Counties Manukau District Health Board

Speech Language Therapist, Ms C

A Report by the

Health and Disability Commissioner

(Case 19HDC00437)

HDC
Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. This report concerns the care provided to a man in his mid-sixties at the time, by Counties Manukau District Health Board (CMDHB) Otorhinolaryngology (ORL) service and a speech language therapist (SLT) in 2018 and 2019. The report focuses on the management of the man's ORL referral and a delay in his ORL follow-up appointment, which resulted in a delay in the diagnosis of his throat cancer. The report highlights the importance of having in place adequate systems to ensure that consumers receive timely and appropriate services for health concerns identified.

Findings

2. The Commissioner considered that inadequacies in CMDHB's electronic referral system and speech language therapy clinic processes at the time resulted in an unacceptable delay in the man receiving a diagnosis of his throat cancer. Accordingly, the Commissioner found that CMDHB breached Right 4(1) of the Code.

3. The Commissioner also found the speech language therapist in breach of Right 4(1) of the Code, as she failed to ensure that her stroboscopy[1] report was reviewed appropriately by an ORL clinician, and requested that the man be seen by an ORL clinician in three months' time without ORL input into the timeframe. These failures contributed to the delay the man experienced in receiving an ORL review.

Recommendations

4. The Commissioner recommended that CMDHB report to HDC on the effectiveness of the changes it has implemented since these events, and consider changes it could make to ensure that systems are in place to enable SLTs to show their reports of endoscopic examinations to an ORL clinician so that timely and appropriate ORL review can occur when required. The Commissioner also recommended that CMDHB use this report for staff training on the issues identified. At the Commissioner's request, CMDHB provided a written apology to the man.

5. The Commissioner noted that since these events, the speech language therapist has provided a written apology to the man, accepted the need for monthly clinical supervision for a period of 12 months, and taken appropriate action to improve her practice. The Commissioner considered that no further recommendations were required in respect of the speech language therapist.

[1] Stroboscopy is a method of imaging and examining the vocal folds with flashing lights.

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Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mr B about the services provided to his stepfather, Mr A, by Counties Manukau District Health Board. The following issues were identified for investigation:

- *Whether CMDHB provided Mr A with an appropriate standard of care in 2018 and 2019.*
- *Whether Ms C provided Mr A with an appropriate standard of care in February 2018.*

7. This report is the opinion of Morag McDowell, Health and Disability Commissioner.

8. The parties directly involved in the investigation were:

Mr A	Consumer
Mr B	Complainant/Mr A's stepson
CMDHB	Provider/district health board
Ms C	Provider/speech language therapist

9. Also mentioned in this report:

Dr D	General practitioner
Dr E	ORL consultant
Dr F	ORL consultant

10. Further information was received from a medical centre and the Ministry of Health.

11. Independent expert advice was obtained from a speech language therapist, Ms Deborah McKellar (Appendix A), and from an otolaryngologist, Dr Robert Allison (Appendix B).

Information gathered during investigation

Introduction

12. This report concerns the services provided to Mr A by CMDHB's Otorhinolaryngology (ORL) service in 2018 and 2019.

ORL service

13. CMDHB operates an ORL service that provides medical and surgical treatment of conditions of the ear, nose, throat, and structures of the head and neck. CMDHB told HDC that at the time of these events its ORL service "was unable to meet clinic demand due to the overwhelming and unrelenting volume of patient numbers exceeding both capacity and staffing. Limited access to operational and capital funds in a climate of tight fiscal constraint has only served to magnify these challenges."

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14. CMDHB's system distinguishes between referrals for "first specialist assessments" and requests for "follow-up appointments". At the time of these events, patients who had been referred for a first specialist assessment were to receive an appointment in accordance with the priority level for which they were graded, and no later than 120 days after their referral.

15. However, non-urgent follow-up appointments, such as for Mr A, were then booked by longest wait time, and did not generate in the time frame required, owing to capacity constraints and more urgent appointment requests. Furthermore, when there were not enough first specialist assessment appointment times available, CMDHB reallocated follow-up appointment times to be used for first specialist assessments. CMDHB acknowledged that this "impact[ed] on the large number of follow-up patients waiting to be seen", and stated that "[a]t the time there were approximately 1800 patients on the follow up waiting list".

16. Between 2014 and 2017, the number of overdue follow-up ORL appointments increased gradually — in July 2014, the number of overdue adult follow-up appointments was 17, whereas in May 2017 it was 1,563. Between 2016 and 2017, CMDHB tried to address the problem by providing weekend clinics, but the extra workload proved to be unsustainable.

17. CMDHB stated that in 2018, at the time of these events, it was in the process of introducing an acuity (prioritisation) system for follow-up ORL appointments, which "was resource intensive and took months of additional unplanned work". CMDHB implemented the system in May 2019.

Mr A

18. At the time of these events, Mr A was in his mid-sixties. He had a history of Crohn's disease,[2] gout,[3] hypertension,[4] liver cirrhosis[5] secondary to chronic hepatitis C infection,[6] and heavy smoking.

Initial visit to GP (10 January 2018)

19. On 10 January 2018, Mr A saw his GP, Dr D, at a medical centre. At this presentation, Dr D documented that Mr A's voice was "hoarse", and that Mr A needed an "ent[7] referral". Dr D sent CMDHB an electronic referral requesting that Mr A be seen for his "hoarse voice".

Booking of first specialist assessment (18 January)

20. On 18 January 2018, Dr E (an ORL consultant) reviewed the referral and graded it as Priority 2, which indicates that the patient is to receive a first specialist assessment within

[2] A long-term inflammatory bowel disease.
[3] A form of arthritis.
[4] High blood pressure.
[5] Poor liver functioning because of liver damage.
[6] A blood-borne virus that attacks the liver.
[7] "ENT" stands for "Ear, Nose, and Throat", and is synonymous with ORL.

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two to four weeks. Dr E determined that Mr A would be seen jointly by an ORL clinician and a speech language therapist at a stroboscopy[8] clinic.

21. When grading a referral, CMDHB's electronic referral system at the time allowed a grading consultant to select both a "category" option and a "clinic" option from computer dropdown menus. A "Stroboscopy" category option and an associated "Speech Language Therapy" clinic option could be selected together. For a patient to be booked to see both an ORL clinician and a speech language therapist jointly at the stroboscopy clinic, the grading consultant needed to select only "Stroboscopy" as the category option, and did not need to select a clinic option. However, when grading Mr A, Dr E selected both the "Stroboscopy" category option and the "Speech Language Therapy Clinic" option.

22. The administrator who booked Mr A's first specialist appointment interpreted Dr E's selections as meaning that Mr A was to see a speech language therapist only, and booked Mr A an appointment with a speech language therapist but no ORL clinician.

