Taranaki District Health Board

A Report by the
Health and Disability Commissioner

(Case 19HDC02393)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns a failure to action a referral for treatment. Following a man's diagnosis of cancer, the Telecommunications Department at Taranaki District Health Board (TDHB) failed to action a specialist referral, which led to a delay in the man receiving his treatment in a timely manner. The man made numerous telephone calls to TDHB to follow up on his referral, but as the referral had not been emailed to Radiation Oncology, clerical staff were unaware of the man's referral or any details about his treatment, and were unable to assist the man in resolving his enquiries.

2. The man did not receive his appointment until some five months after the original referral had been made. He underwent several unsuccessful rounds of chemotherapy but, sadly, he died.

3. The Commissioner reinforces the importance of having a robust referral system in place, supported by adequate policies and procedures that allow for prompt identification when a referral has not been actioned.

Findings

4. The Commissioner found that TDHB breached Right 4(1) and Right 6(1) of the Code, because there were several failures by a number of TDHB's staff and systems. Specifically:

- By failing to email the referral to the appropriate department, there were significant delays in the man receiving timely and appropriate services.
- TDHB did not have robust policies and safety-netting in place to ensure that it was able to identify when referrals had been missed, and it was unable to track and audit the non-performance of a missed referral. The process was almost entirely manual and reliant on human accuracy.
- The environment in which the telecommunications operator was working was less than ideal.
- TDHB did not adhere to Faster Cancer Treatment indicators, in that the man did not receive his first specialist appointment until four months after the referral was received.

Recommendations

5. The Commissioner recommended that TDHB provide a written apology to the man's whānau; report to HDC on the progress it has made in implementing a fully automated referral system; develop a live auditing system to monitor referrals; provide a summary of its audits of the automated part of its referral system; provide clear wording to staff regarding the referral process, in line with the continuing development of its automated system; and develop a specific training document for staff for transferring calls to the appropriate departments.

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Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided to her husband, Mr A, by Taranaki District Health Board (TDHB). The following issue was identified for investigation:

- *Whether Taranaki District Health Board provided Mr A with an appropriate standard of care between Month1[1] and Month14 (inclusive).*

7. The parties directly involved in the investigation were:

Mrs A	Complainant/consumer's wife
Taranaki District Health Board	Provider/DHB

8. Also mentioned in this report:

Dr B	General practitioner (GP)
Dr C	General surgeon

9. Further information was received from a medical centre.

10. Independent expert advice was obtained from a medical administrator consultant, Dr Grant Howard (Appendix A).

11. Mr A died in Month14 following treatment for his illness. I extend to Mr A's whānau my condolences for their loss.

Information gathered during investigation

Background

12. On 3 Month1, Mr A presented to GP Dr B at the medical centre, with a pink, elevated, firm nodule on his left front thigh. The nodule had been present and growing over the past few months and was tender with no bleeding. It was removed on the day of presentation owing to concerns about cancer, and the tissue was sent for review.

13. On 17 Month1, another doctor at the medical centre referred Mr A to TDHB's General Surgery Outpatient Department with a high suspicion of cancer.[2] The referral stated: "Merkel Cell Cancer[3] of the skin. A rare but aggressive form of skin cancer. Needs prompt evaluation by surgery and further excision and lymph nodes evaluated and removed." The

[1] Relevant months are referred to as Months 1–14 to protect privacy.
[2] At the time of these events, the Ministry of Health FCT indicators defined best practice for management of a patient with a high suspicion of cancer as 14 days between receipt of referral and first specialist appointment (FSA), and 62 days between receipt of referral and commencement of definitive treatment.
[3] A rare form of skin cancer that may be very aggressive and often spreads to other parts of the body.

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referral was triaged by TDHB on the same day, and Mr A was prioritised as a Faster Cancer Treatment (FCT) patient.[4]

14. On 17 Month2, Mr A underwent an elective procedure to remove further tissue[5] and the sentinel lymph node[6] from his left thigh scar, to be examined for the presence of cancer.[7] This was performed by general surgeon Dr C at TDHB. The histology results showed that one out of four lymph nodes had cancerous cells that had spread from the place of origin.[8] A letter to Mr A's GP explained that management would include a further chest CT scan to establish how big the cancer was and how far it had spread.[9]

15. The results were discussed at the Oncology Multidisciplinary Team Meeting (MDM)[10] on 7 Month3, and it was decided that radiation would be the preferable treatment option. A referral letter from Dr C to the Radiation Oncology Department dated 20 Month3 stated:

> "I would very much appreciate it if you find the time to meet up with [Mr A] for discussion of radiotherapy to his left groin … I have conveyed the recommendation from the MDM and he is keen to meet up with you for a discussion on radiotherapy."

Referral to Radiation Oncology Department

16. TDHB told HDC that the referral letter was received and typed by medical typing staff,[11] sent to Dr C for review and approval, and then sent back to the medical typists. The medical typist conducted the final check of the referral and emailed it to the document processing email inbox. TDHB stated that this inbox is checked daily and worked on by the overnight telecommunications operators (TCOs).

