

Southern District Health Board

A Report by the Health and Disability Commissioner

(Case 17HDC02066)

(Case 17HDC01491)

(Case 17HDC01700)

(Case 17HDC01385)

(Case 18HDC00326)



Health and Disability Commissioner
Te Tuhou Hauora, Hauātanga

Contents

Executive summary	1
Complaints and investigation	3
Information gathered during investigation — Southern DHB	4
Patient A	20
Patient B	23
Patient C	31
Patient D	40
Conclusions: Southern DHB.....	45
Recommendations.....	52
Follow-up actions	53
Appendix A: Independent advice to the Commissioner — Patient A	54
Appendix B: Independent advice to the Commissioner — Patient B	57
Appendix C: Expert Advice from Dr David Maplesden — Patient B.....	60
Appendix D: Independent advice to the Commissioner — Patient C	69
Appendix E: Independent advice to the Commissioner — Patient D	74

Executive summary

1. The Commissioner received complaints about the urology services provided by Southern District Health Board (Southern DHB) to a number of patients. The Commissioner commenced a Commissioner-initiated investigation of the Urology Service, in which he addressed four individual cases.
2. On 1 May 2010, the Otago and Southland DHBs were merged to form a new Southern DHB. The urology services provided subsequently by Southern DHB at Dunedin and Invercargill were derived from the two previous DHB services, and largely continued operating as two separate entities after the merger, with different clinical pathways relating to the different clinical facilities available at each site. By 2017, it was apparent that there were lengthy delays in a number of aspects of the assessment and treatment of Urology patients, and consequently there was substantial clinical risk.
3. The Southern DHB triage guidelines (in force from 2016) state that triage must be completed within 10 days of receipt of the referral, and the referrer and patient advised of the outcome. Urgent cases are to be seen within six weeks, and routine cases within four months. An appointment for a First Specialist Appointment (FSA) is made. If surgery is required, the specialist completes a “surgical booking form” setting out the procedure required and, if Faster Cancer Treatment (FCT) applies, the level of urgency for the surgery.
4. Southern DHB stated that when the demand for an FSA or surgery exceeds capacity, the priority of appointments is based around three areas — clinical need, length of time on the waiting list, and whether the patient requires a procedure.
5. Southern DHB commissioned an external review of its urology services that began in June 2017. By that time, delays had become apparent in the cancer pathway for Urology patients, particularly those with prostate cancer. Biopsies were taking up to six months from request and that, together with other delays, meant that patients with prostate cancer were having a prostatectomy¹ up to 12 months after it had become apparent that this was a likely treatment.
6. By July 2017, 37.8% of Urology patients were not being treated within the ESPI5 target (being given a commitment to treatment but not treated within the required timeframe). This was an increase from 2.6% in November 2016.
7. The review team presented its final report in August 2017. The report states that management had limited knowledge of the demand required to be met by the Urology Service in the context of changing demographics, and there was little planning for urology services across the entire DHB. There was a concerning level of clinical risk because of the long waiting period for patients on the Dunedin site. The review team made multiple recommendations, which have been implemented.

¹ Partial or complete removal of the prostate.

Findings: individual complaints

8. The four individual complaints are incidents of suboptimal performance that fit within the pattern demonstrated in this report.
- Patient A — His time to treatment was almost double the target timeframe. This was compounded by a failure to keep him informed about a likely date for his surgery. Southern DHB failed to provide his services with reasonable care and skill, and breached Right 4(1)² of the Code of Health and Disability Services Consumers' Rights (the Code).
 - Patient B — There was an unacceptable delay in Patient B receiving treatment. He was graded as priority 3 (expected to be seen within six weeks), but he was not seen until over five months after his initial referral. It was then a further seven weeks until his biopsy was performed, even though the booking form was marked urgent, with multiple circles and a star to emphasise the urgency. Southern DHB failed to provide his services with reasonable care and skill, and breached Right 4(1) of the Code.
 - Patient C — Despite being triaged as “to be seen within 6 weeks”, the first date for the FSA that Patient C was offered was over four months after the GP’s referral. Subsequently, the appointment was brought forward after his GP made a further referral noting the “high suspicion of cancer”, unexplained weight loss, pulmonary embolism, elevated PSA, and abnormal DRE. Information regarding the change from dabigatran to Clexane and back to dabigatran was conveyed by a member of the non-clinical staff. Southern DHB failed to provide Patient C’s services with reasonable care and skill, and breached Right 4(1) of the Code.
 - Patient D — On 19 July 2016, Patient D was booked for a flexible cystoscopy,³ but it was not performed until after a gynaecologist made an “urgent referral” on 31 January 2017. Southern DHB failed to provide Patient D’s services with reasonable care and skill, and breached Right 4(1) of the Code. In addition, Southern DHB failed to facilitate the fair, simple, speedy, and efficient resolution of Patient D’s complaint, and breached Right 10(3)⁴ of the Code.

Findings: Southern DHB — adverse comment

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

² Right 4(1) states: “Every consumer has the right to have services provide with reasonable care and skill.”

³ Insertion of a thin tube, with a camera and light on the end, through the patient’s urethra and into the bladder to visualise the inside of the bladder.

⁴ Right 10(3) states: “Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.”

10. The Commissioner stated that it is essential that providers assess, plan, adapt, and respond effectively to the foreseeable effects that changing demographics in their population will have on systems and demand. In the context of resource constraint, appropriate waiting list and appointment management systems are vital to managing risk. With increasing demand, capacity needs to be monitored. Having mechanisms to monitor wait times and make these transparent to both the public and to referrers is essential. Organisations also need to consider initiatives such as different models of care to reduce the gap between capacity and demand.
11. Southern DHB failed to ensure that a system was in place that effectively managed patients waiting for urology services during the period in question. Clinicians and members of the public came to expect delays, and delays became normalised.
12. Relationships within Southern DHB became strained. Southern DHB stated that managers were presented with considerable challenges regarding a lack of willingness by clinicians to work together to find solutions to the problems within the service, other than to provide an additional urologist.
13. The Commissioner stated that effective service delivery requires collaborative and mutually accountable relationships, and no party to this relationship can step away from the mutual accountability and responsibility to work constructively to solve the complex challenges that are an inevitable part of the health and disability sectors. These are issues of central importance for all DHBs that, if not recognised and acted on, can have severe consequences for patients. Southern DHB's inadequate response failed each of the patients discussed in this report.

Complaints and investigation

14. The Commissioner received complaints about the services provided by Southern DHB to a number of consumers, including Patient A, Patient B, Patient C, and Patient D. All complaints concerned Southern DHB's Urology Service. A Commissioner-initiated investigation of the Urology Service was commenced, and included the individual complaints received.
15. The following issues were identified for investigation:
 - *The appropriateness of services provided by Southern DHB to patients referred to the Urology Service since 1 January 2016.*
 - *The appropriateness of services provided by Southern DHB to Patient A.*
 - *The appropriateness of services provided by Southern DHB to Patient B.*
 - *The appropriateness of services provided by Southern DHB to Patient C.*
 - *The appropriateness of services provided by Southern DHB to Patient D.*

16. This report considers the systems and processes within the Southern DHB Urology Service and makes recommendations relevant to all cases. The “information gathered” section relating to Southern DHB is relevant to each individual case, and is not repeated in each. The report addresses the facts of each case and the care provided to each consumer separately. Each individual case should be read with the “information gathered” section relating to Southern DHB.
17. Independent expert advice was obtained from a urologist, Dr Jonathan Masters, with respect to each consumer (**Appendices A, B, D, and E**). Expert advice was obtained from in-house vocationally registered general practitioner (GP) Dr David Maplesden with regard to the care provided to Patient B (**Appendix C**).
18. Also mentioned in this report:

Dr E	Medical Director for Surgery
Mr F	Service Manager
Ms G	General Manager of Surgical Service
Mr H	Quality Performance and Systems Manager
Ms I	Urology Service Manager
Mr J	Urology Service Manager
Dr K	Urologist
Dr L	Urologist
Dr M	Urologist
Dr N	GP
RN O	Clinical nurse specialist
Dr P	Urologist
Dr Q	GP
Dr R	GP
Dr S	Surgical registrar
Dr T	Respiratory physician
Ms U	Department secretary
Dr V	Consultant gynaecologist
Dr W	Urology registrar

Information gathered during investigation — Southern DHB

Introduction

19. From 2017 I received a number of complaints about delays Southern DHB patients were experiencing in accessing urology services. I initiated an inquiry into the steps taken by Southern DHB to identify and address the issues. This report assesses the delivery of urology services by Southern DHB against the Code of Health and Disability Services

Consumers' Rights and the accountability dimension, and what has been done to remedy the deficiencies. It also considers the services provided to four individual patients.