23. CMDHB told HDC that it accepts that "the configuration of the electronic referral system at the time of these events contributed to [Mr A] being booked into the wrong clinic".

Speech language therapy clinic (7 February 2018)

Endoscopic examination

24. Mr A attended the speech language therapy clinic on 7 February 2018. He was seen by speech language therapist Ms C.[9] Ms C performed an endoscopic[10] examination of Mr A's throat and vocal cords using stroboscopy.

25. Ms C's report of her examination documented the following:

- Mr A had had a hoarse voice for 2–3 months;
- Mr A consented to an endoscopic examination;
- There was an "irregularity" on Mr A's right vocal cord, which she suspected was a cyst;
- Mr A was aware that an ORL clinician needed to review the examination, and would discuss management with him; and
- She would follow up with an ORL clinician.

26. The report included a stroboscopic image of Mr A's throat and vocal cords.

27. Ms C told HDC that her comment about a cyst was "not intended as a definitive diagnosis", and that she informed Mr A that he needed to see an ORL clinician to receive a diagnosis. Ms C noted that it was "outside [her] scope of practice to diagnose pathology", and that

[8] Stroboscopy is a method of imaging and examining the vocal folds with flashing lights.
[9] Ms C is a full practising member of the New Zealand Speech-language Therapists' Association. At the time of these events, she had been working at CMDHB for less than a year.
[10] A procedure to look inside the body.

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the purpose of her examination was to determine whether voice therapy was appropriate for Mr A.

28. Ms C stated:

> "Usual practice is that if, as a result of such an examination a pathological abnormality is detected, the patient is referred to the Oto[rhino]laryngology (ORL) service for diagnosis and management. This occurred in [Mr A's] case."

No documented consultation with an ORL clinician

29. There is no documentation of an ORL clinician having reviewed Ms C's report, either on 7 February 2018 or at any point before 23 January 2019.

30. Ms C told HDC that following the examination, she "briefly" showed her report to an ORL consultant, but "omitted to document the conversation held or the name of the consultant involved". She stated: "I deeply regret not documenting this critical documentation and acknowledge my documentation was lacking."

31. CMDHB told HDC that the ORL consultant to whom Ms C showed her report was probably Dr F. However, Dr F cannot recall reviewing the report, and CMDHB accepts that there is no evidence of an ORL review of Ms C's report. Furthermore, CMDHB told HDC that it "acknowledges that a corridor consultation does not constitute an adequate review of the examination".

32. CMDHB stated:

> "There was an expectation that all images taken by the SLT [speech language therapist] would be reviewed by an ORL consultant and there was a common practice around this. How this was to be completed and the timeframe involved was not specified."

33. CMDHB acknowledged that "this was not a robust process and was not documented as a policy or procedure".

34. Ms C told HDC:

> "There was no documented process in place of the procedures I was expected to follow in clinic [for obtaining an ORL review of the stroboscopic images she had taken]. My process was that I typically get a consultant with specialty in head and neck or laryngology to review the examination … This depends on who is present and available in clinic at the time."

35. Ms C stated that "there was no documented policy" regarding the timeframe in which she was expected to show stroboscopic images to an ORL clinician for review. She noted: "My expectation on myself is for the endoscopic/stroboscopic exam to be reviewed by ORL SMO within 2 weeks."

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36. CMDHB stated: "[I]n February 2018 there were no documented processes, policies or procedures in place to guide [Ms C]."

Request for ORL follow-up appointment

37. Following the examination, Ms C determined that Mr A needed an ORL appointment, and requested this for him. CMDHB explained to HDC that as Mr A had been seen by a speech language therapist, its system considered that he had already received his first specialist assessment, so Ms C's ORL referral for Mr A was treated as a follow-up appointment.

38. CMDHB's ORL clinics can be booked up to six weeks in advance. Where no appointment times are available in the following six weeks, the patient is placed on a "planned appointment" list to be booked when a slot becomes available. When Ms C tried to book an appointment for Mr A, no clinics were available in the next six weeks, so she added him to the "planned appointment" list.

39. Ms C requested that Mr A be seen by an ORL clinician within three months.

40. Ms C told HDC:

> "[H]aving just worked at [CMDHB] for less than 1 year, I had not appreciated that 'planned' appointment did not entail an actual appointment i.e. there is a high possibility that the appointment will be deferred."

41. CMDHB told HDC that the clinic Charge Nurse could have escalated Ms C's appointment, but Ms C did not know this. CMDHB said that if Ms C had had any queries concerning the clinic's processes, it would have expected her to ask the clinic Charge Nurse in the first instance. Furthermore, CMDHB stated: "[I]t is common practice for clinic Charge Nurses to be closely involved in the orientation to the clinic." However, CMDHB noted that it is "unclear what orientation [Ms C] would have received", owing to the time frame involved and changes in staff since these events. CMDHB considers that the orientation would have involved a close working relationship with the Charge Nurse and clinicians in the ORL service.

42. CMDHB acknowledged that "the ORL Service, together with the DHB, failed to ensure that adequate procedures and guidelines were in place at the set up of the SLT clinic to provide clear expectations, responsibilities, and processes".

Delay in receiving follow-up appointment (February–December 2018)

43. Despite Ms C having requested that Mr A be seen within three months, no follow-up appointment was generated for him within that timeframe. As of 12 December 2018, Mr A had still not heard back from CMDHB about when he would see an ORL clinician.

44. As noted above, at the time of these events there were approximately 1,800 patients ahead of Mr A on the follow-up waiting list. CMDHB stated that Mr A's "appointment was never generated in May 2018 as intended due to high levels of clinic demand", and "there was no safety netting in place to ensure [Mr A] was seen as intended within the timeframe requested".

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Second visit to GP (12 December 2018)

45. On 12 December 2018, Mr A saw Dr D at the medical centre. Dr D documented that Mr A had "still not heard from ent re [right] vocal cord cyst", and that he "re referred" Mr A. Dr D sent CMDHB an electronic referral stating that in February 2018 Mr A had been found to have a probable cyst, that he was "due to be seen for a discussion of management" about this, but that no appointment had been arranged. Dr D also noted that Mr A presented as "much more hoarse" than at his previous presentation, and asked CMDHB to check Mr A's place on its waiting list.

Review and surgery (December 2018–February 2019)

46. On 15 December 2018, Mr A's referral was graded as "Priority 1 (P1) — high suspicion of cancer at grading; to be seen within 2 weeks". An appointment on 31 December 2018 was confirmed for Mr A, but he did not attend the appointment. A further appointment was arranged for 23 January 2019, which Mr A attended.