17. Mr A's referral was added into his clinical documents within the patient portal (called IBA/WebPAS) at 3.10am on 21 Month3. However, the TCO failed to email the referral to the referral centre or to the Oncology referrals inbox. The referral letter was therefore not received by the appropriate parties.[12]

TDHB referrals process

18. A statement from the TCO involved details the usual steps taken in processing referrals once they have been received from the medical typists. These are outlined as follows:

[4] https://www.health.govt.nz/our-work/diseases-and-conditions/cancer/previous-cancer-initiatives/faster-cancer-treatment.
[5] Wide local excision (WLE).
[6] The first lymph node to which cancer cells are most likely to spread from a primary tumour.
[7] Sentinel lymph node biopsy (SLNB).
[8] Metastatic carcinoma.
[9] A staging CT.
[10] Meetings at which health professionals with a range of expertise in different specialties discuss options for patients' care.
[11] A contracted service that types the referral letters that have been received, after they have been reviewed by the consultant.
[12] Radiation Department; TDHB Oncology Department shared inbox; personal inboxes of Oncology administration staff.

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"• Referrals and clinic letters are sent from the typists into the Typist New Zealand (TNZ) email folder.

- [A TCO] would pick up the email from the TNZ folder as it would have been flagged urgent, with the attached email highlighted. [The TCO's] initials would have been added to the email to indicate who the referral was being processed by. The letter would have been saved into the 'H drive'.
- [The TCO] would have opened the letter and checked if it needed printing, emailing[13] or faxing, and it would be actioned accordingly.
- [The TCO] would search the NHI number and link the referral to the patient's electronic clinical record in the patient portal.
- [The TCO] would return to the open email, save changes and put the email in the completed TNZ file.
- [The TCO] would complete the clinic list if required to confirm that a letter had been actioned via TNZ typists."

19. The TCO stated that Mr A's referral letter required emailing to the appropriate department, which in this case was Radiation Oncology. As part of TDHB's internal investigation, Information Technology (IT) services checked multiple inboxes but could find no evidence to suggest that the email was ever sent from the telecommunications office to the Radiology Oncology Department. Therefore, on the evidence presented, it appears that the referral was not sent to the Radiology Department.

20. TDHB was unable to provide HDC with a Standard Operating Procedure (SOP) regarding processing of internal referrals that was in place in Month3, as TDHB's practice is to keep only its most current SOPs to minimise the chance of erroneous use of outdated processes.

Attempts to contact TDHB

21. Mr A contacted TDHB on several occasions between 21 Month3 and 13 Month7, approximately three times per week, and was transferred between multiple departments — including Orthotics, Urology, Orthopaedics, Bookings, and Oncology — attempting to find out when he could begin his radiation treatment.

22. Because the referral had not been emailed to Radiation Oncology, clerical staff were unaware of Mr A's referral or any details about his treatment, and so were unable to assist Mr A in resolving his enquiries. In response to the "information gathered" section of my provisional opinion, Mrs A told HDC that Mr A was frequently told by the telephone operator that there was no referral for him, and that they could not see any information about his treatment on the system.

Re-presentation to GP

23. On 1 Month7, Mr A re-presented to Dr B with a new lump that had appeared around the original surgical site and had been present for about three weeks. Dr B telephoned the TDHB

[13] Mr A's referral required emailing.

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Outpatient Department and was told that Mr A had been referred for radiotherapy. Dr B advised TDHB: "[The patient] has not heard from them and given diagnosis this needs to be expedited."

24. Mr A presented to the medical centre on 13 Month7. The GP documented: "[I]ncreasing pain, and mass in area groin, thinks this is new … Needs urgent review surgical side and arrange ongoing [follow-up]." A further referral letter was sent to TDHB General Surgery and was marked as "Urgent". The reason for referral was stated as: "Possible satellite lesions and [metastases] L groin, Merkel cell cancer." The referral was prioritised on 18 Month7 with the comment: "[W]as meant to be booked for Radiation Oncology review in [Month3] last year. Not sure what happened there. Urgent review with [Dr C]."

25. Mr A was seen on 26 Month7 in an outpatient clinic appointment with Dr C's surgical registrar with the outcome being to undertake a further restaging CT scan (chest to knee) and attend a follow-up clinic appointment on 9 Month8, and to be re-referred to Radiation Oncology.

26. The registrar stated:

> "Unfortunately this referral appears to have been lost in the system and no follow-up has occurred. We were very sorry to hear of this and it is most concerning that this has managed to fall through the cracks particularly with him subsequently presenting with a mass in his groin."

Subsequent care

27. On 3 Month8, a Surgical Oncology MDM took place. Notes of the meeting stated: "Referred to Radiation Oncology for adjuvant[14] treatment but, due to a clerical error, this referral was not processed and he has not been seen by them." It was agreed at the MDM that owing to various clinical factors, the groin mass was not amenable to surgical management. A mass around the kidneys had also been discovered, and this was to be managed with a referral for chemotherapy and radiotherapy for localised control.

28. A medical oncologist saw Mr A for his first specialist appointment on 9 Month9. The oncologist decided not to proceed with further investigation of the kidney mass, but rather to commence chemotherapy and monitor the response in this region. He documented:

> "In view of the extent of his disease, I think he would be best managed with systematic treatment in the first instance with consideration of palliative radiation therapy[15] should his inguinal disease progress."

