Standard of urology services
17HDC01491, 17HDC01385, 17HDC01700, 17HDC02066, 18HDC00326
21 August 2019

District health board ~ Urology services ~ Rights 4(1), 10(3)

The Commissioner received complaints about the urology services provided by Southern District Health Board to a number of patients. The Commissioner commenced a Commissioner-initiated investigation of the Urology Service, in which he addressed four individual cases.

On 1 May 2010, the Otago and Southland DHBs were merged to form a new Southern DHB. The urology services provided subsequently by Southern DHB at Dunedin and Invercargill were derived from the two previous DHB services, and largely continued operating as two separate entities after the merger, with different clinical pathways relating to the different clinical facilities available at each site. By 2017, it was apparent that there were lengthy delays in a number of aspects of the assessment and treatment of Urology patients, and consequently there was substantial clinical risk.

The Southern DHB triage guidelines (in force from 2016) state that triage must be completed within 10 days of receipt of the referral, and the referrer and patient advised of the outcome. Urgent cases are to be seen within six weeks, and routine cases within four months. An appointment for a First Specialist Appointment (FSA) is made. If surgery is required, the specialist completes a "surgical booking form" setting out the procedure required and, if Faster Cancer Treatment (FCT) applies, the level of urgency for the surgery.

Southern DHB stated that when the demand for an FSA or surgery exceeds capacity, the priority of appointments is based around three areas — clinical need, length of time on the waiting list, and whether the patient requires a procedure.

Southern DHB commissioned an external review of its urology services that began in June 2017. By that time, delays had become apparent in the cancer pathway for Urology patients, particularly those with prostate cancer. Biopsies were taking up to six months from request and that, together with other delays, meant that patients with prostate cancer were having a prostatectomy up to 12 months after it had become apparent that this was a likely treatment.

By July 2017, 37.8% of Urology patients were not being treated within the ESPI5 target (being given a commitment to treatment but not treated within the required timeframe). This was an increase from 2.6% in November 2016.

The review team presented its final report in August 2017. The report states that management had limited knowledge of the demand required to be met by the Urology Service in the context of changing demographics, and there was little planning for urology services across the entire DHB. There was a concerning level of clinical risk because of the long waiting period for patients on the Dunedin site. The review team made multiple recommendations, which have been implemented.

Findings: individual complaints

The four individual complaints are incidents of suboptimal performance that fit within the pattern demonstrated in this report.

- Patient A — His time to treatment was almost double the target timeframe. This was compounded by a failure to keep him informed about a likely date for his surgery. Southern DHB failed to provide his services with reasonable care and skill, and breached Right 4(1).
- Patient B — There was an unacceptable delay in Patient B receiving treatment. He was graded as priority 3 (expected to be seen within six weeks), but he was not seen until over five months after his initial referral. It was then a further seven weeks until his biopsy was performed, even though the booking form was marked urgent, with multiple circles and a star to emphasise the urgency. Southern DHB failed to provide his services with reasonable care and skill, and breached Right 4(1).
- Patient C — Despite being triaged as "to be seen within 6 weeks", the first date for the FSA that Patient C was offered was over four months after the GP's referral. Subsequently, the appointment was brought forward after his GP made a further referral noting the "high suspicion of cancer", unexplained weight loss, pulmonary embolism, elevated PSA, and abnormal DRE. Information regarding the change from dabigatran to Clexane and back to dabigatran was conveyed by a member of the non-clinical staff. Southern DHB failed to provide Patient C's services with reasonable care and skill, and breached Right 4(1).
- Patient D — On 19 July 2016, Patient D was booked for a flexible cystoscopy, but it was not performed until after a gynaecologist made an "urgent referral" on 31 January 2017. Southern DHB failed to provide Patient D's services with reasonable care and skill, and breached Right 4(1). In addition, Southern DHB failed to facilitate the fair, simple, speedy, and efficient resolution of Patient D's complaint, and breached Right 10(3).

Findings: Southern DHB — adverse comment

Referrals to the Urology Service exceeded Southern DHB's capacity to manage them, despite attempts to tighten triage criteria and reduce referral volumes. When the system was unable to meet the demand, the DHB was slow to act in a way that was cohesive and would bring effective, sustainable improvement. There was little planning for urology services across the entire DHB.

The Commissioner stated that it is essential that providers assess, plan, adapt, and respond effectively to the foreseeable effects that changing demographics in their population will have on systems and demand. In the context of resource constraint, appropriate waiting list and appointment management systems are vital to managing risk. 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 essential. Organisations also need to consider initiatives such as different models of care to reduce the gap between capacity and demand.

Southern DHB failed to ensure that a system was in place that effectively managed patients waiting for urology services during the period in question. Clinicians and members of the public came to expect delays, and delays became normalised.

Relationships within Southern DHB became strained. Southern DHB stated that managers were presented with considerable challenges regarding a lack of willingness by clinicians to work together to find solutions to the problems within the service, other than to provide an additional urologist.

The Commissioner stated that effective service delivery requires collaborative and mutually accountable relationships, and no party to this relationship can step away from the mutual accountability and responsibility to work constructively to solve the complex challenges that are an inevitable part of the health and disability sectors. These are issues of central importance for all DHBs that, if not recognised and acted on, can have severe consequences for patients. Southern DHB's inadequate response failed each of the patients discussed in this report.