Background

20. This section outlines the background to the development of the Southern DHB Urology⁵ Service and the problems that had arisen by 2017. The report then describes the processes for managing elective services within DHBs, prioritising referrals, and allocating appointments for Urology patients' First Specialist Appointments (FSAs) and treatment.
21. On 1 May 2010, the Otago and Southland DHBs were merged to form a new Southern DHB. The urology services provided by Southern DHB since that time at Dunedin and Invercargill were derived from the two previous DHB services, and largely continued operating as two separate entities after the merger, with different clinical pathways relating to the different clinical facilities available at each site. The Invercargill services worked in relatively modern facilities at Southland Hospital, whereas the Dunedin service had inadequate facilities sited within the Dunedin Hospital clinical services building.
22. On the Southland site, procedures such as flexible cystoscopy and trans-rectal ultrasound (TRUS) biopsies⁶ of the prostate were performed in the outpatients' clinic as part of the FSA, but that was not possible in Dunedin because of the limited space in the consulting rooms. Consequently, in Dunedin, second appointments for the procedures were required. A 2014 discussion paper noted that there was concern about urologist and nurse resource. There was a lack of physical space, especially clinic rooms, and a lack of equipment and clerical support staff. As a result of these factors, the concerns and delays related primarily to the Dunedin site.
23. By 2017, there was substantial clinical risk to patients. The external review⁷ identified the following issues:
 - Surveillance cystoscopies were up to a year overdue.
 - Serious clinical events had occurred.
 - Some patients were three years overdue for follow-up.
 - Some major oncology operative cases waited for six months or longer for surgery.
 - Patients seen by a consultant and assessed as needing follow-up were reviewed by a Clinical Nurse Specialist (CNS) and discharged because follow-ups could not be accommodated.

⁵ Urology is the branch of medicine that looks at diseases of the urinary system in females and the genitourinary system in males.

⁶ Use of trans-rectal ultrasound (through the lining of the rectum) imaging to guide several small needles through the wall of the rectum into the prostate to remove small amounts of tissue to be examined for abnormalities. Usually six or more biopsies are taken to test various areas of the prostate.

⁷ See "External Review Southern DHB Urology Services" report, June 2017: https://www.southerndhb.govt.nz/files/21050_20170815132646-1502760406.pdf.

- The Oncology Department was accepting referrals from Urology without a histological diagnosis because of concerns about how long the Urology Service might take to work up the patient adequately.

24. This report considers the Southern DHB's response to the level of clinical risk, and the effect that had on the services provided to a number of patients.

Elective services

25. Elective services are medical or surgical services for people who do not need to be treated immediately. Elective urology services provided within Southern DHB include consultations, investigations, and elective surgery. Urology outpatient clinics provide first assessment and follow-up appointments.

26. The usual process as described by the Ministry of Health is as follows:⁸

- a) The GP (or primary care provider) will refer the patient to the DHB hospital to be assessed by a specialist (the first specialist appointment — FSA). If the referral is accepted, DHBs should provide the FSA within four months.
- b) The specialist will recommend what treatment the patient needs, and whether this should be provided by the DHB, or by the GP (or primary care provider), perhaps with support from a specialist.
- c) If the patient requires treatment by the DHB, the specialist determines a priority score, depending on the patient's need and how much he or she will benefit from treatment compared to other people. The DHB should make treatment available in priority order, given available resources.
- d) If it is decided that the patient meets the priority required for treatment, he or she should receive it within four months.

27. In 2000, the Government Electives health strategy was released in a document titled "Reduced Waiting Times for Public Hospital Elective Services".⁹ This strategy remains in place, but was updated in 2012 to reflect new and future waiting time expectations.

28. The current Elective Services Patient Flow Indicators (ESPIs) measure whether DHBs are meeting the required performance standard at each of the following points:¹⁰

⁸ See: <https://www.health.govt.nz/our-work/hospitals-and-specialist-care/elective-services>.

⁹ <https://www.health.govt.nz/our-work/hospitals-and-specialist-care/elective-services/about-electives-programme>.

¹⁰ In July 2013, the waiting times standard for ESPI 2 (FSA) and ESPI 5 (treatment) reduced to a maximum of five months. In January 2015, the waiting times standard for ESPI 2 (FSA) and ESPI 5 (treatment) reduced to a maximum of four months. In July 2016, the ESPI 1 definition changed so that DHB services are required to appropriately acknowledge and process more than 90% of patient referrals in 15 calendar days or fewer. (The 15 calendar days includes weekends and public holidays.) The previous timeframe was "within 10 working days".

- DHB services appropriately acknowledge and process more than 90% of all patient referrals in 15 calendar days or fewer.
 - No patients wait longer than four months for their FSA.
 - No patients whose priorities are higher than the actual treatment threshold (aTT) are waiting without a commitment to treatment.
 - Patients given a commitment to treatment are treated within four months.
29. The electives health strategy provides that if a patient's condition is not urgent enough to require specialist care within four months, but the condition may worsen, the patient may be given the status of Active Review. Active Review is a care pathway for patients for whom elective surgery is considered to be the best option for their care, but where:
- The service is not available within the current public funding or provider capacity.
 - There is a realistic probability that the patient's condition may meet the threshold for treatment in the foreseeable future.
30. Active Review patients are those who would next receive treatment if provider capacity increased. While in the category of Active Review, patients should receive a clinical assessment every six months. If at any time a patient's condition deteriorates to the point where his or her priority score exceeds the aTT, the patient should be given a commitment to treatment. If a patient's condition remains unchanged by the time of the third assessment, the patient should be returned to the care of his or her GP. The goal is to ensure that no patients in Active Review fail to receive their review every six months.

Urology treatment pathways

31. The New Zealand Section of the Urological Society of Australia and New Zealand (USANZ) has national guidelines regarding timeframes for urology services. These have not been adopted nationally, but Southern DHB said that the guidelines were used at Dunedin Hospital from April 2017.
32. The Ministry of Health publication "Prostate Cancer Management and Referral Guidance" (2015)¹¹ states that a routine referral (ie, the patient should be seen within 6–8 weeks) applies to the following situations:
- PSA¹² is between 4 and 10 µg/L AND macroscopic haematuria¹³ is present (in the absence of infection)

¹¹ <https://www.health.govt.nz/publication/prostate-cancer-management-and-referral-guidance>.

¹² The prostate specific antigen (PSA) test measures the level of PSA in the blood. PSA levels can be higher in men who have prostate cancer, and may also be elevated in other conditions that affect the prostate. There is no specific normal or abnormal level of PSA in the blood, and levels may vary over time in the same man. In the past, most doctors considered PSA levels of 4.0 µg/L and lower as normal. Therefore, if a man had a PSA level above 4.0 µg/L, often doctors would recommend a prostate biopsy to determine whether prostate cancer was present. However, more recent studies have shown that some men with PSA levels below 4.0

- PSA is < 10 µg/L AND prostate feels hard and/or irregular on DRE¹⁴
 - Two clearly abnormal PSA results 6–12 weeks apart
33. The Ministry of Health publication states that the Government’s Faster Cancer Treatment (FCT) programme¹⁵ aims to reduce waiting times for appointments, tests, and treatment, and to standardise care pathways for all patients wherever they live.
34. The target is for patients with a confirmed cancer diagnosis to receive their first cancer treatment (or other management) within 31 days of a decision to treat. The target for patients referred urgently with a high suspicion of cancer is to receive their first treatment (or other management) within 62 days of the referral being received by the hospital. From 2017/18, the faster cancer treatment target was to achieve the targets in 90% of cases. The rationale for implementing the FCT programme is that prompt treatment is more likely to ensure better outcomes for cancer patients.
35. The Ministry of Health publication “Prostate Cancer Management and Referral Guidance” states that men who meet any of the criteria set out above are considered to have a “high suspicion of cancer”. However, only men who require immediate or urgent referral to a urology or radiation oncology service should be included in the cohort for the FCT 62-day health target. Prostate cancer is not yet fully integrated into Ministry of Health (FCT) pathways. However, generally urology departments are working towards complying with FCT time frames for prostate cancer.

Southern DHB triage process

36. The Southern DHB Urology nurse referral triage guidelines (in force from 2016) state that triage must be completed within 10 days of receipt of the referral. The stated timelines are for urgent cases to be seen within six weeks,¹⁶ and for routine cases to be seen within four months.
37. Following triage, the referrer and patient are advised of the outcome. Subsequently, an appointment for an FSA is made and the patient advised. If surgery is required, the specialist then completes a “surgical booking form” setting out the procedure required and, if FCT applies, the level of urgency for the surgery.

µg/L have prostate cancer, and that many men with higher levels do not have prostate cancer. As a rule, the higher the PSA level in the blood, the more likely a prostate problem is present.