47. On 23 January 2019, Mr A saw a head and neck oncological[11] and reconstructive surgeon. In his clinical notes, the surgeon documented:

> "ENT note
> Prev[iously] seen [Ms C] SLT
> ? cyst [right vocal cord]
> Then no follow up"

48. On 30 January 2019, the surgeon wrote to Dr D. The letter stated:

> "[Mr A] has previously been seen by the speech pathologists back in February 2018. At the time he was diagnosed with a possible right vocal cord cyst but I cannot see any ENT follow-up in our notes. He has been re-referred because of increasing dysphonia.[12] He does have some intermittent mild dysphagia[13] as well … I have organised an urgent CT scan of his neck and chest and also microlaryngoscopy[14] and biopsy of his right vocal cord."

49. Following several discussions about the proposed procedures, Mr A underwent microlaryngoscopy and a biopsy on 25 February 2019. The histology results showed a squamous cell[15] carcinoma.[16]

[11] Cancer.
[12] An abnormal voice.
[13] Swallowing difficulties.
[14] A procedure to examine the vocal folds.
[15] Flat cells that look like fish scales.
[16] Cancer.

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Further information — CMDHB

50. CMDHB told HDC that since these events, the following has been undertaken:

- It "has implemented an Acuity Index tool (AI) to prioritise follow up patients according to clinical need, rather than time on the waitlist. Every follow up appointment is allocated a clinical priority as well as a timeframe to enable more accurate scheduling. The AI tool provides a score for the patient determined by clinical priority and waiting time. If this tool had been in place in 2018, [Mr A] most likely would have been seen much earlier."
- "The wording of the drop down boxes [for grading referrals] has been changed to enable one selection only — a joint SMO/SLT Stroboscopy or SLT only selection. This will prevent a similar incident from occurring."
- "All outpatient follow up appointments are now to indicate the clinical level of priority required."
- "If the Speech Language Therapist identifies any abnormality on an endoscopic examination, an e-referral directly to ORL Services will be completed rather than booking a follow up appointment."
- "Advice to [the] patient to contact [the] clinic if an appointment is not received within [the] expected timeframe has been added to the Stroboscopy Speech Language Therapy report template and clinic consultation templates."
- "Patients who have been seen in the SLT clinic are given an ORL clinic contact number to ensure they have contact details if an appointment is not received in a timely manner."
- "The stroboscopy report which includes the laryngeal images is now available centrally on Éclair.[17]"
- "A revised template has been developed for the SLT clinic documentation to ensure the ORL consultant details are recorded."
- It has developed further speech language therapy clinic policies and procedures, which have not yet been finalised but currently are under consultation within the service.

51. CMDHB told HDC that it is planning to:

- Continue to try to recruit more ORL clinicians.
- Develop standardised "ORL referral acceptance guidelines".
- Undertake a "systematic review" of "all specialty electronic grading drop down options".
- Conduct a "review of capacity and demand for ORL services and development of a business case for staffing and infrastructure to manage any unmet need".

[17] Software used for sharing clinical results.

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52. In response to the provisional report, CMDHB stated that an additional ORL surgeon had been successfully recruited and commenced in February 2021. In addition, there is a temporary locum position until June and then another temporary position after that. The ORL long-term business plan has staggered recruitment plans embedded over the next five years for SMOs, nurses, and other appropriate workforce. CMDHB also noted that all CMDHB referral acceptance guidelines are being reviewed on the electronic platforms Healthpathways and Healthpoint, and monitoring by the monthly ORL Quality Forum will be ongoing. In relation to the systemic review of electronic grading dropdown options for specialty services, CMDHB said that this review was completed in December 2020. In addition, CMDHB told HDC: “ORL services has been added on the Vulnerable Regional Services list and is currently under review.”

53. CMDHB’s Chief Medical Officer stated:

> “I would like to apologise again to [Mr A] and his family for the distress that this delay has caused and to reassure him that CMDHB is taking steps to help ensure this situation is not repeated. We would like to extend an offer to meet with [Mr A] and his family if they wish, when the investigation is completed to discuss the findings and recommendations.”

Further information — Ms C

54. Ms C told HDC that since these events she has made the following changes to her practice:

- She uses a template report for her clinic consultations to ensure the quality of her documentation.
- She is now aware of a “must see” option on the consultation outcome form, which indicates priority. She selects this option when she is suspicious.
- She gives patients her contact details, so they can let her know if they do not receive follow-up appointments in a timely manner.
- She has developed a policy for first specialist assessment stroboscopy clinics to be led by speech language therapists at CMDHB.

55. Ms C told HDC that following these events her practice was reviewed and validated by two senior speech language therapists. The New Zealand Speech-language Therapists’ Association renewed Ms C’s registration with the proviso that she receive monthly clinical supervision from a senior speech language therapist for 12 months.

56. Ms C told HDC that it was distressing for her to discover that she contributed towards Mr A’s delay in diagnosis. She stated:

> “I unreservedly apologise for the delay [Mr A] experienced as a result of me not ensuring [Mr A] [was] seen in a timelier manner, the distress caused by the delay and for the impact that this has had on [Mr A] and [his] family. This is not the outcome I wish for anyone and am very sorry that this was [Mr A’s] experience.”

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Responses to provisional opinion

57. Mr B, CMDHB, and Ms C were given the opportunity to respond to relevant sections of my provisional opinion. Their responses have been added to the report where relevant.

Mr B

58. Mr B responded that he was satisfied that the "information gathered" section of my report covered what occurred adequately.

Ms C

59. Ms C accepted my provisional findings. She stated: "I will never forget this incident and have learnt and most importantly improved on it. I am also now more risk aware."

CMDHB

60. CMDHB "unreservedly" accepted my provisional findings and reiterated that a number of improvements have been made by the ORL service as a result of this case. CMDHB offered a further apology to Mr A.

61. CMDHB told HDC that while it will implement the proposed recommendations and continue to make the required changes to its systems in the areas noted in this report, the issues facing CMDHB in the provision of ORL services are "still of significant concern". CMDHB stated that the ongoing challenges it faces include meeting additional demand posed by growing numbers within the service, and having adequate funding and staffing.

Opinion: Counties Manukau District Health Board — breach

Introduction

Resourcing pressures on CMDHB

62. At the time of these events, the ORL service was under significant resourcing pressure. CMDHB itself stated that it "was unable to meet clinic demand due to the overwhelming and unrelenting volume of patient numbers exceeding both capacity and staffing". My expert ORL advisor, Dr Robert Allison, advised that resourcing pressures are common to "most Otolaryngology Departments throughout the country, particularly the larger DHBs".

63. However, as this Office has stated previously in relation to resourcing pressures in ophthalmology, the existence of systemic pressures does not remove provider accountability in addressing such issues.[18] A key improvement that all DHBs must make, now and in the future, is to assess, plan, adapt, and respond effectively to the foreseeable effects that skills shortages in the health sector will have on systems.

