,[8] and some aspects of outpatient waitlist management have been improved:

a) It is still working with reduced staff capacity ('unprecedented 3.75 consultant FTE') in the ophthalmology service with three more resignations in the previous three months, with two of those citing burn-out. The stress and demands on medical and non-medical teams is significant;

b) The risk register (for September 2024) stated that the rating after controls for this service was 'Consequence Major; Likelihood Almost Certain; Risk rating Extreme'; and

c) The wait list is very large, with significantly overdue patients, and due to the staff capacity shortfall, this means that patients will still experience delays.

[7] South Island Patient Information Care System.
[8] Including the establishment of Virtual Clinics to review some of the injection patients requiring assessments; 'assessment only' patients now referred to as 'watch and wait' remain with the injection service waiting list, instead of on the general waiting list as happened with Mr A; and recruitment for the 3.75 consultant FTE gap.

**Further concerns raised with Health NZ (national office)**

16. On 30 August 2024 HDC raised further concerns with Health NZ as a result of a cluster of complaints received by HDC regarding ophthalmology follow-up care and ongoing issues with ophthalmology systems and processes across the country.

17. On 6 November 2024 Health NZ confirmed further improvements to the ophthalmology service on a national level, such as:

- Development of a standardised national dashboard with monthly information on follow-up delays across the country;
- Progression of a data and digital roadmap for ophthalmology, and initiation of a single First Specialist Assessment (FSA) wait list for the Northern Region;
- Development of a programme of work to implement an image storage and viewing system called Harmony, in Canterbury and the Northern Region;
- Work in process to establish consistent regional clinical governance groups that will feed into the existing national clinical governance group;
- Exploration of the option of implementing a national incident management system; and
- Piloting of an issues escalation process.

18. Health NZ also acknowledged that individual districts are addressing capacity challenges, which has not been helped by recruitment restrictions and a reduction in outsourcing options. Health NZ recognised that the more efficient it is, the more resources it can move into frontline services to improve outcomes for patients.

19. Health NZ stated that overdue follow-up figures are reported to the Ministry of Health monthly for ongoing review.

20. HDC is continuing to engage with Health NZ to ensure that there are improvements for patients in the ophthalmology service.

**ACC independent advice**

21. On 11 April 2024 ACC obtained independent advice from Professor Helen Danesh-Meyer, who noted that the standards of care for ophthalmology were not met in the management of care of Mr A. A failure of Health NZ's system occurred when the request from Dr C for a follow-up appointment in three months' time did not occur, and secondly, when Mr A developed sudden visual loss and made attempts to obtain an appointment. Professor Danesh-Meyer found that the unacceptable delay in review times was directly responsible for the failure of Mr A to receive adequate treatment.

**Responses to provisional decision**

22. Mr A and his wife were given an opportunity to respond to the provisional decision. They stated that it was 'a sad but accurate account of events and the correct provisional decision that the treatment caused [Mr A's] sight to be severely impinged due to macular bursting due to the appointments being overlooked/missed'.

23. Health NZ national office was given an opportunity to respond to the provisional decision. In response to a recommendation made in the provisional opinion regarding a request to provide HDC with the details of any work being undertaken nationally in respect of workforce planning for ophthalmology services, Health NZ national office stated:

> 'Health NZ is working progressively to improve the data and analysis which underpins its national health workforce planning. Health NZ's *Health Workforce Plan 2024* includes national-level data on the medical workforce by specialty, including for ophthalmology, which examines estimated present and decade-out pressures on our workforce.
>
> This data supports workforce planning and investment decisions at regional and local levels, including (for example) prioritisation decisions for recruitment and role expansion. There are no ophthalmology-specific national workforce planning initiatives currently underway.'

24. In response to further recommendations made in the provisional decision regarding managing clinical risk in ophthalmology follow-up waitlists, Health NZ national office clarified:

> 'At present, there is no national dataset capturing waitlists for follow-up appointments after ophthalmology procedures or process change to record the time from when a patient is promised a follow-up appointment until they receive one.
>
> For context, Health NZ uses an application called NNPAC Qlik[9] that compiles district level data and provides a well-developed national dashboard which shows patients waiting for opththalmology (or any other speciality) first specialist assessments and procedures. The dashboard also shows those waiting for treatment in several ways, by month, week, day, ethnic group, and time on a waitlist. No dashboard can be developed because follow-up waitlists are not routinely recorded in the districts and while the follow-up appointment itself is recorded, it does not record the time waiting for the follow-up treatment.
>
> While we are unable to generate a national dashboard for follow-up appointments at this stage, we can advise that national-level data compiled from district sources indicates a 12% increase in overdue ophthalmology follow-ups compared to the previous year. This reflects the growing demand and pressure on services, and we acknowledge that further work is needed to improve data capture and visibility in this area.'