¹³ Visible blood in the urine. Macroscopic haematuria is also referred to as “visible haematuria” (VH) or “gross haematuria”. Non-visible haematuria (NVH) is also known as “microscopic haematuria” or “dipstick positive haematuria”.

¹⁴ Digital rectal examination.

¹⁵ For more information on the Faster Cancer Treatment health target, visit: www.health.govt.nz/new-zealand-health-system/health-targets/about-health-targets/health-targets-faster-cancer-treatment.

¹⁶ The USANZ guidelines state that urgent cases (including where there is a possibility of cancer) should be seen within eight weeks.

38. Southern DHB stated that the priority of appointments for the FSA or surgery when the demand exceeds capacity is based around three areas — clinical need, length of time on the waiting list, and whether the patient requires a procedure or not, as detailed below:¹⁷
- *Clinical need*: Patients are reviewed by clinicians who will make an assessment on who has the greatest need. For example, if two patients are triaged at the same priority and both have a scan as per that priority, and one shows a mass while the other is a normal study, the patient with the mass will get priority.
 - *Length on waiting list*: Patients with the same triaged priority are given appointments in the order they have entered the waitlist, i.e., those who have been waiting longest get their appointment first (providing that there are no other factors involved).
 - *Whether the patient requires a procedure or not*: Depending on clinical staff availability, some appointments have limitations and will be booked accordingly and within the above two guidelines.

Awareness of concerns

39. This section considers the problems within the Southern DHB Urology Service from 2014, the extent to which management was made aware of the issues, the effects on relationships between management and clinicians, and the steps taken to address the issues.

July 2014 discussion paper

40. Southern DHB had been aware since at least July 2014 that its Urology Service was unable to meet the demand for services. In July 2014, a discussion paper was prepared — the “Discussion Paper Urology Services Southern District Health Board”. The purpose of the paper was to consider the number of urologists needed in the Southern DHB Urology Service. The paper states that triage of ESPI2 patients (those who have been waiting for more than five months for an FSA) was non compliant with government targets. It states that more staffing and additional sessions (such as clinics and operating theatre slots) were required.
41. The discussion paper states that the number of urologists needed for an ideal level of service was subject to debate. However, it notes that a report of the Australian Medical Workforce Advisory Committee had quoted from a report from the United States that suggested a ratio of one urologist per 80,000–85,000 population which, if applied to Southern DHB, would require 3.2 FTE (full-time equivalent) in Dunedin and 1.9 FTE in Invercargill. The report states that at that time, the SMO (senior medical officer) roster complement was 2.6 FTE in Dunedin and 1.8 FTE in Southland.

¹⁷ Southern DHB confirmed that there is no written policy or process, and that this is the established practice.

42. The discussion paper notes that at that time (2014) the cancer target¹⁸ could be achieved, provided all scheduled “sessions” were available and utilised, which required that all operating theatres and urologists were available when scheduled. However, at Dunedin Hospital, some sessions were not able to be utilised, and the ESPI2 target was non-compliant unless additional sessions were available. The discussion paper notes that there was no national clinical prioritisation tool, but a local tool had been used at the Dunedin site since 1998.
43. The discussion paper states that access to services between the sites was inequitable. It notes that at that time there was no permanent full-time urology clinical nurse specialist at the Dunedin site, and that problems arose when urologists were on leave because limited cover was available on both sites.

Proposal for a system quality review of Urology Service

44. In May 2015, Southern DHB made a request for proposal (RFP) to the Ministry of Health for a system quality review of the Urology Service. The RFP notes that Urology was a large service with poorer FCT outcomes than other departments, which was caused by system-wide issues — such as an inefficient interdepartmental process and variations in tumour stream-specific practices, including the appointment booking processes.
45. The RFP states that it was proposed that the system quality review would include:
- Interdepartmental referrals
 - Interdepartmental patient flows
 - Departmental triage practices
 - Departmental booking practices
 - Departmental documentation practices

Surgical General Manager report

46. On 9 February 2016, the Surgical General Manager reported to the Directorate Leadership Team and Executive Leadership Team that there was a need to review and develop different ways of delivering the Urology Service, as the current service was unable to meet ESPI5 (treatment). The report recommends that a plan be developed to manage patients who were waiting unacceptable lengths of time for ureteric stone surgery, owing to the demands of cancer patients.

¹⁸ Under the Ministry of Health target “Shorter waits for cancer treatment”, all patients who were ready for treatment were to wait fewer than four weeks for radiotherapy or chemotherapy. From 1 October 2014, “Faster cancer treatment” replaced “Shorter waits for cancer treatment” as the cancer health target. From 1 October 2014 until 30 June 2017, the target was 85% of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks. Subsequently, the target became that 90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

System quality review final status report

47. The system quality review of Urology took place between February and June 2016. On 29 June 2016, the system quality review final status report, “System Quality Review Urology — Improving Patient Pathways”, was provided to Southern DHB. The report notes that inequities in processes and timeframes had been identified between the sites at Dunedin and Invercargill in relation to bladder and prostate cancer patients. These inequities had been brought to the attention of the Clinical Lead, General Manager, service managers, and staff within the services, and district-wide meetings were commenced to discuss solutions to the issues.
48. The report notes that Invercargill patients had faster access to diagnostics and surgery, but that they were required to attend Dunedin Hospital to receive radiotherapy. It also notes that the processes differed. For example, in Invercargill, patients who were referred with macroscopic haematuria¹⁹ would have a CT scan²⁰ ordered prior to attending the outpatient clinic, whereas patients in Dunedin were generally seen in the clinic and the CT scan ordered after a cystoscopy had been performed.
49. The report states that a standardised urology triaging form to be used across the whole DHB was being finalised in collaboration with other DHBs around the South Island. The intention was to help reduce inequities in triaging across the DHB, as previously the triaging codes for Urology differed between the two sites.²¹
50. During the project, an electronic FCT flag that tracked patients was introduced, with a Dashboard to give managers a snapshot of services. District-wide meetings were arranged to discuss the urology services at each site, and to identify possible solutions to the issues.
51. The report shows that from February 2016 until May 2016, the median time from decision to treat until first definitive treatment for reported Urology patients on the 31-day pathway reduced by more than five days. The report suggests that TRUS biopsies be conducted in the clinic rooms at Dunedin during the FSA rather than requiring a day surgery slot. However, it notes that a number of issues including staffing, available clinic space, and processes needed to be resolved for procedures to be carried out in the clinic rooms. It also notes that an increase in throughput would have impacts on other services, such as the need for theatre slots and radiation oncology.
52. The medical director for surgery, Dr E, told HDC that the report highlighted the differences in the clinical pathways at the two sites, in particular the delays in Dunedin for patients requiring TRUS biopsies and the complex imaging required to make treatment decisions. He said that the measures introduced, including better tracking of patients on the FCT pathway, resulted in early improvement in the median time between making the decision to treat a patient and the patient’s first treatment. However, he said that sustaining the

¹⁹ See footnote 14.

²⁰ Computerised tomography scan (CT scan) — an X-ray that produces detailed images of the organs and other structures in the body.

²¹ From 2016, clinical prioritisation was undertaken by clinical nurse specialists using the standard form.

improvements became increasingly difficult, and subsequently the gains on the Dunedin site were lost.

Service Manager concerns

53. Mr F stated that he worked at Southern DHB in the General Surgery department as Service Manager from 4 May 2015 until 28 October 2016, and part of his remit was managing the Urology Service. He stated that he met with the Urology SMOs on a fortnightly basis to discuss operational issues within the service. He stated:

“It is fair to say that from the outset of my appointment and also prior to my appointment that there were major issues in them effectively being able to manage the number of patients that electively required attendance, within either the out-patient service as well as on-going surgical treatment. This had also been handed over to me from my predecessor as an issue that she had been trying to manage.”

54. Mr F stated that the main issue was that there was insufficient time in outpatient clinics to see all the patients because of the total patient numbers and, in addition, there was insufficient theatre capacity to be able to undertake surgery within the allocated theatre time. He said that there were two main operating sessions each week, two day-case²² sessions each week, and a monthly lithotripsy²³ session on a mobile bus. He stated that due to the on-call roster, at least once per month one theatre list was not covered because of staff on-call commitments and holidays.

55. Mr F stated that he spent large amounts of time each week looking at theatre capacity and spare lists, and working with each SMO to try to accommodate all patients in priority order. He added:

“I must say that all three of the SMOs in general were accommodating and assisted me in picking up extra lists that they could possibly do in conjunction with juggling their other clinical commitments including their private work at [a private hospital in Dunedin].”