29. The plan was for treatment to commence under an oncologist and Mr A was to undergo four cycles of chemotherapy.[16]

[14] Drug/s used to increase the effectiveness of certain other drugs.
[15] Radiation therapy to reduce the severity of a disease without curing it.
[16] Treatment of disease, especially cancer, using chemical substances.

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30. Mr A underwent two unsuccessful rounds of chemotherapy between 14 May and 15 Month11. Mr A was referred for palliative radiotherapy, but, sadly, he died on 17 Month14.

Further information

TDHB

31. TDHB accepts that the referral was not sent to the Radiation Oncology Department mailbox as required, and that the inability of hospital staff to assist Mr A when he was following up on his referral for some four months was "not acceptable and very frustrating".

Serious and Sentinel Event Root Cause Analysis (RCA) Report

32. TDHB undertook an RCA on 19 Month7 and the incident was given an initial severity assessment code (SAC) rating of major/2.[17] The report was completed on 16 Month12 and was submitted to the Serious and Sentinel Event Review Committee (SSERC) Secretary for inclusion on the agenda. An SSERC meeting was held on 17 Month13. However, Mr A's case was not discussed at this meeting owing to a "large agenda". The RCA was later circulated to SSERC members on 16 Month14 and was discussed on 23 Month14. The RCA was unsigned, as TDHB said it was "incomplete and needed more specific recommendations which SSERC members were going to discuss with the authors". Subsequently, the SAC rating was downgraded to an SAC 3[18] in November 2019 "as it did not meet SAC 2 criteria at this point" and was therefore not discussed further with the SSERC.[19]

33. In the RCA report, TDHB identified a number of factors that could have contributed to the referral not being sent to the correct department, including interruptions, heavy workloads, and a largely manual process that allowed for human error to occur. TDHB concluded that it was human error that the original referral from Dr C to Radiation Oncology was not emailed after being linked in the patient portal. TDHB stated that the individual TCO is well trained and experienced, and noted that there are "protocols in place surrounding letter typing and emailing".[20] TDHB did concede that the time at which these processes occur (on the night shift) is not ideal.

ACC

34. On 18 Month14, ACC accepted a claim for a treatment injury. It stated:

> "We identified that [Mr A] suffered progression of Merkel cell carcinoma to metastatic disease with development of large lobulated left groin mass with central necrosis, extending to the extraperitoneal abdomen caused by a failure to refer for radiation therapy."

[17] Severity Assessment Code 2 refers to: "Permanent major or temporary severe loss of function, not related to the natural course of the illness; differs from the immediate expected outcome of the care management; can be sensory, motor, physiological, psychological or intellectual."
[18] Severity Assessment Code 4 refers to: "Permanent moderate or temporary major loss of function, not related to the natural cause of the illness; differs from the immediate expected outcome of the care management; can be sensory, motor, physiological or intellectual."
[19] TDHB told HDC that SSERC criteria is for SAC 1 & 2 events only.
[20] As set out above, TDHB was unable to provide relevant protocols from the time of these events.

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Responses to provisional opinion

35. Mrs A and TDHB were given an opportunity to comment on relevant sections of the provisional opinion. Where appropriate, changes have been incorporated into the report.

Mrs A

36. Mrs A told HDC that both she and Mr A felt as though Mr A's care was not prioritised by TDHB, despite his treatment already being delayed owing to the error in actioning the referral. Mrs A reiterated that she and Mr A remained unclear about Mr A's changing treatment options after the omission had been identified, and that they felt as though Mr A's options were never fully explained to them.

TDHB

37. TDHB told HDC that it acknowledged and accepted the proposed findings, recommendations, and follow-up actions. TDHB said that the proposed recommendations are in line with what was identified in its serious event review. TDHB stated that it has implemented many important changes already (discussed in paragraph 58) as a result of these events.

Opinion: Taranaki District Health Board — breach

Background

38. Mr A was referred to the Radiation Oncology Department at TDHB on 20 Month3, to receive radiotherapy following his diagnosis with an aggressive form of skin cancer (Merkel cell cancer). The referral was sent to the document processing inbox by the medical typists, and the handling of Mr A's referral was assigned to a TCO. However, the correct steps for actioning referrals were not undertaken, and this led to Mr A's referral not being received by the Radiation Oncology Department. Despite four months of follow-up from Mr A, no information regarding the referral was provided to him, and the error was not discovered. It was only when he presented to his GP with new symptoms, and a new referral was made, that Mr A received further care from TDHB. His treatment did not begin until 14 Month9.

39. TDHB accepted that the actioning of Mr A's referral by the TCO did not occur as it should have, and explained that the process for managing referrals was not followed correctly in this case.

Management of Mr A's referral

New Zealand Health and Disability CORE standards

40. The New Zealand Health and Disability CORE standards[21] outline the responsibility of healthcare providers to ensure that "consumers receive timely, competent, and appropriate

[21] New Zealand Standard Health and Disability Services (CORE) Standards (NZS 8134:2008). NZS8134.3 outlines the expectations for continuum of service delivery. NZS 8134.1.3.3 states: "Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals." NZS

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services in order to meet their assessed needs and desired outcome/goals". It is clear that in Mr A's case, the error of not emailing the referral letter to the Radiation Oncology Department led to significant delays in Mr A receiving timely and appropriate services to treat his skin cancer.