Services provided to Mr A

64. On 7 February 2018, Ms C produced a stroboscopic image of Mr A's throat and vocal cords for CMDHB; she identified and documented that the image depicted a "Right vocal fold

[18] Opinion 16HDC01912 (20 June 2018), and Opinion 16HDC01010 (12 March 2018).

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irregularity" and requested that Mr A have a follow-up appointment with an ORL clinician. Dr Allison reviewed the image and advised that the irregularity "appears to be almost certainly an early squamous cell carcinoma of the right vocal cord".

65. As a result of a series of systemic failings, Mr A experienced an unacceptable delay in receiving a diagnosis of his throat cancer. I discuss these failings below.

Unclear booking system

66. At the time of events, CMDHB's electronic referral system allowed a grading consultant to select both a "category" option and a "clinic" option from computer dropdown menus. It was possible for a grading consultant to select both "Stroboscopy" as the category and "Speech Language Therapy" as the clinic, as did Dr E when he graded Mr A on 18 January 2018 with the intention that Mr A be seen jointly by an ORL clinician and a speech language therapist at the stroboscopy clinic.

67. However, the administrator who booked Mr A's first specialist appointment interpreted Dr E's selections as meaning that Mr A was to see a speech language therapist only, and booked Mr A an appointment with a speech language therapist but not an ORL clinician.

68. CMDHB accepted that "the configuration of the electronic referral system at the time of these events contributed to [Mr A] being booked into the wrong clinic".

69. Dr Allison advised:

> "[T]hrough a clerical error [Mr A] was given an appointment to be seen in a clinic run by a speech therapist in isolation without proper training in the recognition of various vocal cord pathologies. I would regard this as being a moderate to severe departure from an appropriate standard of care."

70. I accept this advice. Notably the system in place at the time was not sufficiently clear to ensure successful communication between the grading consultant and the booking administrator. As a result, Mr A was not booked to see an ORL clinician as intended by the grading consultant.

71. I note that since these events, CMDHB has changed the wording of its dropdown boxes to give the grading consultant a clear choice between either a stroboscopy clinic with both an ORL clinician and a speech language therapist, or a speech language therapy clinic only. This is a sensible improvement.

Inadequate speech language therapy clinic processes

Inadequate process for obtaining ORL review

72. At the time of events, CMDHB did not have any documented policies or processes concerning how speech language therapists were expected to show stroboscopic images to an ORL clinician for review, or the timeframes in which they were expected to do this. CMDHB stated that there was "an expectation that all images taken by the SLT would be

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reviewed by an ORL consultant", and also a "common practice" regarding how this was done.

73. Ms C noted the lack of documented procedures at CMDHB for obtaining an ORL review of the stroboscopic images she had taken. She stated that her ability to show stroboscopic images to an ORL clinician depended on "who [was] present and available in clinic at the time". Her expectation of herself was "for the endoscopic/stroboscopic exam to be reviewed by ORL SMO within 2 weeks".

74. CMDHB acknowledged that "this was not a robust process and was not documented as a policy or procedure". It accepted that "in February 2018 there were no documented processes, policies or procedures in place to guide [Ms C]".

75. My expert speech language therapist, Ms Deborah Keller, advised that "when SLTs are undertaking endoscopy as part of the initial assessment of a voice disorder under the delegation of ORL, the recorded examination must be viewed and interpreted by an ORL [clinician]". Dr Allison advised that at his DHB it is normal practice that "all patients who have the larynx examined with flexible endoscopy are seen by an Otolaryngologist, or, at least, have the recorded images viewed by an Otolaryngologist within 1–2 weeks".

76. I accept my experts' advice that at the time of events it was accepted practice for any stroboscopic images taken by a speech language therapist to be reviewed by an ORL clinician appropriately. Accordingly, CMDHB needed to have in place a clear process for Ms C to follow to ensure that any stroboscopic images she took would be reviewed by an ORL clinician within a specified and appropriate timeframe.

77. I am critical that CMDHB did not have such a process in place; this failure hindered Ms C's ability to carry out her role adequately, and contributed to the delay in ORL review of the stroboscopic image of Mr A's vocal cords.

Inadequate orientation on follow-up appointments system

78. CMDHB told HDC that the clinic Charge Nurse could have escalated Ms C's requested appointment, and that if Ms C had had any queries concerning the clinic's processes, she should have asked the Charge Nurse, who was closely involved in orientation to the clinic. However, CMDHB noted that it was "unclear what orientation [Ms C] would have received" given the length of time and staff changes since this event. Nevertheless, CMDHB considered it likely that Ms C would have had an orientation that involved a close working relationship with the Charge Nurse and clinicians.

79. Ms C has indicated that she was not aware that if she requested a planned appointment (to be seen within three months), there was a high probability that CMDHB's system would not generate an appointment for the patient within that timeframe. Furthermore, she was not aware that the clinic Charge Nurse could escalate a patient's appointment, and that she could have requested this.

80. It is concerning that CMDHB failed to ensure that Ms C understood how follow-up appointments were prioritised, or the fact that the clinic Charge Nurse could escalate a

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patient's appointment. These were aspects of CMDHB's organisational systems, and there is no evidence that Ms C was specifically educated about these matters.

81. The failure to orientate Ms C to CMDHB's system adequately meant that she was unaware both that Mr A would probably not receive an appointment within the time period she had requested, and that she could have asked the clinic Charge Nurse to escalate his appointment. As noted above, this contributed to the delay in Mr A being booked for an ORL review.

Conclusion

82. I conclude that Mr A experienced an unacceptable delay in receiving a diagnosis of his throat cancer, owing to inadequacies in CMDHB's electronic referral system and its speech language therapy clinic processes at the time. I consider that CMDHB was not managing its service in an efficient and effective manner to ensure the provision of timely, appropriate, and safe services to consumers. Accordingly, I find that CMDHB failed to provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[19]

Other comment — acuity systems

83. As discussed, at the time of events CMDHB's ORL service was under significant resourcing pressure. The number of overdue follow-up ORL appointments increased from 17 in July 2014 to 1,563 in May 2017. I recognise that CMDHB cannot control the demand for its ORL clinics. However, it can control how it responds to and manages the demand. In the context of increasing demand and increasing delays over a number of years, it is prudent to have an acuity system to ensure that more serious requests for follow-up appointments are prioritised over less serious requests. I note that CMDHB implemented such a system in May 2019, and I acknowledge its efforts to improve its systems and reduce delays.

Opinion: Ms C — breach

84. On 7 February 2018, Ms C examined Mr A's throat and vocal cords using stroboscopy, and documented a report of her examination; this included a stroboscopic image of Mr A's throat and vocal cords. The image showed an "irregularity" on Mr A's right vocal cord, which Ms C noted in her report.