56. Mr F stated that treatment of some Dunedin patients was outsourced to a private hospital, and some were treated by the Urology SMOs at Southland Hospital. Southland SMOs came to Dunedin and took some outpatient clinics and day-surgery theatre lists. Mr F noted that it was extremely embarrassing for him not to be able to give more concrete plans to patients who had sometimes been waiting longer than six months for their surgery. He said that he escalated the issues at least weekly at the elective surgery meeting at which the General Manager and Medical Director were present.

²² Day-case surgery is the admission of selected patients to hospital for a planned surgical procedure, returning home on the same day.

²³ A technique for treating stones in the kidney and ureter that does not require surgery.

Capacity concerns

57. Dr E told HDC that there had been difficulty in recruiting urologists to both sites for a number of years.
58. In 2016, the urologists proposed that the DHB fund an additional 0.5 FTE urologist in Dunedin because they considered that there was insufficient SMO resource to meet the patient need. The proposal was that the additional urologist would be employed by Otago University and contracted to the DHB as an honorary staff member.
59. On 19 September 2016, Dr E emailed the Urology SMOs and senior managers at Southern DHB stating that he had talked with a number of colleagues and the Chief Medical Officer (CMO) about a possible academic Urology appointment in Dunedin and the difficulties with service provision in Urology, workload, organisation of the service, and the delays in faster cancer treatment. Dr E referred to “the current persistent difficulties”, and noted that the CMO was considering instigating an external review of Urology.
60. On 18 October 2016, the Quality Performance and Systems Manager of the surgical directorate, Mr H, emailed Dr E, Ms G (General Manager of Surgical Services until July 2017), and the Nursing Director of the surgical directorate stating that the Dunedin Urology Service had a growing number of overdue patients. Mr H noted that he would put the recent issues down to “general chaos in the system” rather than “a pure capacity/demand issue at the present time”. He wrote that there was a need to adjust the outpatients’ structure, as there was probably a need for about 80 appointments per week, whereas only 60 were available at that time. Mr H noted that there were booking issues as well as general systems and communication issues regarding Pathology and Radiology meetings.
61. In December 2016, the CMO wrote to the urologists referring to the possibility of an academic Urology appointment in Dunedin. The CMO acknowledged that there were ongoing difficulties on the Dunedin site in respect of:
- Reliably meeting demand for new patient assessments (FSAs)
 - Meeting the expected follow-up times for patients
 - Supplying telephone-based cover to the Southland site.
62. The CMO noted that he had discussed the matter with the Chief Executive Officer (CEO) and the Chief Operating Officer (COO), and it had been decided that there were insufficient funds available to reimburse the university for the additional clinician time. The CMO noted the additional resourcing requirements that would be generated by such an appointment, such as clinic time, investigations required, and theatre time. The CMO stated that there was clearly a need to review how things were being done, and said that in the New Year (2017) there would be a review of the total Urology Service with a focus on the provision of services, the efficiency of processes, and the balance of provision and demand.

Relationship between management and clinicians

63. From 2016, there were a number of changes of Urology Service managers. From November 2016 to March 2017, Ms I was in the role. From March 2017 until October 2017, Mr J was in the role, and thereafter Mr H was in the role.
64. Dr E stated that there was continuing pressure from the Dunedin urologists to progress an SMO appointment, as they considered that an extra 0.5 FTE was likely to provide sufficient resource to match the workload. He said that in 2016 when no appointment was allowed, “This added to tensions between clinicians and management, which impacted on the ability to initiate change but did contribute to the agreement to have an External Review of the service.”
65. Dr E stated that as the waiting list for TRUS biopsies increased on the Dunedin site from June 2016, the option of undertaking biopsies and other treatments at Southland was offered to patients, with some uptake. However, while waiting for the external review to take place, there was “seemingly little appetite by the Dunedin urologists to undertake extra clinics or operating lists, whereas previously extra lists or clinics had been more readily filled”. He noted that there was a continuing difficulty in providing sufficient operating time across many surgical disciplines, not just Urology, with the constraints being related to the limited number of theatres available, and limited bed numbers. He noted that the issues were contributed to by the continued reconstruction of the Dunedin Hospital Intensive Care Unit impacting on patient services.
66. Ms G told HDC that before and after 2016 there was a high level of awareness within Southern DHB that the Urology Service was stretched. She stated that there was “limited co-operation across the district”, and that when the SMOs suggested an external review, this was welcomed by the leadership team. She said that it was agreed that the external review would be clinically driven and led by the CMO. Ms G stated:
- “As the general manager I highlighted the need for clinical leadership to support resolution of issues within the service as there was an obvious lack of trust of management, that was at times inexplicable and possibly historic in nature and the External Review was seen as a way to understand the issues clearly and to drive change in a transparent manner.”
67. Ms G noted that from her perspective, the key issues within the Urology Service related to:
- The difference in models of care across the two sites and the measurable impact on the length [of the] patient pathway that resulted.
 - The belief of the SMOs on the Dunedin site that the key solution to improving the patient pathway was to increase the SMO FTE and the clinical nurse specialist resource to urology.
 - The lack of buy in to review systems, such as the clinical structure and the type of case utilising the theatre resource.

- The use of the existing SMO FTE [over the two sites].
- The impact of available theatre time for urology.
- The lack of suitable procedure spaces on the Dunedin site.
- The inability of the Dunedin site to be ESPI compliant.
- The inability of the Dunedin service to meet surveillance guidelines.”

68. Ms I told HDC that with regard to the information she supplied to management, between November 2016 and March 2017, she provided the General Manager with status reports, a Urology Service requirements paper, and a business case.

69. Ms I said that at that time, no leave cover arrangements were in place for urologists. One of the Invercargill-based urologists undertook extra lists in Dunedin, and some procedures were outsourced to the private sector to reduce the waiting list for biopsies and surgery, but the capacity remained insufficient to substantially clear the increasing waiting list.

70. On 9 March 2017, Ms G emailed the COO noting that the Dunedin clinical team was no longer willing to undertake extra sessions or offer capacity in the private sector. Ms G noted that undertaking the external review of Urology would provide an opportunity to look at all aspects of the service across the district.

71. On 14 March 2017, urologist Dr K emailed the SMOs and others stating that although the Long Wait Co-ordinator of the Surgery Department had requested that he or urologist Dr M fill vacant surgery lists while urologist Dr L was on leave, they were unable to commit to extra work. Dr K noted that the patients were having to wait for an unacceptable level of time, but added that doing extra lists in clinics was adding to the long-term problem. He stated:

“Many of these patients who are now breaching the accepted time to surgery have been placed on the waiting list due to extra clinics by ourselves and by visiting urologists — we have just shifted the problem without a long term solution.”

72. The external review began in June 2017. The review committee conducted site visits at Dunedin and Southland Hospitals on 6 and 7 June 2017 and met with a range of people involved with the management of Urology Services in Southern DHB.

73. On 16 June 2017, the CMO emailed the COO noting that delays had become apparent in the cancer pathway for Urology patients, particularly those with prostate cancer. He noted that biopsies were taking up to six months from request, and that together with other delays, this meant that patients with prostate cancer were having a prostatectomy up to 12 months after it had become apparent that this was a likely treatment. He stated: “This amount of delay would certainly have an impact on patients outcome including survival chances.”

74. The CMO added that he considered it likely that organisational challenges in Urology were contributing to the slowness for patients on the cancer pathway. He said that he believed that the external review would help, but that even if the outcome was process improvements and/or added resource, there would still be a considerable backlog, which would take a long time to clear.
75. On 19 June 2017, Ms G emailed the COO and Dr E stating that there was a need for an urgent action plan that was endorsed by senior medical staff to address the backlog. Ms G noted that the clinical team on the Dunedin site was unable to provide any extra resource either in-house or privately to help reduce the backlog that had been growing since November 2016.
76. On 21 June 2017, Dr K emailed the CEO (with the email copied to all the urologists) expressing concerns about a management proposal to recruit a new urologist in Invercargill before the results of the external review had been published. The CEO responded that he was not directly involved with appointing senior doctors, and the concerns should be discussed with Ms G as the General Manager of Surgical Services. Dr M responded that the concerns had been raised with management, including Ms G, over three months previously, and he expressed concern that recruitment was still going ahead without any consultation with the SMOs.
77. By July 2017, 37.8% of Urology patients were not being treated within the ESPI5 target (being given a commitment to treatment but not treated within the required timeframe). This was an increase from 2.6% in November 2016.

External Review Report

78. This section considers the outcomes from the external review, and the actions taken subsequently.
79. The review team²⁴ presented its final report in August 2017. The report notes that clinicians had said that they had been told repeatedly that if they did additional clinics and outsourced operations to meet targets, then senior management would make changes to improve outputs over the longer term. However, from their perspective, no changes were ever looked into, or proposed. The report states that management had limited knowledge of the demand the Urology Service needed to meet in the context of changing demographics, and there was little planning for urology services across the entire DHB. The report notes that there was a concerning level of clinical risk because of the long waiting period for patients on the Dunedin site.