41. My expert advisor, medical administrator Dr Grant Howard, advised that this omission was a significant departure from the accepted standard of care in that "no patient with cancer or any other serious illness should fail to receive adequate care as an outcome of a failure to coordinate care, in this case on the basis of a referral between services". I agree that TDHB failed to provide Mr A with timely and competent service, and, accordingly, did not meet the Health and Disability CORE standards in this case.

TDHB referral system

42. TDHB did not have robust policies and procedures in place to ensure that it was able to identify when referrals had been missed. Dr Howard commented that the inability to identify that the referral had not been received by the Radiation Oncology Department amounted to a further departure from an acceptable standard of care. He summarised:

> "The inability to identify what did not happen (an omission) with respect to [Mr A's] referral, or in fact why it did not happen (even in retrospect) suggests that audit capacity in terms of identifying what referrals had not been made that should have, was very limited at the time."

43. I agree, and find that the lack of a robust referral system contributed to the unacceptable situation of Mr A's referral not being processed, and the error not being recognised, even after follow-up on the referral from Mr A, until Mr A sought further care for his deteriorating health.

44. The TCO in charge of sending Mr A's referral outlined the usual practice for processing referrals at the time of these events. This showed the process as being almost entirely manual and reliant on human accuracy. The task in question was undertaken at 3.10am, in an environment that was busy and under increased work pressure at the time. The TCO and TDHB accepted that their internal processes were not followed, which, in this case, was for the referral letter to be emailed to the Radiation Oncology Department following the referral being added into the patient portal.

45. Further, owing to the predominantly manual nature of the TDHB referral system, TDHB was unable to track and audit the non-performance of a missed referral. Dr Howard highlighted that there did not appear to be any consistent practice of auditing referral generation, transmission, and receipt. Consequently, there was no safety-netting in place to ensure that patients did not get lost in the system. Dr Howard advised that this was "a departure from the standard, but one which my peers would consider almost inevitable in a highly manual task-complex environment such as set out in the TDHB at the time for referral

81341.1.3.10 further states: "Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services."

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management". I agree with Dr Howard, and find that although the policies and procedures were not followed correctly in this case, the inability of the system to identify promptly that a referral had been missed contributed to TDHB's overall failure to manage Mr A's referral appropriately.

Faster Cancer Treatment

46. Faster Cancer Treatment (FCT) indicators were introduced in July 2012, requiring district health boards to collect standardised information about patients who had been referred urgently with a high suspicion of cancer. The 31-day indicator requires that patients with a confirmed cancer diagnosis are to receive their first cancer treatment (or other management) within 31 days of a decision to treat.

47. Mr A had a confirmed cancer diagnosis when he was referred to Radiation Oncology on 20 Month3. Mr A did not receive his first specialist appointment with Radiation Oncology until 26 Month7 — four months after his specialist referral was originally received. Therefore, the FCT indicators were not met by TDHB with respect to Mr A's care.

Conclusion

48. It is the responsibility of healthcare organisations to ensure that there are robust systems in place to minimise the risk of such errors occurring. Dr Howard stated:

> "I am of the view that very little can be assigned to human error even though the final act of failure was individual. It is far more likely the error, and possibly others undiscovered as yet, is the result of the system referral as it was designed."

49. I agree, and find that overall TDHB is responsible for the failings in Mr A's care for the following reasons:

- TDHB did not have a robust referral system, supported by adequate policies, to ensure that referrals were processed appropriately, or to identify when this had not occurred.
- The environment in which the TCO was working was less than ideal in that there was increased work pressure, the area was prone to distractions occurring, and this task was undertaken at 3.10am.

50. Overall, TDHB failed to comply with the New Zealand Health and Disability CORE standards by failing to provide Mr A with the timely, competent, and appropriate services he needed for the treatment of his cancer. The care that Mr A received also failed to comply with TDHB's own internal processes at the time of these events, and with national FCT indicators. The failure of TDHB to action Mr A's referral meant that Mr A did not have services provided to him by TDHB with appropriate care and skill. Accordingly, I find that TDHB breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[22]

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

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Communication with Mr A

51. Mr A contacted TDHB numerous times following his initial appointment and planned referral, but was not able to get any information on the status of his referral or his treatment plan. The Health and Disability CORE standards state that healthcare providers need to ensure that "[c]onsumers experience a planned and coordinated transition, exit, discharge, or transfer from services". Mr A's transfer to Radiation Oncology did not adhere to the CORE standards in that there was a clear lack of communication and coordination between TDHB departments, highlighted when Mr A attempted to follow up on his referral.

52. Dr Howard noted:

> "In the end [Mr A] was not able to find the help he was looking for, and indeed he returned to his General Practitioner for assistance, indicating both that he took his responsibilities in the patient–service relationship very seriously, and that the service was not navigable, albeit because the required referral had not come about."

53. The inability for Mr A to navigate the TDHB system and to find an answer to his valid questions constitutes an unacceptable situation, as outlined by Dr Howard:

> "I believe that my peers would consider an event where a patient was unable to determine where they stood in respect to the progress of a service referral, an unacceptable situation."

54. I agree, and am also of the view that Mr A's inability to get any information on the status of his referral or care is very concerning.