85. Ms C determined that Mr A needed an ORL follow-up appointment, and requested this for him. As there were no available appointment times in the following six weeks, she added Mr A to the "planned appointment" list, and asked that he be seen on 7 May 2018.

86. There is no documentation of Ms C's report being seen by an ORL clinician at any point before 23 January 2019. Ms C stated that she showed her report to an ORL consultant

[19] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

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briefly, and CMDHB stated that the consultant was probably Dr F. However, Dr F cannot recall reviewing the report, and there is no documentation that he did so.

87. My expert speech language therapy advisor, Ms Deborah McKellar, advised:

> "[W]hen SLTs are undertaking endoscopy as part of the initial assessment of a voice disorder under the delegation of ORL, the recorded examination must be viewed and interpreted by an ORL [clinician]. [Ms C] showing the SLT report to an ORL consultant in a corridor consultation does not constitute a review of the examination. [Ms C's] failure to ensure a review was undertaken, and lack of documentation of the recommendations from the corridor consultation with ORL would be a serious departure from accepted practice."

88. Ms McKellar also identified that there was no documentation on the actions Ms C took to discuss the case and determine the timeframe of three months for the follow-up appointment. Ms McKellar noted that it is not standard practice for a speech language therapist to determine the urgency of ORL follow-up or the associated timeframe for an ORL assessment to occur. Ms McKellar considered this to be a serious departure from accepted practice.

89. I accept Ms McKellar's advice on these matters. Ms C needed to ensure that her report (including the stroboscopic image) was reviewed promptly by an ORL clinician, so that the clinician could determine the appropriate timeframe in which Mr A should be seen. Ms C's omission to do this was a serious departure from accepted practice.

90. I recognise that Ms C was not well supported by CMDHB's speech language therapy clinic processes. There was no documented policy or process concerning how speech language therapists were expected to ensure that their reports were reviewed by an ORL clinician, and the timeframes in which this was to occur. There is no evidence that Ms C was made aware that she could ask the clinic Charge Nurse to escalate a patient's appointment where appropriate, or that merely requesting that a patient be seen within three months (as she did for Mr A) did not guarantee that the patient would actually be seen within that time period. Ms C told HDC that her ability to show stroboscopic images to an ORL clinician depended on "who [was] present and available in clinic at the time".

91. I acknowledge that this lack of support affected the quality of care that Ms C was able to provide to Mr A. However, as a senior professional, Ms C remained individually responsible for providing reasonable care and skill to Mr A. Having identified an irregularity on the stroboscopy images and in her report, and being aware that it was "outside [her] scope of practice to diagnose pathology", Ms C's responsibility was to ensure that her report was reviewed by an ORL clinician appropriately in a timely manner. In this case, Ms C failed to ensure such a review. She also requested that Mr A be seen by an ORL clinician within three months, without ORL input into the timeframe. Although these were not the sole factors that caused the delay in Mr A's ORL review, they were contributing factors, and I

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consider that the deficiencies in Ms C's clinical decision-making amount to a breach of Right 4(1) of the Code.[20]

Recommendations

92. In the provisional report it was recommended that CMDHB:

a) Provide evidence to HDC that the changes described at paragraph 50 of this report have been implemented. In its response to the provisional report, CMDHB provided the evidence requested and met this recommendation in full, with the exception of providing its newly developed speech language therapy clinic policies/procedures, which CMDHB is in the process of finalising. As such, I retain my recommendation that evidence regarding the implementation of the above new policies/procedures be sent to HDC within three months of the date of this report.

b) Complete its "review of capacity and demand for ORL services" and report to HDC on the outcome of that review. In its response to the provisional report, CMDHB provided evidence that the review has been completed along with detailed future planning for the service. I am therefore satisfied that this recommendation has been met.

c) Provide a written apology to Mr A. In its response to the provisional report, CMDHB sent the apology to HDC, and this has been forwarded to Mr A.

93. I also recommend that CMDHB:

a) Complete its development of standardised "ORL referral acceptance guidelines", and provide these to HDC within six months of the date of this report.

b) Report to HDC regarding the outcome of the review of ORL services since it has been added to the Vulnerable Regional Services list, within six months of the date of this report.

c) Consider changes it could make to ensure that time is available for speech language therapists to show their reports of endoscopic examinations (including stroboscopic images) to an ORL clinician, and that ORL clinicians review the reports promptly and adequately. CMDHB is to report to HDC on the outcome of its consideration within six months of the date of this report.

d) Complete its "systematic review" of "all specialty electronic grading drop down options", and report to HDC on the outcome of that review within six months of the date of this report.

e) Conduct a review of the effectiveness of the changes described at paragraph 50 of this report, and report to HDC on the outcome of its review within six months of the date of this report.

[20] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

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f) Use this report as a basis for training staff at CMDHB, focusing on the breach of the Code identified, and provide evidence of that training to HDC within six months of the date of this report.

94. I acknowledge that since these events Ms C has undergone a review by the New Zealand Speech-language Therapists' Association, and that she has cooperated with a decision by that Association that she be subject to monthly clinical supervision from a senior speech language therapist for 12 months. I also acknowledge that she has made several changes to her practice and that she has provided a written apology to Mr A. In these circumstances, no further recommendations have been made in respect of Ms C.

Follow-up actions

95. A copy of this report with details identifying the parties removed, except CMDHB and the experts who advised on this case, will be sent to the New Zealand Speech-language Therapists' Association, and it will be advised of Ms C's name.

96. A copy of this report with details identifying the parties removed, except CMDHB and the experts who advised on this case, will be sent to the Ministry of Health, the Health Quality & Safety Commission, Technical Advisory Services, the Medical Council of New Zealand, and the New Zealand Society of Otolaryngology, Head and Neck Surgery, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Ms Deborah McKellar on 30 August 2019:

"I have been asked to provide an opinion to the Commissioner on case number 19HDC00437. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I am a speech language therapist (SLT) and a registered member of the New Zealand Speech Language Therapists' Association (NZSTA). I graduated from the University of Canterbury, New Zealand in 2005 with a Bachelor of Speech Language Therapy. I have worked for 14 years as a SLT based in District Health Boards (DHBs) and hospital trusts in New Zealand and the United Kingdom. I have worked across inpatient, outpatient and community settings with adults with acquired communication and swallowing disorders. For the last 6 years I have also undertaken SLT management and leadership roles.

I have been asked by the Commissioner to provide advice on whether I consider the care provided to [Mr A] by [Ms C] was reasonable in the circumstances, and why. In particular I have been asked to comment on:

- The appropriateness of [Ms C's] clinical assessment of [Mr A's] vocal fold irregularity.
- The appropriateness of [Ms C's] plan and follow-up care for [Mr A].
- Whether there was any other course of action [Ms C] should have taken in light of [Mr A's] clinical presentation.
- Any other matters in this case that I consider warrant comment.