²⁴ The review began on 1 June 2017. The review team consisted of a urologist, a programme manager, and a clinical nurse specialist.

80. The review team made the following recommendations:

1. Relationships and collaboration

Enable a facilitated process to build trust and collaborative relationships across the Urology Service and sites between clinicians and management.

2. Urology Service plan

Develop a Southern DHB Urology Service plan to:

- a) Review the size of service at both sites including theatre and outpatient capacity, waiting times, and after-hours care.
- b) Assess whether current resources were adequate and distributed equitably.
- c) Ensure that facilities on the Dunedin site were upgraded as soon as possible, as the service could not wait for the rebuild/upgrade to occur.

It was recommended that the plan be agreed between clinicians and management, and be transparent about review and updating processes, and include a clear governance structure for this to occur.

3. After-hours care

Consider district-wide provision of after-hours care based on the two options considered by the review committee:

- (a) All SMOs within Southern DHB participate in a single on-call roster and do their on-call from where they live.
- (b) On-call service is delivered from a single site.

4. Standardised protocols and policies

Standardised protocols and policies across the whole DHB, including but not restricted to:

- (a) Job sizing, remuneration and professional development of SMO staff, and a Clinical Lead position.
- (b) Job sizing, remuneration, and professional development of nursing staff.
- (c) Development and review of referral pathways.
- (d) Health care information/pamphlets.
- (e) Triaging of general practice (GP) and internal referrals.
- (f) Thresholds for access to surgical waitlist.
- (g) Waiting times for outpatients and surgical procedures.

5. Nursing service

Review the nursing service to ensure that nursing is standardised across the two sites, with clear guidelines, protocols, and policies, and designated urologist support as well as visible support from Southern DHB.

6.0 Dunedin Site

6.1 Site specific recovery plan

Develop an immediate plan for managing the backlog of work and its significant attendant clinical risk to the patient population.

6.2 Outpatients

- a) Make urgent changes to the outpatients booking process to improve its efficiency and throughput.
- b) Make urgent changes to the use of the physical space available in the outpatients area to improve efficiency and throughput.
- c) Enable procedures to be performed in the outpatients area during clinics.
- d) Make urgent changes to the deployment of staff and outpatient clinics, and streamline the use of SMO and clinical nurse specialist time.
- e) Review patients scheduled for follow-ups to see if these are required.
- f) Ensure that consistent letters are sent across the DHB, based on the Southland model.
- g) Introduce use of virtual clinics and surveillance databases, based on existing models available in Southland and at other South Island DHBs.

6.3 Theatre

- a) Use all lists allocated to Urology.
- b) Increase theatre lists.

6.4 Staffing

- a) Review the roles of all staff members (clinical and non-clinical) working within the department because some staff were being asked to perform roles well outside their scope.
- b) Review SMO job plans and sizing.
- c) Amend the SMO 2:3 weeks' roster and give each SMO a specified job plan for each week.

Further actions

81. The report and recommendations were accepted by Southern DHB. An action plan was developed to implement the recommendations.

82. HDC requested that Southern DHB provide it with three-monthly updates on the implementation of the recommendations. These continue to be provided and reviewed.
83. Southern DHB arranged for two “mega-surgery” weekends using external clinicians in November and December 2017 to reduce the backlog. Twelve urologists — nine from elsewhere in New Zealand — saw several hundred patients over two weekends to reduce the backlog.
84. In late 2017, recruitment of an 0.5 FTE urologist SMO was commenced, and a further registered nurse was appointed.
85. On 9 November 2018, an applicant interview was conducted. A locum for a one-year fixed term was approved and advertised to cover the vacancy until an appointment was made.
86. Southern DHB reported in November 2018 that patients were being seen in outpatients clinics and for diagnostics within appropriate timeframes. It said that there was still a backlog of patients with benign conditions, but the DHB was addressing that.
87. On 30 May 2019, Southern DHB reported that an appointment of an 0.5 FTE urologist SMO had been made, to commence in October 2019. Locums were booked to cover urologists’ leave in August and October 2019, and a workshop in June 2019 was organised to plan how to provide cover for urologists.

Complaints

88. HDC obtained details of 38 patient complaints Southern DHB had received from 1 January 2016 relating to concerns about the Urology Service. Attempts by patients to find out about their appointments or obtain an appointment are described in the complaints to the DHB. It is clear that the responses or lack thereof from Southern DHB caused considerable frustration to patients.

Response to provisional opinion

89. Southern DHB stated that although it accepts that management of the Urology Service was below that of an acceptable standard, “there were also considerable challenges presented to the managers in regard to the lack of willingness at times by the clinicians to work together to find solutions to the problems with the service other than that of provision of additional SMO FTE”.

Individual complaints

90. The following section considers four individual cases where consumers complained to HDC about the services they received from the Dunedin Hospital Urology Department.

Patient A²⁵

Factual background

91. In February 2017, Patient A, aged 73 years, was seen by his GP, who diagnosed him with suspected prostate cancer. Patient A said that his GP advised him to have a prostate biopsy in the private system because there was a “very long waiting list” at Dunedin Hospital.
92. On 11 February 2017, Patient A was seen by a urologist, Dr L, at a private hospital in Dunedin. Dr L reported back to the GP that Patient A had an abnormal left lobe of the prostate, although his PSA²⁶ was normal at 4.5µg/L. Dr L booked Patient A to have a prostate biopsy on 23 March 2017.
93. On 30 March 2017, Dr L reported to the GP that the prostate biopsy histology had shown that Patient A had “moderate disease at the left apex and mid area. Gleason²⁷ 4+3 and 3+4²⁸ involving 40- and 15% of the biopsies²⁹”. Dr L wrote that he had discussed with Patient A “the treatment options of surgery and radiotherapy” and the complications of incontinence, impotence, and bladder neck stenosis (narrowing). Dr L noted that Patient A had elected to have surgery, and that Patient A needed to have his surgery in the public system.
94. Patient A’s clinical records at Southern DHB include two referrals made by Dr L to Dunedin Hospital. The first referral is dated 4 April 2017, and “faster cancer tracking” is circled. The form indicates that it was “entered” into the Southern DHB system. The “A” urgent category is not circled on that form.
95. The second form (undated) has the “A” urgent category circled. Southern DHB told HDC:

²⁵ Case 17HDC01491. The parties directly involved were: Patient A (consumer), Southern DHB (provider), and Dr L (urologist/provider). Further information was received from the private hospital. Independent expert advice was obtained from a urologist, Dr Jonathan Masters (Appendix A).

²⁶ See footnote 13.

²⁷ A Gleason score is determined when biopsy tissue is examined microscopically. If cancer cells are present, the score indicates how likely the cancer is to spread.

²⁸ Since prostate tumours are often made up of cancerous cells that have different grades, two grades are assigned for each patient. A primary grade is given to describe the cells that make up the largest area of the tumour, and a secondary grade is given to describe the cells of the next largest area. For instance, if the Gleason score is written as 3+4=7, it means that most of the tumour is grade 3, and the next largest section of the tumour is grade 4, which together makes the total Gleason score. If the cancer is almost entirely made up of cells with the same score, the grade for that area is counted twice to calculate the total Gleason score. Typical Gleason scores range from 6–10. The higher the Gleason score, the more likely that the cancer will grow and spread quickly. Scores of 6 or under describe cancer cells that look similar to normal cells and suggest that the cancer is likely to grow slowly. A score of 7 suggests an intermediate risk for aggressive cancer (and means that the primary score (largest section of the tumour) scored a 3 or 4). Tumours with a primary score of 3 and a secondary score of 4 have a fairly good outlook, whereas cancers with a primary Gleason score of 4 and a secondary score of 3 are more likely to grow and spread. Scores of 8 or higher describe cancers that are likely to spread more rapidly — these cancers are often referred to as “poorly differentiated” or “high grade”.

²⁹ The total percentage of cancer in the entire specimen.

“This second form had not been used or entered by the Booking Clerk whatsoever. This form was not, and is not, therefore considered to be specifically relevant in this complaint process.”