55. Right 6(1) of the Code states that "[e]very consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive". It is clear that Mr A was a strong advocate for his own healthcare treatment. However, TDHB failed to communicate effectively with Mr A about what was happening with his radiation treatment when he enquired, and therefore TDHB was unable to provide him with the information that a reasonable consumer in Mr A's circumstances would expect to receive. Accordingly, I find that TDHB breached Right 6(1) of the Code.

Retention of policies and procedures — adverse comment

56. TDHB was asked to provide HDC with copies of the policies and procedures in place from the time of these events in 2018. TDHB advised that it was unable to do so because of its practice of keeping only its most current SOPs in order to minimise the chance of erroneous use of outdated processes. The ability to track policy changes within an organisation, along with the ability to audit performance and compliance over a period of time, relies on the accessibility of records. Therefore, I am critical that TDHB was unable to produce any policies and procedures that were in place at the time of these events, and that there was not a system in place for archiving these safely.

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Changes made at TDHB

57. TDHB made the following changes as a result of the events in this case:

- An extra (fourth) team member was employed to cover the peak days in the call centre.
- A process was established whereby any concerning patient telephone calls or telephone calls that are not being actioned appropriately (for Oncology services) will be put through to the Clinical Nurse Manager's cell phone.
- An anonymised version of TDHB's RCA Report in relation to Mr A's care was circulated by email to all telecommunications staff to highlight the importance of ensuring that enquiries are directed to the correct service.
- A DHB-wide project to automate internal referrals has been commenced.
- The IT Department set up an electronic audit programme to ensure that typed letters are actioned from the processing folder.
- An automated system has been introduced whereby referrals are created in the patient portal and, when completed, are automatically sent to the requested service or department administrator to book the appointment. (This replaced the paper-based referral process.)
- It introduced a system whereby linking of referrals now occurs prior to the referral being sent for prioritisation. This ensures that the referral is linked to the patient's electronic portal so that if the referral is not returned by the triaging doctor, an error report is generated.
- It introduced a system whereby all referrals that have the words "Faster Cancer Treatment (FTC)", "Oncology", or "Radiation Therapy" are headed "Urgent" on the letter.
- It introduced a process whereby "Urgent" referrals are sent to the service or department prior to formatting and author approval, with a note "not viewed by author".
- An education session was delivered to referral centre administrative staff about FCT and High Suspicion of Cancer referrals on 15 Month11.
- Mr A's case was anonymised and discussed with the Oncology administration staff who were involved in the investigation, and with the Cancer Coordination Team.
- A Clinical Coordinator (with a recent nursing background) has been employed since Month9 to oversee the booking and referrals centre as a clinical presence and resource.

58. In addition, in response to the provisional opinion, TDHB told HDC that the following initiatives have been undertaken:

- TDHB has created a new clinical role, the Planned Care Manager (PCM), to manage the booking office (Telecommunications Department). The PCM reports to the Clinical Operation Lead within the Surgical Directorate. The PCM is able to access patient records, and all clinical enquiries such as Mr A's would now be investigated by clinical staff.

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- TDHB is able to generate exception reports to help staff track referrals through the electronic system, the Telecommunications Department now has the ability to be audited, and telephone calls/enquiries are able to be recorded. The booking office staff are now specialty specific and deal with referrals from specific departments, working closely with clinical staff.
- TDHB telecommunications staff are now able to follow a patient's journey from initial booking through to discharge (within the surgical and medical departments). These systems are audited regularly by the PCM, who works closely with the Clinical Governance Support Unit to ensure that any referrals failures are reported via the Incident Management system (DATIX), and are investigated and escalated.
- TDHB conducts weekly audits regarding unread referrals as part of its usual monitoring.
- TDHB confirmed to HDC that it now stores all of its SOPs from September 2020 onwards on a secure drive.
- TDHB has implemented a training programme for new TCOs, which includes a four-week (minimum) one-on-one training session, in which the new operator sits with a trainer using a paired headset, answering real patient calls. This allows the trainer to provide feedback to the operator throughout this period. At the end of the training period, the new operator's competence is assessed. For up to one year following this period, the operator will always be on the roster with an experienced operator, and their progress is monitored.

59. I acknowledge and commend the DHB for its response to this incident, and its progress in implementing change.

Recommendations

60. Dr Howard commented on the changes made by TDHB (prior to the further changes made as outlined in paragraph 58), and noted the following:

- The new process map for referral management as supplied by TDHB suggests that the majority of referral translation from dictated letters continues to be done by the telecommunications office. Dr Howard is not satisfied that there is a clear job description and accountability in place for telecommunications staff, and the room for human error in these processes is still evident.
- Dr Howard commented that despite the misgivings noted above, the referral arrangement could be proven reliable if a live audit were in place and TDHB could reconcile the number of referrals made and the number of referrals "lost".
- Dr Howard advised that overall, he found all of the changes difficult to follow in detail, and that although it can be difficult to convey a process change succinctly, "it is also likely true that if the process change cannot be simply conveyed to the Commissioner it may

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not be able to be simply conveyed to the Health Board's staff, or indeed it may not actually be simple enough yet or reliable enough".