The following information has been reviewed and used to provide advice:

1. The letter from the Commissioner asking me to provide expert advice
2. The original letter of complaint, dated 6 March 2019
3. CMDHB's letters to HDC dated 30 April 2019 and 16 July 2019, and an addendum to the second letter
4. [Ms C's] statement to HDC dated 8 July 2019
5. CMDHB's clinical notes which specifically deal with the care that [Ms C] provided on 7 February 2018
6. New Zealand Speech-language Therapists' Association (NZSTA) Scope of Practice, April 2012. Retrieved from: http://www.speechtherapy.org.nz/wp-content/uploads/2013/09/NZSTA-Scope-of-Practice-2012.pdf
7. American Speech-Language-Hearing Association (ASHA). Use of Endoscopy by Speech-Language Pathologists: Position Statement. Retrieved from: https://www.asha.org/policy/PS2008-00297/
8. American Speech-Language-Hearing Association (ASHA). The roles of otolaryngologists and speech-language pathologists in the performance and interpretation of strobovideolaryngoscopy [Relevant Paper], 1998. Retrieved from https://www.asha.org/policy/RP1998-00132/

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9. American Speech-Language-Hearing Association (ASHA) Scope of Practice in Speech Language Pathology, 2016. Retrieved from: https://www.asha.org/uploadedFiles/SP2016-00343.pdf

Factual Summary

[Mr A] saw his GP in January 2018 because he had a hoarse voice. On 10 January the GP referred [Mr A] to Counties Manukau DHB (CMDHB). On 18 January, a CMDHB ORL graded [Mr A's] referral as Priority 2, to be seen within two to four weeks by both an SLT and an ORL at a stroboscopy clinic. However, due to an administrator's error, [Mr A] was booked to only see an SLT, and was not booked to see an ORL.

[Mr A] saw the SLT, [Ms C], on 7 January 2018. She performed an endoscopic examination on his throat and vocal cords which revealed a vocal fold irregularity and she suspected this was a cyst. She discussed her findings with [Mr A] and explained he would need to be seen by the ORL consultant for an ongoing management plan. She discharged him and added him to CMDHB's 'planned follow up appointment waiting list', to be seen by an ORL within three months.

Due to high levels of clinic demand, [Mr A] had still not received an appointment with an ORL as of December 2018 — ten months after [Ms C] had originally added him to the waiting list. In December 2018, [Mr A] saw his GP about this matter, who referred him yet again to CMDHB. In January 2019, an ORL reviewed [Mr A] and found that he had throat cancer.

Advice Requested

The appropriateness of [Ms C's] clinical assessment of [Mr A's] vocal fold irregularity

It is accepted practice for SLTs to use instrumentation such as endoscopy to view the throat and vocal folds for the diagnosis of communication disorders[6,7]. This can include initial assessments of patients referred to ORL with voice difficulties, where the ORL has delegated the initial assessment to a SLT. The SLT must have received specialised training in order to undertake this assessment.[8]

However it is not accepted practice for SLTs to differentially diagnose medical conditions[8,9] and confirm the presence or absence of any throat or vocal fold abnormalities. Therefore when SLTs are undertaking endoscopy as part of the initial assessment of a voice disorder under the delegation of ORL, the recorded examination must be viewed and interpreted by an ORL[8]. The purpose of this ORL review is to identify the presence or absence of any throat or vocal cord abnormalities. A SLT may identify that there are irregularities, and propose a hypothesis as to the nature of that irregularity, however they are unable to differentially diagnose.

[Ms C's] assessment of [Mr A's] vocal fold irregularity is not a departure from the standard of care or accepted practice. She identified an irregularity and recommended that this would need to be reviewed by an ORL. However there is no record of the endoscopy recording being reviewed by ORL. A failure to ensure this review was

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undertaken would be a serious departure from accepted practice. When a SLT is undertaking endoscopy as part of an initial assessment of a voice disorder under the delegation of ORL, it is accepted practice for the recordings of these assessments to be reviewed by an ORL after the clinic to identify presence or absence of any anatomical pathology. If [Ms C] did ensure a review was undertaken, but did not document who undertook this review, then this would be a moderate departure from accepted practice.

The appropriateness of [Ms C's] plan and follow-up care for [Mr A]

It is accepted practice for a SLT to discharge a patient when their clinical input is not required or appropriate. It was appropriate for [Ms C] to discharge [Mr A] from SLT and recommend follow up from ORL. Due to the vocal fold irregularity she noted, and the unknown cause of this, [Mr A] required further investigation and management from ORL. Voice therapy from a SLT at that time would not be appropriate until the cause of the irregularity could be identified, and determined if voice therapy would be indicated for that diagnosis.

Information is lacking on who made the decision for [Mr A] to be placed on the follow up list to be seen in three months. There is no documentation on what actions [Ms C] took to discuss the case and determine the timeframe of three months for the follow-up appointment. If [Ms C] made this decision, then this would be a serious departure from accepted practice. It is not standard practice for a SLT to determine the urgency of ORL follow up and associated timeframe for their assessment to occur. It is standard practice for this priority and timeframe to be determined by ORL after reviewing the clinical information available, and determining the clinical urgency.

Whether there was any other course of action [Ms C] should have taken in light of [Mr A's] clinical presentation

No information is available relating to the availability of ORL in the clinic when [Ms C] saw [Mr A]. Given the irregularity seen on [Mr A's] vocal fold, it may have been appropriate for [Ms C] to seek a review by ENT while [Mr A] was present at the clinic, depending on their availability and vicinity.

[Ms C] could have documented more clearly the steps that she took to ensure that the endoscopic examination was reviewed by ORL, and the actions that she took to organise a follow-up appointment with ORL including how the timeframe was determined.

Any other matters in this case that you consider warrant comment

Information is not available as to if [Ms C] was aware from the referral information that the appointment had been incorrectly booked by administration into a SLT clinic, rather than a combined clinic with ORL. If she was aware, and continued to see the patient without documenting a discussion with ORL or the reasons for continuing without a discussion, then this would be a serious departure from accepted practice as she would be undertaking an assessment that the ORL had not delegated to her. If she

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was not aware, and believed the ORL had triaged [Mr A's] referral to be seen by SLT alone, then this would not be a departure from accepted practice."