96. Southern DHB stated that as a consequence of the “A” urgent category not being circled on the form entered into the Southern DHB system, the categorisation was not considered at the time to be “urgent”, but Patient A should have been treated within the faster cancer tracking treatment timeframe of 62 days.
97. On 26 April 2017, a specialist anaesthetist conducted an anaesthesia assessment of Patient A by telephone, which concluded that he had an ASA rating³⁰ of 2.
98. Patient A said that he heard nothing further from Southern DHB regarding his theatre date.
99. Southern DHB stated that patients were told that once they had been assessed as fit for the anaesthetic, they were placed on the waiting list, which meant that they would get their surgery within four months from that date. However, patients with a cancer diagnosis would be expected to have treatment times that complied with the FCT targets of 31 or 62 days.
100. The surgical booking form notes that on 12 July 2017, Patient A rang and left a message asking for an operation date, and that a reply was texted to him. However, the form does not note the content of the reply. Patient A said that at the end of July he rang the hospital to try to confirm an appointment for his surgery, and was told that there were 10 other people with life-threatening cancer who were in a similar position to him and had been waiting for some time. Patient A said that he was told that there was no scheduled date for his surgery.
101. On 27 July 2017, Patient A emailed Patient Affairs pointing out that he had a reasonable chance of cure because he had been diagnosed early. He expressed concern that he had been waiting for five months, and that his cancer could spread and require more invasive surgery. He stated that the media was reporting that patients were dying while waiting for surgery, and that he was worried as he was “facing potentially fatal medical problems”.
102. Southern DHB stated that its next communication with Patient A was to offer him surgery on 4 September 2017, which was then brought forward to 23 August 2017, following the external review of the Urology Service and scheduling of extra operating sessions. Patient A was contacted by the urologist, Dr K, and by the Long Wait Co-ordinator, who ensured that Patient A understood the process to be followed, because he was having his surgery off site at the private hospital.

³⁰ The American Society of Anesthesiologists (ASA) score is a global score that assesses the physical status of patients before surgery. ASA 2 means a patient with mild systemic disease.

103. Dr L, assisted by Dr K, performed Patient A's surgery (a radical prostatectomy³¹) on 23 August 2017. Patient A was discharged home on 26 August 2017 and returned to Dunedin Hospital to have his indwelling catheter (IDC) removed on 6 September 2017.
104. Patient A expressed concern to HDC about the lack of contact from Dunedin Hospital regarding his surgery date. He told HDC that he was offered no follow-up or monitoring of his illness while he was awaiting surgery, and that now he has a life-threatening illness that potentially has spread to other areas of his body. He considers that should he develop terminal cancer, the DHB will be directly responsible for his health outcome, as it failed to deliver the appropriate care that he required in a timely manner.

Opinion: Southern DHB — breach

Care of Patient A

105. Initially, Patient A consulted Dr L privately at the private hospital. A biopsy of Patient A's prostate performed on 23 March 2017 confirmed the diagnosis of prostate cancer. Patient A was not able to have his surgery performed in the private sector, so Dr L referred him to Dunedin Hospital for treatment.
106. Although Dr L completed two referral forms, Southern DHB stated that the relevant form was the one dated 4 April 2017, with "faster cancer tracking" circled. My expert advisor, urologist Dr Jonathan Masters, advised that this indicated that a diagnosis had been established at referral. Dr Masters stated that the maximum waiting time from referral to treatment should have been 62 days. Southern DHB accepts this.
107. Patient A had an anaesthesia pre-appointment on 26 April 2017, but remained on a waitlist for surgery and was given no updates as to when the surgery might occur prior to being offered a surgery date some months later. On 12 July 2017, Patient A rang Southern DHB and left a message asking for an operation date. While DHB records indicate that a reply was sent to him by text message, Patient A told HDC that at the end of July he rang the hospital again to try to confirm an appointment for his surgery and was told that there was no scheduled date for his surgery. He said that he was also told that there were 10 other people with life-threatening cancer who were in a similar position to him who had been waiting for some time.
108. On 27 July 2017, Patient A emailed Patient Affairs and expressed concern that he had been waiting for five months and his cancer could spread and require more invasive surgery. He stated that the media had been reporting that patients were dying while waiting for surgery, and he was worried as he was "facing potentially fatal medical problems".
109. Patient A was offered surgery on 4 September 2017, which was then brought forward to 23 August 2017 to be performed off site at the private hospital.

³¹ Surgical removal of the prostate gland, surrounding tissues, lymph nodes, and the tubes that carry semen (seminal vesicles).

110. Dr Masters advised:

“[A]fter completing both the anaesthetic and continence assessments I believe communication then fell below an acceptable level but this would be a mild departure from an acceptable level of care.”

111. Dr Masters advised that the timeframe for Patient A’s surgery was outside Southern DHB’s³² and the Ministry of Health’s FCT guidelines for cancer treatment. Dr Masters considers the delay to have been a moderate departure from accepted standards, and noted: “The psychological stress for [Patient A] must have been considerable with a delay of over [four] months from referral to treatment.” I agree with this advice.

112. Dr Masters noted that the delay was unlikely to have harmed Patient A because he had an intermediate grade cancer. However, that is not the issue. I am concerned that not only did the DHB fail to meet the target times for treatment for cancer, but Patient A’s time to treatment was almost double the target timeframe. This was suboptimal, and was compounded by the failure to keep Patient A informed about a likely date for his surgery, which caused him anxiety about his prognosis. District health boards are responsible for the operation of clinical services they provide, and are responsible for service failures. Overall, I consider that Southern DHB failed to provide services to Patient A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Patient B³³

Factual background

GP assessment

113. On 12 September 2016, Patient B (aged 62 years) presented to his GP, Dr N, at a medical centre, with a history of lower urinary tract symptoms (LUTS). Dr N conducted a DRE (digital rectal examination) and recorded that Patient B had a “hard, firm prostate — large right lobe, larger than the left and more tender with ridge feeling to the right lobe. Assessment: prostatic hypertrophy³⁴”. Dr N prescribed doxazosin.³⁵

Referral and triage

114. Dr N completed a referral to Dunedin Hospital’s Urology Service, which states, “High suspicion of cancer,” and notes that 12 months previously Patient B’s PSA had been

³² Southern DHB Urology nurse referral triage guidelines.

³³ Case 17HDC01700. The parties directly involved were Patient B, Dr N, and Southern DHB. Further information from urologist Dr K was reviewed. Independent expert advice was obtained from Dr Masters (Appendix B) and in-house GP Dr David Maplesden (Appendix C).

³⁴ Enlarged prostate (benign prostatic hyperplasia). It is normal for a man’s prostate gland to enlarge from the age of 40 years (known as benign prostatic hyperplasia or benign prostatic hypertrophy (BPH)). This enlargement can cause a range of symptoms related to urination.

³⁵ Doxazosin is used to treat BPH and high blood pressure.

0.9µg/L. Results dated 12 September 2016 showed that Patient B's PSA had increased to 2.4µg/L.

115. Dr N stated that at the time of his referral letter to Dunedin Hospital he was of the view that although Patient B was experiencing LUTS and had a suspicious area in the right prostate, the suspicious prostate examination was not the whole picture. Dr N said that Patient B was also experiencing obstructive symptoms, possibly from a benign prostatic enlargement. Dr N stated that at that point, he considered that Patient B's obstructive symptoms were not caused by prostate cancer.
116. Dr N told HDC that he discussed with Patient B his concerns about the suspicious nature of the prostate examination.
117. On 15 September 2016, the referral was triaged by the Urology Clinical Nurse Specialist, RN O, using the Southern DHB Urology nurse referral triage guidelines. Patient B was given a priority 3 (semi-urgent) on the triage form (expected to be seen within six weeks). Under the heading "Cancer Flagging", RN O ticked, "There is a high suspicion of cancer".
118. Southern DHB told HDC that the prioritisation score system promulgated by USANZ would have scored Patient B's presentation as needing to be seen within eight weeks.
119. Patient B said that he received a letter from Southern DHB dated 21 September 2016 advising him that the referral had been prioritised as semi-urgent, and there would be a 12-week wait. The letter was copied to Dr N.
120. On 23 September 2016, Dr N made the following entry into Patient B's clinical notes: "Urology — semi urgent within 6 weeks."

GP reviews

121. Patient B's next consultation with Dr N was on 11 October 2016 for review of a back lesion. Dr N noted that Patient B had had a good response from doxazosin and his urine flow was better, and he was getting up to urinate only once a night. Dr N also noted that Patient B had a family history of prostate cancer.
122. Dr N saw Patient B again on 29 November 2016 because Patient B had experienced pressure behind his eyes since he had started taking doxazosin. Dr N changed Patient B's medication to terazosin.³⁶ The notes include the comment, "await flow studies". Dr N's recollection is that when he saw Patient B on 29 November 2016, Patient B had "been notified by the district health board of when he was due to be seen". However, Dr N noted that his memory may be incorrect.
123. On 6 December 2016, Patient B spoke with the practice nurse regarding his worsening LUTS since stopping the doxazosin. After discussion with Dr N, Patient B was advised to increase his dose of terazosin but to restart doxazosin if that was ineffective.