61. In light of the changes already made by TDHB, and considering Dr Howard's comments, I recommend that TDHB:

a) Within three weeks of the date of this report, provide a written apology to Mr A's family for the failings identified in this report.

b) Provide an update on the progress that has been made in implementing a fully automated referral system (specifically the integration of the BPAC and WebPAS systems).

c) Take steps to develop a live auditing system that can monitor the number of referrals received against the number of referrals sent.

d) Provide HDC with a summary of the results of its weekly audits of the automated part of its system (where referrals are created in the patient portal and, when completed, are automatically sent to the requested service or department administrator to book the appointment), over a period of six weeks.

e) Continue to update the current referrals process with clear wording for all staff, in line with the continuing development of its integrated electronic referrals system.

f) Develop a specific training document for all telecommunications staff around receiving and transferring concerning patient telephone calls, or calls that are not being actioned appropriately (and what to do in such situations), between departments within TDHB.

g) Report back to HDC on the progress of recommendations b) to f) within six months of the date of this report.

Follow-up actions

62. A copy of this report with details identifying the parties removed, except Taranaki District Health Board and the expert who advised on this case, will be sent to the Health Quality & Safety Commission, Te Aho o Te Kahu — Cancer Control Agency, and the Ministry of Health, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent clinical advice to the Commissioner

The following expert advice was obtained from medical administrator Dr Grant Howard:

"I have been asked to provide an opinion to the Commissioner on case reference 19HDC02393.

I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

My qualifications are as follows MBChB, FRACP, FCICM, FRACMA, MBA.

I am a senior medical officer of 20 years experience. I have had experience in senior operational management roles, as Chief Operating Officer of a large District Health Board, and in senior professional leadership roles both in New Zealand and Australia. I am a fellow of the College of Medical Administrators, the focus of which College is clinical Governance, and have in the past been Chair of the New Zealand Chapter of the College.

With respect to the case I have been asked to provide comment on:

1. **The adequacy of Taranaki DHB's systems, policies and procedures in place at the time of [Mr A's] care, including (but not limited to) those related to:**
   a) **Ensuring referrals were forwarded to the appropriate departments.**
   b) **Alerting staff when a planned action had not been completed for a particular period of time (in this case, emailing a referral to Oncology).**
   c) **Ensuring adequate standards of care *were* maintained when workload and pressure on staff was high.**
   d) **Communication with patients in relation to treatment plans, including when patients contacted Taranaki DHB for updates or information regarding those plans.**
2. **Adequacy of actions taken by Taranaki DHB once the referral error and delayed treatment came to light.**
3. **Changes made at Taranaki DHB as a result of these events.**
4. **Any other matters in this case that warrant comment.**

1. The adequacy of Taranaki DHB's systems, policies and procedures in place at the time of [Mr A's] care

The standard against which the service provided to [Mr A] is to be assessed, is described in the New Zealand Standard Health and Disability Services (CORE) Standards (NZS 8134: 2008) and attached guidance.[1] NZS 8134.1.3 describes the expectations for continuum of service, and subsections 1.3.3 (consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcomes) and 1.3.10 (consumers experience a planned and coordinated transition, exit, discharge or transfer from services) apply. In addition, prior rulings and recommendations made by

[1] Accessed at: https://www.standards.govt.ndassets/Publication-filesiNzs8134.0-2008.pdf

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the Commissioner have been considered where these point to a required or desired standard.

a) Ensuring referrals were forwarded to the appropriate departments

There appears to be no dispute that the intended referral of [Mr A] to the oncology service by surgeon [Dr C], following the surgical multi-disciplinary meeting of the 7th of [Month3] did not occur. The explanation provided was that the process described for this to happen did not occur, which was for a Telecommunications Officer to receive the typed referral letter and then to pass that referral on to the referral centre email address. In a means-end analysis therefore the standard of care was not met, which for a patient with cancer is a significant departure from the expected standard. In considering how this departure from standards would be viewed by my peers, I believe that most would agree that no patient with cancer or any other serious illness should fail to receive adequate care as an outcome of a failure to coordinate care, in this case on the basis of a referral between services. This is different to the question of whether someone would be surprised that such had occurred, which would I suspect elicit a less emphatic opinion. This is largely due to the heterogeneous nature of non-electronic referral systems and their constituents such as the one described to exist in the Taranaki DHB at the time.

b) Alerting staff when a planned action had not been completed for a particular period of time (in this case, emailing a referral to Oncology)

The standard of care is as stated above in part a. In this instance staff from the referring service were not alerted to the fact that the referral had not been received. This would constitute a departure from the standard.

The relative responsibilities of the referrer and the receiving service or department have been explored in previous investigations and findings by the Commissioner and has suggested that the referrer retains some responsibility for tracking the referral although it is not clear how this should be undertaken.[2] It would seem reasonable but not sufficient that [Dr C] could assume that the referral would be actioned once he followed the agreed process. For a clinician to keep a list of referred patients and then check these against a list of referrals received at some future point as an assurance that the process worked, would be an unusual occurrence.