25. In relation to the suggested recommendation made in the provisional decision regarding an update on the pilot of an issues escalation process in Te Waipounamu, Health NZ (national office) stated that work is ongoing regarding the implementation of a national incident management system that will enable patient harm incidents to be captured within a single, consistent system. Health NZ (national office) also confirmed that it is now developing a

[9] National Non-Admitted Patient Collection.

National Solution for Risk Management, which will form part of the national standard governance framework and will support a broader, system-wide approach to risk management and patient safety awareness.

26. Health NZ Waitaha Canterbury was also given an opportunity to respond to the provisional decision. Health NZ Waitaha Canterbury confirmed that it accepted the provisional recommendations made and noted that 'the ongoing clinical risk to patients due to delayed ophthalmology follow-up continues to be of significant concern'. It also stated that the total waiting list for the service is over 15,000, of which 5,682 are overdue, which is an increase of over 1,500 patients in the previous nine months.

27. Health NZ Waitaha Canterbury also outlined that the 'turnover of Senior Medical Officers [SMOs] continues with difficulties managing the service as new SMOs are appointed', with vacancies in the non-training registrar role and a general fellow position. It also stated:

> 'First Specialist Assessment (FSA) waiting list is currently 1115 — of which 50% are waiting longer than 120 days to be seen. Of those waiting for vitreo-retinal surgery 80% of FSAs for this group are overdue — the service can only see immediate and urgent currently.
>
> The positive aspect of the service is in relation to the surgical waiting list with >70% waiting less than 120 days. This is largely due to out-sourcing of which 80% are cataract operations.
>
> Despite all of this the service delivered 48000 outpatient visits last year — up from 44000 the previous year. This is achieved through innovation, efficiency and overwhelming goodwill from the staff to go the extra mile for our patients.'

**Decision: Health NZ — breach**

28. Previously, HDC has found multiple different providers in breach of the Code for the harm caused by delays in the provision of ophthalmology care. While I acknowledge that the constraints in ophthalmology are complex, I am concerned that capacity issues remain unaddressed, and patients continue to be put at risk.

29. Having reviewed all the available information in this case, and the ACC advice from Professor Danesh-Meyer, I consider that in relation to Mr A's care, Health NZ Waitaha Canterbury breached Right 4(4) of the Code of Health and Disability Services Consumers' Rights (the Code). Right 4(4) states that every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer. The reasons for my decision are outlined below.

30. It has been established that Mr A's follow-up appointment was substantially outside the clinical timeframes required by his clinician. This caused long-term harm to him — namely, the non-remedial loss of vision in his right eye. I consider that the unacceptable delay in providing a timely appointment for Mr A's injections fell well below expected standards.

31. It is also of concern that when Mr A followed up his late appointment in September 2022 as a result of a change in his vision, he received what appears to be a generic response from administrative staff. While Mr A did not allude to his worsening condition in his email query, at that point an opportunity was lost to consider the impact of the delay on Mr A's condition, from a clinical perspective. That is, there appears to have been no clinical re-evaluation and management of the waiting list in relation to Mr A to assist with his clinical prioritisation. While safety-netting advice was provided, that did not mitigate the provider's responsibility to ensure that Mr A's acuity of need was assessed in the context of delays.

32. It is for these reasons that I have concluded that Health NZ Waitaha Canterbury was in breach of Right 4(4) of the Code.

*Resourcing issues and responses — other comment*

33. The evidence shows that since at least 2016, the ophthalmology service had identified that overall demand was outstripping the capacity of the service to provide timely and safe care to patients. This was being flagged through the formal Risk Management processes and through communications with senior management at Health NZ. Of particular significance, in my view, were the efforts of both the manager and clinical director of the service to escalate to management their growing concerns about clinical risk from 2021, including that patients were suffering avoidable harm. That risk had grown to the level of 'extreme'.

34. On 18 August 2022 Dr C, together with 10 senior clinicians, wrote a letter to Health NZ, noting among many other issues of concern that follow-up appointments were 'probably [their] greatest area of risk', with the numbers showing that 39% (4,709 patients) were overdue. Of these, 1,597 had been waiting for greater than double the follow-up interval requested. I note that Mr A was in that category. The letter sought more funding, more workforce, and outsourcing to the private sector. A further letter dated 15 June 2023, again to leaders in Health NZ, referred to a 'looming crisis' in the injection service and sought help to manage the problem, including outsourcing packages of care, and analytical support to understand and plan for future demands.

35. It is important to acknowledge that the correspondence provided to my investigation shows that considerable efforts were being made by the service itself to manage its concerns within the resource constraints, but that it needed support at a higher level for more sustainable and effective solutions to the serious issues being faced. There is no doubt, in my view, that senior staff at Health NZ (national office) were on notice about the pressures in the district's ophthalmology service and the consequential risks for patients.

36. Several initiatives led to some incremental improvements. This included, from 2023, waitlist reviews to ensure that those waiting longest were (and are) treated first, within clinical priority bandings.