³⁶ Terazosin is a selective alpha-1 antagonist used for treatment of symptoms of BPH.

124. On 15 December 2016, Patient B contacted the practice nurse to advise that he had restarted doxazosin, and to request a repeat prescription. On 17 December 2016, Patient B attended the medical centre with regard to a back injury. There is no reference to urinary symptoms or any discussion regarding Patient B's urology appointment.

Urology review

125. Southern DHB stated that Patient B's FSA was "not actuated", and he was not given an FSA until he was called to a special clinic to deal with overdue appointments on 20 February 2017. There is no record of when Patient B was advised of the date of his FSA.
126. On 20 February 2017, urologist Dr P saw Patient B in the Urology outpatients clinic. Dr P reported to the medical centre that a DRE had revealed a "40 gram rock hard prostate bilaterally and it was nodular and felt like T3³⁷ prostate cancer". Dr P noted that Patient B needed an immediate prostate biopsy, and that in the event that he did not have prostate cancer he would need a TURP.³⁸ The biopsy booking form is marked with a circle around "A URGENT" and a circled star beside the "A" to emphasise the urgency.
127. Patient B said that Dr P told him that he needed an urgent biopsy, and that it would be performed in two to five weeks' time. Patient B stated that when he did not receive an appointment within that time frame, he contacted the Urology booking administrator on 6 March 2017. He said that she could not find him in the system, and told him that he would not have a biopsy until the end of May or into June 2017. He said that after he pleaded his case she called him back and told him that an appointment had been made for 10 April 2017.
128. Dr P referred Patient B to the continence nurse to teach him self-catheterisation with a Foley catheter. However, Patient B declined self-catheterisation because of the pain and difficulty of inserting a catheter. He told HDC that he declined self-catheterisation because of the infection and hygiene risks, and that he continued to work with a catheter in situ until 7 June 2017.
129. A PSA test conducted on 21 February 2017 showed a PSA of 2.6µg/L.

Biopsy

130. On 10 April 2017, Dr M performed a TRUS biopsy³⁹ of Patient B's prostate. The biopsy showed a Gleason score of 4 + 4 = 8 with 90% involvement.
131. On 18 May 2017, Patient B underwent an MRI scan of his prostate. The findings state:

"Primary lesion almost the entire prostate gland is replaced with tumour. There is breach of the capsule at the anteroinferior margin and also at the posterior lateral

³⁷ Cancer that has grown outside the prostate and may have spread to the seminal vesicles.

³⁸ A transurethral resection of the prostate (TURP) is surgery to remove parts of the prostate gland through the penis.

³⁹ Trans-rectal ultrasound-guided biopsy — biopsy using a long needle inserted through the rectum into the prostate.

aspect superiorly on the right. There is involvement of the bases of both seminal vesicles.”

132. The report, verified by a consultant radiologist, stated: “Appearances are of an at most T3 bNOMO⁴⁰ prostate tumour.”

Prostatectomy

133. On 23 May 2017, at an outpatient appointment with Dr K, Patient B was told that he had advanced high-risk prostate cancer, and he was offered a radical prostatectomy with a likely need for postoperative radiotherapy.
134. That day, Dr K completed a surgical booking form. The form notes the diagnosis of high-risk prostate cancer, faster cancer tracking “URGENT A” is circled, and the priority score written on the form is “100+++”. Patient B’s management was discussed at the Urology X-ray meeting on 24 May 2017, and surgery was confirmed. Patient B’s management was discussed further at the DHB Genito-Urinary multi-disciplinary meeting on 6 June 2017.
135. On 6 July 2017, Patient B underwent a radical prostatectomy and bilateral lymph node dissection. On 14 August 2017, he was seen by a radiation oncologist and a plan was made for him to have radiotherapy to the prostatic bed. However, it was noted that the cancer carried a poor prognosis and was of the type that advanced rapidly if untreated.

Further information

136. Patient B told HDC:

“If I had received the surgery sooner the cancer would have been contained inside the prostate and would not have been as large or cancerous ... Now I am faced with cancer in the surrounding tissue and organs. I have been told that I have now got an extremely poor prognosis because of the delays in treatment.”

137. The CEO stated that the delays in progressing Patient B’s investigation and treatment for his prostate cancer were unacceptably long, and apologised. The CEO said:

“We have not been able to precisely define the specific reasons for the delays in [Patient B’s] care and treatment, but it is symptomatic of the current inability of the service to manage demand and to provide services in a timely manner.”

138. Dr N stated that the medical centre has Cornerstone accreditation and uses EARMS as its electronic referral mechanism. He said that EARMS was used to generate Patient B’s “high suspicion of cancer” referral. Dr N stated: “We have raised the issue of the referral system not generating a recall with the Southern PHO and we have requested this be a further update to the system.”

139. Dr N also stated:

⁴⁰ The cancer had grown outside the prostate and may have spread to the seminal vesicles (T3). It had not spread to nearby lymph nodes (N0) or elsewhere in the body (M0).

“With the delays experienced in the urology service and the fact that there is a reduction in first specialist assessments over the Christmas, New Year and January holiday period it was no surprise that [Patient B’s] appointment would be in February. What is disappointing from my practicing perspective is that the regular delay in first specialist appointments becomes expected and part of normality and therefore accepted, even when it is unacceptable. When the system fails to meet recommended referral response times and historic requests to expedite fail, a sense of futility pervades. This has a consequence on the degree of ‘good enough advocacy’. What [Patient B’s] case has highlighted to me is that this normalisation of unacceptable response times has to be seen as unacceptable and not impinge on my sense of what is good enough advocacy.”

ACC

140. On 21 August 2017, Patient B submitted an ACC claim for treatment injury.
141. Southern DHB’s Quality Performance and Systems Manager, Mr H, completed a report to ACC on 26 October 2017, which notes that although Patient B was graded as priority 3 (expected to be seen within six weeks), he was not seen until a special clinic was arranged for overdue appointments over five months after his initial referral. Mr H stated:

“This was a considerable delay on what [Patient B] should have expected. [Southern DHB] is unable to offer a specific explanation for the cause of this delay in assessment but it is symptomatic of the current difficulties with the service to manage demand and provide services in a timely manner.”

142. Dr K sent a memo to ACC that states:

“There has been an unacceptable delay to [Patient B’s] treatment. We would ideally treat patients within 62 days of referral and if high suspicion of cancer as [Patient B] had. Due to the aggressive nature of his prostate cancer, it is highly likely that faster treatment may have allowed a more complete resection of his disease and less collateral damage to surrounding organs.”

143. Dr K noted that as the disease was advanced at the time of surgery, a wider excision than usual was necessary, which resulted in injury to Patient B’s rectum and more injury to his urinary sphincter than was usual, leading to urinary incontinence. Dr K noted: “There was also extra-prostatic extension of the cancer at the time of surgery significantly reducing the chance of cure.” Dr K said that the delay had caused Patient B’s disease to be less treatable and probably had reduced his life expectancy.

Responses to provisional opinion

144. Patient B said that he is concerned about the delays he experienced. He believes that if he had been treated within 61 days he may have been cured, but he has had to undergo chemotherapy and radiotherapy and now has secondary prostate cancer in his lungs.

145. Dr N stated: “I accept Dr Maplesden’s view that I should have advocated more strongly. I have apologised to [Patient B] and deeply regret my lack of advocacy.”
146. Dr N said that the letter from Southern DHB of 23 September 2016 stating that Patient B would be seen within six weeks meant that he did not write to the DHB in October and November 2016. He said that neither he nor Patient B was aware that “actually nothing was being done to progress [Patient B’s] assessment and treatment”.

Opinion: Southern DHB — breach

Referral

147. Dr N referred Patient B to Southern DHB on 12 September 2016. RN O triaged the referral for Patient B to be seen within 6–12 weeks. My expert advisor, urologist Dr Masters, advised that this was entirely appropriate, and that the referral was triaged in a timely fashion without delay. However, he noted that some DHBs would have triaged Patient B directly for a prostate biopsy rather than a clinical appointment, as clearly he was going to need a biopsy, and that would have reduced the wait for a diagnosis.

FSA

148. Despite being triaged to be seen within 6–12 weeks, Patient B did not have an FSA until 20 February 2017 — five months after the triage. Dr Masters advised:

“This delay significantly impacted the quality of [Patient B’s] life and he had gone into chronic retention with associated pain by the time he was seen on 20 February 2017 ... I would consider this a substantial departure from the expected level of care in New Zealand.”

149. In my view, the delay was very poor. Patient B had a high risk, and should have been seen in a timely manner. Instead, it seems that he became “lost in the system”. Southern DHB has not been able to explain why the delay occurred.