The following further expert advice was obtained from Ms McKellar on 8 December 2019:

"On 30 August 2019 I provided a report to the Commissioner providing an opinion on case number 19HDC00437. I have been asked to provide further opinion to the Commissioner on this case in relation to further documents provided. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I am a speech language therapist (SLT) and a registered member of the New Zealand Speech Language Therapists' Association (NZSTA). I graduated from the University of Canterbury, New Zealand in 2005 with a Bachelor of Speech Language Therapy. I have worked for 14 years as a SLT based in District Health Boards (DHBs) and hospital trusts in New Zealand and the United Kingdom. I have worked across inpatient, outpatient and community settings with adults with acquired communication and swallowing disorders. For the last 6 years I have also undertaken SLT management and leadership roles.

I have been provided further documents:

CMDHB's letter to HDC, dated 1 November 2019

A better quality version of the stroboscopic image taken of [Mr A's] larynx on 7 February 2018.

I have been asked by the Commissioner to provide further advice on the care provided to [Mr A] by [Ms C]. In particular I have been asked to comment on:

Whether the documents provided cause me to change, or add to, my original advice in any way.

Whether the documents raise any new issues.

Factual Summary

[Mr A] saw his GP in January 2018 because he had a hoarse voice. On 10 January the GP referred [Mr A] to Counties Manukau DHB (CMDHB). On 18 January, a CMDHB ORL graded [Mr A's] referral as Priority 2, to be seen within two to four weeks by both an SLT and an ORL at a stroboscopy clinic. However, due to an administrator's error, [Mr A] was booked to only see an SLT, and was not booked to see an ORL.

[Mr A] saw the SLT, [Ms C], on 7 January 2018. She performed an endoscopic examination on his throat and vocal cords which revealed a vocal fold irregularity and she suspected this was a cyst. She discussed her findings with [Mr A] and explained he would need to be seen by the ORL consultant for an ongoing management plan. She discharged him and added him to CMDHB's 'planned follow up appointment waiting list', to be seen by an ORL within three months.

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Due to high levels of clinic demand, [Mr A] had still not received an appointment with an ORL as of December 2018 — ten months after [Ms C] had originally added him to the waiting list. In December 2018, [Mr A] saw his GP about this matter, who referred him yet again to CMDHB. In January 2019, an ORL reviewed [Mr A] and found that he had throat cancer.

Advice Requested

Whether the documents provided cause me to change, or add to, my original advice in any way

CMDHB's letter dated 1 November 2019 states that '[Ms C] has confirmed that she did briefly show the SLT report to an ORL consultant', and that this was a '"corridor consultation" rather than the ORL consultant reviewing the video or seeing the patient themselves'. The CMDHB letter also states that 'in February 2018 the standard practice by the ORL consultations was to carry out a virtual review of the still images or video of the examination'. As per my report dated 30 August 2019, when SLTs are undertaking endoscopy as part of the initial assessment of a voice disorder under the delegation of ORL, the recorded examination must be viewed and interpreted by an ORL. [Ms C] showing the SLT report to an ORL consultant in a corridor consultation does not constitute a review of the examination. [Ms C's] failure to ensure a review was undertaken, and lack of documentation of the recommendations from the corridor consultation with ORL would be a serious departure from accepted practice.

CMDHB's letter dated 1 November 2019 states that '[Ms C] was not aware that [Mr A] had been booked into her clinic in error'. As she was not aware, and believed ORL had triaged [Mr A's] referral to be seen by SLT alone, then it was appropriate for her to continue with the assessment, and was not a departure from accepted practice.

Whether the documents raise any new issues

The documents provided do not raise any new issues."

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Appendix B: Independent advice to the Commissioner

The following expert advice was obtained from Dr Robert Allison on 7 November 2019:

"I am an Otolaryngologist/Head & Neck Surgeon employed by the Canterbury District Health Board, as well as working in private practice. I have a particular interest in the management of head and neck tumours and voice disorders.

In answer to the particular questions you raised:-

1. The appropriateness of the grading of the referrals on 18 January 2018 and 15 December 2018.

On 10 January 2018 CMDHB received an e-referral from the patient's GP, [Dr D] — a two month history of a hoarse voice in a patient who was a heavy smoker. The referral was logged on 16 January and, on 18 January, accepted and graded by Otolaryngology Consultant [Dr E] as being P2 category: stroboscopy, clinic: SLT. Priority 2 meant to be seen within 2–4 weeks.

The grading of this referral is appropriate. In a patient who is a heavy smoker with a history of hoarseness, the possibility of laryngeal cancer needs to be considered, and this can only be done by visualisation of the larynx by a medical practitioner who is experienced in laryngoscopy. In most, if not all DHBs in the country this would mean referral to be seen by a specialist Otolaryngologist or, at least a trainee Otolaryngologist.

With regard to the referral made on 15 December this was graded as being priority 1 i.e. to be seen within two weeks. I do not have access to the referral letter from the GP but understand that his voice had become much worse and, since he had not actually been assessed by an Otolaryngologist at this point, he was given priority 1 — 'High Suspicion of Cancer' — to be seen within two weeks. This is appropriate. An appointment was made for 31 December 2018. However [Mr A] did not attend this appointment.

2. The accepted time frames for [Mr A] to be seen by ORL. If you consider there to have been delays, how significant were those delays? Please refer to guidelines and standards if available.

The accepted time frames for him to be seen by ORL i.e. initial grading of P2 (to be seen within two to four weeks) and, following the second referral graded as P1 (to be seen within two weeks) are entirely appropriate when there is a suspicion of cancer. However delays occurred following both referrals. The first delay occurred because, in error, the patient was referred to be seen by Speech Language Therapy only, and not an Otolaryngology Consultant. I believe that, having been assessed by a Speech Language Therapist, a significant delay did occur in arranging for a follow up appointment due to a number of factors. Firstly, when seen by [Ms C], Speech Language Therapist, the significance of the abnormality noted was not appreciated — comment is made in the clinical notes of the 'cyst suspected' and a follow up appointment with Otolaryngology was arranged. However, it appears that no

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particular urgency was attached to this appointment. [Ms C] states in her letter that all endoscopies with stroboscopic examinations performed by a SLT are reviewed by an ORL SMO for diagnosis. However there is no evidence that this occurred. [Ms C] states that 'it is outside my scope of practice to diagnose pathology'. However the fact that she has the responsibility of running a Stroboscopy Clinic on her own does cause some concern since, by definition, having carried out the investigation, she does carry some responsibility for making a diagnosis, or at least ensuring that the images are reviewed by an Otolaryngologist, within an appropriate time frame, to make a diagnosis. Although she mentioned that a 'cyst is suspected' on reviewing the images myself, this clearly does not look like a cyst. Despite the quality of the image, it appears very clearly to be an early laryngeal cancer.

In summary, the lack of understanding of the significance of the lesion identified by the Speech Language Therapist combined with the pressure on the Otolaryngology Department and lack of ability to see routine follow up patients in a timely manner, led to [Mr A] not receiving a follow up appointment.