In the communication by the Taranaki DHB to the Commissioner on the 20th July 2020 (bullet point 9) the telecommunications operator assigned the task of actioning the referral, according to the established process, outlined clearly the difficulty with identifying what did not happen with respect to [Mr A's] referral, or in fact why it did not happen, even in retrospect. This suggests that the audit capacity in terms of identifying what referrals had not been made that should have, (acts of omission not commission), was very limited at the time as is often the case with errors of omission. In terms of overall system capability there appears to have been no practice of auditing

[2] https://www.hdc.org.nz/decisions/search-decisions/2012/09hdc01883/

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referral generation, transmission and receipt. As such it is no surprise that staff were not alerted that the planned action had not been completed.

This system and process flaw, the inability to track and audit the non-performance of an action in a manual process is a departure from the standard, but one which my peers would consider almost inevitable in a highly manual task-complex environment such as set out in the Taranaki DHB at the time for referral management. There are more electronic referral systems in New Zealand across DHBs since the issue of referral management was considered previously by the Commissioner[3], however short of the implementation of an electronic system, the ability to track and audit referrals where manual handling and multiple interfaces are common is fraught and prone to error.

c) Ensuring adequate standards of care were maintained when workload and pressure on staff was high.

The particular nature of the referral management process is germane in considering this question. [Mr A's] care was not compromised as a function of clinical care as such, but as part of a process to generate, transmit and receive referrals.

At the time it appears the process consisted of a letter being generated by the medical staff, which was then transcribed by a third party contractor and then sent to an email address to be picked up by a member of the telecommunications staff who undertook a number of tasks such as printing the letter, attaching it to the patient management system, and forwarding on a referral if this was required.

This task was undertaken at night, or overnight, and in [Mr A's] case at 03h10 in the morning, in an environment that was busy. The position description for this role provided by the Taranaki DHB outlines a number of competing tasks the telecommunications officer would be required to undertake. By the Taranaki DHB's admission the environment was under increased workload pressure at the time further increasing the likelihood that distraction was a likely contributor to the referral not being forwarded to the oncology service. In the same correspondence this arrangement is described as 'not ideal'[4].

I believe that this arrangement would be seen as less than ideal by my peers in the same way as this was expressed by the organisation's own quality and risk staff. It is unclear what the overarching committee (the Serious and Sentinel Event Review Committee) made of this commentary as the root cause analysis document is unsigned by the committee and no additional commentary is available.

[3] https://www.hdc.org.nz/decisions/search-decisions/2018/15hdc01667-16hdc00035-16hdc00328/
[4] Appendix C, Taranaki DHB response to the Commissioner 20 July 2020, Serious and Sentinel Event Root Cause Analysis.

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d) Communication with patients in relation to treatment plans, including when patients contacted Taranaki DHB for updates or information regarding those plans

The reference point for whether or not communication with the patient and his family was of a reasonable or expected standard must, sensibly, be the experience of the patient. I don't think there is any doubt based on the available documentation that [Mr A] and his family felt that communication about his care was unacceptable, in part because of the manner in which this was conducted, but also in part contributed to by the inability of staff to ascertain what the plan for him was.

The position description of the telecommunications officer outlines some of the required behaviours and actions with respect to the customer or client interface, however in the end [Mr A] was not able to find the help he was looking for, and indeed he returned to his General Practitioner for assistance, indicating both that he took his responsibilities in the patient–service relationship very seriously, and that the service was not navigable, albeit because the required referral had not come about.

It seems self-evident that someone with the time and inclination could have determined what the issue was given sufficient time and curiosity, whether that was a member of the telecommunications staff or one of the staff members [Mr A] was transferred to as a possible touch point within the Taranaki DHB. I am unsure what the reason for this not happening was, but on the face of it staff were either too busy, disinclined, or the task too difficult even for them to navigate.

I believe that my peers would consider an event where a patient was unable to determine where they stood with respect to the progress of a service referral, an unacceptable situation.

2. Adequacy of actions taken by Taranaki DHB once the referral error and delayed treatment came to light.

In my view the service delivered to [Mr A] once it came to light that his referral had been lost, and treatment delayed, was of a reasonable standard albeit it would not have been possible to mitigate the consequences of the error.

It is clear that [Mr A] and his whānau struggled with the timing and indications of different therapies (for example radiotherapy versus chemotherapy). In the first instance his initial referral for radiotherapy appears to have been made in the context of local disease only with a potentially curative intent, whereas in subsequent discussions (and following chemotherapy) radiotherapy was offered for local disease in a more palliative intent, I can understand how this would be a point of contention and a focus.

A further point of contention was the delay in accessing ACC related assistance. Whilst it is true that it may in some instances take time for the consequences of a delay in therapy or some similar error to manifest clearly, I don't believe that this fully explains the patient's frustration with a delay in the application process. Although not clearly

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evident in the available documentation it is not uncommon for clinical staff in my view to continue to regard patient claims under ACC as some form of personal or professional risk as a throwback to prior ACC regimes or even the stigma of admission of an error in countries in which they trained and practised previously. The ACC has spent much time and resource on training and education programmes in terms of re-educating clinical staff and changing attitudes but some concerns remain hard to change.

3. Changes made at Taranaki DHB as a result of these events

On the face of it Taranaki DHB have employed more resource in the areas that were of concern, namely the addition of a further telecommunications officer, the addition of clinically trained staff to assist with process issues, and improving access to a senior clinician (Clinical Nurse Manager) to answer any patient or whānau generated queries.

These kinds of adaptive changes to existing work processes are common after an error but rarely address the underlying system and process issues completely.