37. Health NZ advised that specific to Health NZ Waitaha Canterbury (and since Mr A's case):

> '[M]ultiple strategies [are] in place to improve service delivery including changes to the entry criteria, changes in operational and clinical models, strategic planning for

upskilling and extended roles for nursing and scientific health staff. These are in line with approaches undertaken overseas which are supported by evidence-based practice.'

38. Health NZ also confirmed that additional actions include 'initiatives such as outsourcing to other providers and ophthalmologists'.

39. Health NZ Waitaha Canterbury also advised HDC of the following:

a) It has changed its standard script for all administration staff in the ophthalmology service. Staff are to forward details of callers who ask to speak to a clinician on to a nurse, who will call the person back within 72 hours. For immediate concerns, this would be to an available health professional in the ophthalmology team.

b) 'The Ophthalmology service is now using the regional waitlist Acuity Index tool, which allows an independent assessment of waitlist sequencing and booking which forms part of waitlist quality assurance.' However, Health NZ noted that this 'does not resolve capacity shortages and cannot eliminate harm due to delayed care occurring, because the waitlist is very large with significantly overdue patients'.

c) 'The Regional Planned Care activity is likely to introduce a new waitlist attribute to indicate "time-critical" or "must not delay" for follow up activity … [W]hilst helpful, there is a risk that the volume of high priority activity within the service is so high that this category of patients will still experience delays in care due to capacity shortfall.'

40. However, in a recent response to a complainant seen by HDC (April 2025), the Waitaha Canterbury district noted that it continues to endure unprecedented capacity constraints and that for the foreseeable future this is not forecast to improve.

41. I note further that in a response to HDC's continued concerns about delays in ophthalmology care (dated 6 November 2024), Health NZ (national office) commented that capacity issues across New Zealand were being addressed by individual districts, while at the same time acknowledging that outsourcing is limited in some places.

42. Taking all this into consideration, I therefore remain very concerned that despite some measures having been put in place, there are ongoing risks to patients. I have therefore made recommendations about this below and have included relevant bodies such as the Ministry of Health and the Health Quality & Safety Commission as part of my follow-up actions, so that they are aware of this ongoing risk and can monitor the situation.

**Recommendations**

*Health NZ Waitaha Canterbury*

43. I recommend that Health NZ Waitaha Canterbury:

a) Provide a further written apology to Mr A for the breach of the Code found in this investigation. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.

b) Report to HDC on the effectiveness of the changes/improvements already made to the ophthalmology service in Health NZ Waitaha Canterbury,[10] within six months of the date of this report.

c) Report to HDC on how any ongoing clinical risk to patients due to delayed ophthalmology follow-up is being managed at Health NZ Waitaha Canterbury, within six months of the date of this report.

d) Provide HDC with an outline of any adverse events that have been reported in the ophthalmology service between 1 July 2024 and 30 June 2025 where delayed care was identified as a contributing factor to the event. This information is to be provided to HDC within six months of the date of this report.

44. In light of Health NZ's (national office) response to the provisional report that service-level planning is managed regionally rather than nationally, I recommend that regional leadership at Health NZ Te Waipounamu work with the district to undertake an assessment of the mid- to long-term sustainability of the ophthalmology service at Waitaha Canterbury and develop an overall service plan for the ophthalmology service, taking into account the geographical demands of the area, the overall capacity of ophthalmology services within the South Island, and allied/technical support needed for any uplift in FTE. An update on the assessment and service plan is to be provided to HDC by Waitaha Canterbury within 12 months of the date of this report.

*Health NZ (national office)*

45. In light of the findings in this report, I recommend that Health NZ:

a) Report to HDC on how the data and digital roadmap for the ophthalmology service to focus on improvements for patient management systems is progressing. This information is to be provided to HDC within six months of the date of this report.

b) Provide an update on the implementation of the national incident management system and development of the National Solution for Risk Management forming part of the national standard governance framework. This update is to be provided to HDC within six months of the date of this report.

46. I also intend to seek a meeting with the leads of the Eye Health National Clinical Network to understand their priorities for ophthalmology nationally, their work programme, and the action being taken to improve access to care more generally.

47. I acknowledge the comments from Health NZ's national office about service-level planning being managed at a regional rather than a national level. However, I am concerned that there appears to be a lack of appreciation at a national level for the significant capacity constraints under which the service has been operating over several years. Therefore, I take this opportunity to emphasise the importance of the national office retaining oversight of work undertaken at a regional level to mitigate the risk of harm to patients from the current

[10] As referenced in Dr C's email to Health NZ Waitaha Canterbury dated 15 June 2023 and those outlined in this report.

constraints in the service. I will also continue to raise these issues with clinical leadership at Health NZ and monitor the action taken.

**Follow-up actions**

48. A copy of this report with details identifying the parties removed, except Health NZ (national office) and Health NZ Waitaha Canterbury, will be sent to the Royal Australian and New Zealand College of Ophthalmologists (RANCO), Te Tāhū Hauora|Health Quality & Safety Commission, the Ministry of Health, and the Minister of Health and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Morag McDowell
**Health and Disability Commissioner**