[Mr A's] second referral from his GP on 12 December, as mentioned above, was given the appropriate grading (priority 1). The patient was given an appointment for 31 December but failed to attend. It appears that he telephoned the call centre on the day of his appointment requesting that his appointment be rescheduled however an email was sent to the clinic on the day of his scheduled appointment and was not seen or actioned and his appointment was marked as 'did not attend'. However, a further appointment was made for 23 January with an [Otolaryngologist/Head & Neck Surgeon].

There was a significant delay between his not attending on the day of his original appointment (31 December 2018) and his second appointment (23 January 2019). Unfortunately this was over the Christmas New Year period and it is likely that there was a break in routine clinic activity in the first week or so of the New Year, accounting for this three and half week delay.

3. The image of [Mr A's] vocal fold irregularity.

As mentioned above, the quality of the image I have received from the Health and Disability Commissioner's office is poor and in black and white, but despite this, the lesion appears to be almost certainly an early squamous cell carcinoma of the right vocal cord, occupying the anterior half of the cord but free of the anterior commissure. (I have requested higher quality images and I suspect these would confirm the strong impression that this is almost certainly a laryngeal cancer.) Other, much less likely, possibilities include a vocal cord nodule or cyst but these have a very different appearance. The image of his larynx, combined with his strong history of smoking would make laryngeal cancer the most likely diagnosis.

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4. Whether you and your peers would expect documentation of a SMO review of the endoscopy findings on 7 February 2018 and who should have documented this.

It is the policy in the Canterbury District Health Board that all images of the larynx are viewed by an Otolaryngologist/Head & Neck Surgeon. This happens in a number of ways. Patients with hoarseness or other symptoms of voice change may be referred directly to an Otolaryngology Outpatient Clinic where they will be seen, and the larynx viewed, by a Consultant Otolaryngologist or a trainee Otolaryngologist (with ready access to a specialist opinion in the clinic).

Secondly, patients may be seen in a Laryngeal Videostroboscopy Clinic which is run by an Otolaryngologist/Head & Neck Surgeon in conjunction with a Speech Language Therapist and both health professionals view the laryngeal images at the same time.

Thirdly, some patients may undergo FEES (Functional Endoscopic Examination of Swallowing) by a Speech Language Therapist using flexible nasendoscopy. However all of these images are reviewed by a specialist Otolaryngologist (with a particular interest in voice and swallowing) within one to two weeks of the images being carried out. If any abnormal features are noted by the Otolaryngologist then the patients are brought back for review in an Otolaryngology Clinic.

In summary, it is the practice in our District Health Board that all patients who have the larynx examined with flexible endoscopy are seen by an Otolaryngologist, or, at least, have the recorded images viewed by an Otolaryngologist within 1–2 weeks.

I am not sure of the practices in other DHBs throughout the country but I would suspect they would be similar to ours.

5. In your experience, who would have determined that [Mr A] should be seen by ORL within 3 months and whether this time frame is reasonable in the circumstances.

As mentioned above in our DHB, all laryngeal images are reviewed by a specialist Otolaryngologist, either at the time of endoscopy, or within two weeks.

If Speech Language Therapists have been trained to the point where they are carrying out laryngeal video stroboscopy on their own, then it is clearly critical that they recognise the pathology that they are looking at. (In CDHB, and as far as I am aware, in other DHBs, it is not usual practice for Speech Language Therapy Therapists to perform laryngeal videostroboscopy without an Otolaryngologist present.) Patients with hoarseness seen in a Laryngeal Videostroboscopy Clinic can have a wide range of underlying pathologies. Most of these are benign, for example muscular tension dysphonia, presbylarynx etc. Some may have discrete pathologies such as benign nodules or polyps but it is important that when serious pathology is present (such as in this case) this is recognised by the Speech Language Therapist (if they are carrying out stroboscopy on their own). If the significance of the lesion had been recognised at the time then clearly a three month wait for a follow up appointment was inappropriate and the patient ideally, should have been seen within two weeks.

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6. How your DHB and, if you are aware, other DHBs prioritise patients on follow-up waiting lists.

It is the practice in the Canterbury District Health Board that if a new patient has been seen in an Outpatient Clinic and needs a follow up appointment within three months, they are given a date for their appointment. However if the follow up is regarded as being 'routine' and is longer than three months, they are then placed on a follow up waiting list which, in some cases can be up to three years. Clearly these are patients with non-urgent, non-progressive conditions. However this is not ideal but it is a reflection of the high volume of patients which are seen and assessed in our DHB. Priority in seeing patients is given to those in whom a high suspicion of cancer is suspected and priority investigations and treatments are focused on these patients. Next in the list of priorities would be those with progressive or potentially life threatening conditions. In those patients whose conditions are not progressive or not causing any serious interference with the patient's quality of life, then the priority for investigation and treatment becomes less and, unfortunately these patients may wait many months, or even years for follow up appointments. (If they reach the threshold to be seen at all.)

7. Whether it was appropriate that in 2018, CMDHB prioritised patients by longest time on waiting list rather than clinical need.

From [CMDHB's] letter patients given a follow up appointment within six weeks are given a specific date. However outside the six week time frame planned appointments go onto a planned appointment waiting list and are prioritised for booking.

Whilst not ideal, this system reflects the increasing demand for a limited resource. This problem is the same in most Otolaryngology Departments throughout the country, particularly the larger DHBs. With limited resource availability a number of measures are carried out to try and prioritise treatment for those who need it most. Firstly, referrals from GPs are triaged and a significant number of patients do not receive an Outpatient appointment if their condition does not appear serious enough. (For example in our own CDHB, between 25–30% of referrals from GPs are declined an appointment.) Secondly those patients who have what appears to be serious conditions or a suspicion of cancer are seen within a relatively short time frame usually within 2–4 weeks. The timing of any subsequent investigations or further follow up appointment depend on the severity of the condition. If it is deemed not to be serious or progressive then the waiting times for any further investigations or follow up appointments may extend out to many months or even years since patients with more urgent conditions will take priority.

8. Any other matters in this case that you consider warrant comment.

In summary, I think that the priority given to this patient for initial appointments was appropriate. However, through a clerical error he was given an appointment to be seen in a clinic run by a speech therapist in isolation without proper training in the

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recognition of various vocal cord pathologies. I would regard this as being a moderate to severe departure from an appropriate standard of care.

I think it would be appropriate that all patients referred with voice change are initially assessed by a specialist Otolaryngologist or trainee Otolaryngologist and if, no serious pathology is present, and it seems appropriate, then the patient could be referred on for Speech Language Therapy. The Speech Language Therapist may deem it appropriate to use laryngeal videostroboscopy as part of their overall management of the underlying voice disorder."

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