There is mention in the various documents of an electronic pathway being created for clinicians to generate referrals themselves as part of risk mitigation of a similar event happening again, however it is unclear that this **is** currently in use. What is clear from the new process map provided as appendix B to correspondence between the Taranaki DHB and [Mr A] on the 19th of [Month12], the majority of referral translation from dictated letters continues to be done by the telecommunications office. In addition the process map indicates that the process requirements for different clinicians is allowed to be different, captured by the words 'not all do this'.

Again in the words of the Taranaki DHB Quality and Risk staff, this isn't ideal and the current arrangement is largely unchanged and subject to the same risks as the historical arrangements. I am unsatisfied by the assertion that telecommunications officers have a clear job description and accountability and there should therefore be no problem. This assertion is Inconsistent with the environmental risks outlined previously, namely:

- Multi-handling of one task including use of a third party (medical typing)
- Multi-tasking in a busy environment (telecommunications office)
- After hours processing

And so on.

It must be noted that despite these misgivings, the current referral arrangement could be proven reliable if a live audit was in place and Taranaki DHB was able to provide a reconciliation of the number of referrals made and the number of referrals lost (or some other form of error) over a period of time. For this to be known a process audit would need to be in place to detect referrals not made when intended. Unfortunately this information was not available or not included in the responses and cannot be used to support the helpfulness or otherwise of the measures implemented.

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4. Any other matters in this case that warrant comment.

The management of referrals, and errors arising from this activity have occupied the Health and Disability Commission[er] (HDC) on a number of occasions previously and whilst not exactly equivalent to case law, nonetheless parallels seem to exist. In previous recommendations significant emphasis has been placed on using technologically enabled safeguards, such as electronic referrals generated by the referring clinician.

The adoption of these systems varies widely across the various DHBs. Reportedly the large Auckland DHB conglomerate now operate fully electronic referral platforms. In other areas the referral interface between primary care and DHBs has been progressed using the BPAC or equivalent system.

In the documentation made available for my consideration there is reference to significant constraints evident in the development of electronic referral systems for the Taranaki DHB, relating to available funding and tying progress to a larger project that may be underway or that is planned to start.

The obvious questions arise as to why one DHB is able to deploy effective solutions while others have not. Clearly DHBs that have progressed these solutions are not surprisingly also those previously found in breach or similar, in terms of referral management.

With respect to matters of governance and in particular clinical governance, it is not clear from the documentation received for review, what knowledge the Board Members have of this error, or how knowledge of such an error may have been factored into prioritising expenditure. Although not evidence of absence, the absence of evidence linking floor-to-Board certainly raises some concern.

Apart from the fact that some Health Boards have prioritised electronic referral enablers more than others, the lack of sector capability to leverage off safety risks discovered somewhere else and to deploy improvements implemented in other services before the same risk manifests locally is a further concern.

With respect to whether to assign the error described in [Mr A's] care and referral to a system or a person, I am of the view that very little can be assigned to human error even though the final act of failure was individual. It is far more likely the error, and possibly others undiscovered as yet (or fortuitously discovered and corrected), is the result of the system for referral as it was designed.

[Mr A's] care, particularly the loss of his referral and his inability to gain assistance when actively trying to do so, represents in my view a 'never event', in the same way that certain clinical events should never happen (like the retention of a swab post-laparotomy). I believe that my peers would hold the same view with respect to management processes and the failure to process a referral for treatment of cancer.

Dr Grant Howard 28 October 2020"

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The following further expert comment was made by Dr Howard on 2 December 2020:

> "There are two further comments I would make with respect to the care of [Mr A] and the steps taken to address the issue, in light of the response from Taranaki District Health Board.
>
> With respect to how [Mr A], and by extension his family, would feel about the care he received, I think that more than one thing can be true. I suspect that [Mr A] would have positive regard towards his interactions with individual staff, but in terms of the overall experience I would find it hard to believe that [Mr A] and his whānau would view his overall care to have been acceptable. I think the Taranaki District Health Board's interpretation of his satisfaction with the care delivered is likely to be positive towards the people he dealt with and those who cared for him, but it is unlikely to have been positive on the whole. It would be possible to ask the family directly however I am not sure this would be helpful to them.
>
> As the Health Board has acknowledged the points made in my report they should acknowledge these shortcomings in care to his family if this has not been done already. I cannot remember seeing a formal apology from the Health Board to [Mr A] and his family in the information pack provided, and although this presumably was done, the Board may want to consider a further apology in the light of the Commission[er's] investigation.
>
> With respect to the steps taken to address the issue, I have read the additional response and find it difficult to follow in detail. This is not surprising as it can be difficult to succinctly convey a process change in long form writing even with screen shots included. However, it is also likely true that if the process change cannot be simply conveyed to the Commission[er] it may not be able to be simply conveyed to the Health Board's staff, or indeed it may not actually be simple enough yet or reliable enough.
>
> With respect to any further suggestions as to improvements that could be made, in this matter I don't feel this is possible without a site visit and a first-hand explanation of the issues and how these have been addressed. I expect that such a site visit is beyond the scope of the request for an expert opinion and in the absence of such I would have to rely on the Health Board having done the best they can in good faith.
>
> Equally I would be happy to do a site visit."

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