Biopsy

150. It was a further seven weeks after the FSA until Patient B’s biopsy was performed on 10 April 2017. Dr Masters noted that the booking form was marked “urgent”, with multiple circles and a star to emphasise the urgency, yet it still took seven weeks to perform the biopsy. He advised that this delay was a moderate departure from the expected level of care. He also noted that Southern DHB’s practice of performing biopsies as a day-case theatre procedure (i.e., at a different time from the FSA) was unusual and inefficient, and would not have helped the wait period. He said that in most DHBs, biopsies are done as outpatient procedures at the time of the FSA.
151. I am critical that despite Dr P having indicated the urgency on the booking form, timely action to arrange the biopsy did not occur. As stated above, the DHB has been unable to define precise reasons for the delays in Patient B’s case.

Prostatectomy

152. With regard to the date of the radical prostatectomy, Dr Masters noted that after the biopsy, Patient B was discussed at Southern DHB multi-disciplinary meetings (MDMs) twice (on 24 May 2017 and 6 June 2017), and a decision was made to proceed with surgery, which took place on 6 July 2017. Dr Masters stated that the delay between the MDM and surgery was “a little long”, but he agreed that Patient B’s case did need to be discussed at an MDM. Dr Masters stated: “I would regard the delay between biopsy and surgery as just acceptable compared with other units in New Zealand.”

Communication

153. Dr N recalls that by the time he saw Patient B on 29 November 2016, Patient B had been notified by the DHB of when he was due to be seen. The triage form states that Patient B was given a priority 3 (expected to be seen within six weeks). However, Southern DHB stated that Patient B was not given a date for his FSA until he was called to a special clinic to deal with overdue appointments, which was held on 20 February 2017.
154. There is no record of when Patient B was informed of the date of the FSA.⁴¹ Dr N considers that his recollection that Patient B had been informed of the date of his FSA on 29 November 2016 may be in error. Consequently, I am unable to make a finding regarding when Patient B was notified of the date of his FSA, including whether he had been notified when he saw Dr N in November 2016.

Conclusions

155. Southern DHB has been unable to ascertain the reasons for the delays in Patient B’s care and treatment. It said that Patient B’s case is symptomatic of its inability at that time to manage demand and to provide services in a timely manner.
156. Dr Masters stated that the very long wait time from Patient B’s referral until his diagnosis at the time of the biopsy was not acceptable, and noted that it had been abundantly clear for some time before June 2017 that there was a significant problem in Southern DHB’s Urology Department. Dr Masters considers that Patient B was, in many ways, a victim of Southern DHB’s inability to “get its house in order”. I agree with this advice. District health boards are responsible for the operation of clinical services they provide, and are responsible for service failures. Overall, Patient B received very poor care up to the date of his biopsy, and an unacceptable level of delay from Southern DHB. Accordingly, I consider that Southern DHB did not provide services to Patient B with reasonable care and skill, and breached Right 4(1) of the Code.

Opinion: Dr N — adverse comment

157. Dr N assessed Patient B on 12 September 2016 and, after detecting an abnormal prostate, referred him to the Dunedin Hospital Urology Department. My expert advisor, GP Dr David

⁴¹ After the final opinion was issued, Patient B found a letter dated 31 January 2017 which advised of the date of his FSA on 20 February 2017.

Maplesden, advised that the combination of LUTS and an abnormal-feeling prostate was suspicious for prostate cancer, irrespective of the PSA reading.

158. Dr Maplesden noted that although Dr N's standard of clinical documentation was not unreasonable, it would have been wise for him to have documented clearly in the clinical notes (not just in the referral letter) that there was a high suspicion of cancer, given that the content of the referral letter would not be readily apparent to another provider viewing the consultation notes.
159. On 23 September 2016, Dr N made an entry in the clinical record indicating that he had been informed that Patient B had been triaged to be seen within six weeks. Dr N then saw Patient B on 29 November 2016. Dr N recalls that by the time he saw Patient B on 29 November 2016, Patient B had "been notified by the district health board of when he was due to be seen". However, Dr N noted that his memory may be incorrect.
160. Southern DHB stated that Patient B's FSA was "not actuated", and he was not given an FSA until he was called to a special clinic to deal with overdue appointments, which was held on 20 February 2017. There is no record of when Patient B was advised of the date of his FSA. Consequently, I am unable to make a finding whether Patient B had been notified of the date of his FSA when he saw Dr N in November 2016, and whether Dr N was aware of it.⁴²
161. Nevertheless, Dr Maplesden noted that by 29 November 2016 it had been 11 weeks since the referral had been sent, and nine weeks since notification had been received of the "within 6 weeks" timeframe. He advised that given the "high suspicion of cancer", there should have been a clear plan in place to ensure that delays did not become "unacceptable".
162. If Dr N was not aware of the February FSA date, Dr Maplesden advised that Patient B should at least have been advised to report back if an appointment had not been confirmed within the next couple of weeks. If this was the case, Dr N should have contacted the Urology Service. Dr Maplesden advised that the option of private referral could also have been raised at this point if further delay was anticipated.
163. If Dr N was aware of the February FSA date, Dr Maplesden advised:
- "I do not think a five month wait for a FSA (First Specialist Appointment) in a patient with high suspicion of prostate cancer, with or without LUTS, can be regarded as acceptable or accepted practice. I think once [Dr N] became aware of the anticipated date of [Patient B's] FSA ... he might have considered two options on behalf of his patient:

⁴² See footnote 41.

- (i) Ring the Urology Department and clarify this patient was high suspicion of cancer, his appointment must be rescheduled for the immediate future (given that it had already been 10 or more weeks since a referral was sent), or
- (ii) Offer the patient the option of a private referral.”

164. As set out above, I am unable to make a finding as to when Dr N became aware of Patient B’s February FSA,⁴³ but I consider there to have been a lack of advocacy for Patient B in any event. Dr Maplesden noted that the disempowerment of primary care providers by the DHB in this situation was a significant mitigating factor. He said that Dr N had been conscientious and followed recommended best practice in his management and referral of Patient B, including following clinical pathways developed in conjunction with the DHB, yet the DHB was apparently consistently failing to meet expected practice with respect to recommended FSA times, and this came to be accepted as the “new normal”. Despite this, Dr Maplesden has advised that, either way, the failure to advocate more, either through the private or public systems, represented a mild to moderate departure from expected standards of care. I agree with Dr Maplesden’s advice, and am critical of Dr N’s lack of advocacy on Patient B’s behalf.

Patient C⁴⁴

Factual background

Introduction

165. On 3 April 2016, Patient C, then aged 68 years, was seen by his GP, Dr Q. Patient C told Dr Q that over the previous nine weeks he had noticed weight loss, a cough, and increasing breathlessness. Patient C was admitted to Dunedin Hospital that day and started on antibiotics for what was thought to be a chest infection. His chest X-ray indicated a pulmonary embolism⁴⁵ (PE), so he underwent a CTPA (a CT scan with contrast specifically looking at the pulmonary artery), which confirmed that he had extensive right-sided pulmonary emboli. He was started on an anticoagulant, dabigatran, and was discharged home on 5 April 2016.

Referral to Urology Department

166. On 27 April 2016, Patient C saw GP Dr R because Dr Q was on leave. Dr R referred Patient C to the Dunedin Hospital Urology Department. The referral states that there was a “high suspicion of cancer”. Dr R noted that Patient C’s previous PSA had been 0.85ng/mL but, by that stage, it had increased to 6.9ng/mL. Dr R wrote that a DRE the previous week had revealed that Patient C had an enlarged firm right lobe of his prostate. Dr R stated that

⁴³ See footnote 41.

⁴⁴ 17HDC01385. The parties directly involved in the investigation were Patient C, Southern DHB, and urologist Dr L. Independent expert advice was obtained from Dr Masters (Appendix D).

⁴⁵ A blood clot that blocks a blood vessel in the lungs.

Patient C's weight had previously been stable at 82.5kg but, at the time of referral, his weight was 77.5kg.

167. On 28 April 2016, the referral was triaged by RN O. Under the heading "urgency", the triage form states "to be seen within 6 weeks". Under the heading "cancer flagging", a full stop (but no tick) was placed in the box that states, "There is a high suspicion of cancer".

Urology appointment

168. Patient C was not contacted further until he was informed that he had an appointment booked at the Urology Department for 2 August 2016. Subsequently he received a letter changing the appointment to 17 August 2016. He told HDC that his wife rang RN O to question why his referral had been given such a low priority given the GP's referral, and his wife was told that the opinions of GPs were not regarded highly by the Urology Department, and the priority she had assigned was appropriate.

Second referral

169. Patient C stated that he saw GP Dr Q, who was also concerned about the delay, and that Dr Q made a further referral to the Urology Department on 9 May 2016. Dr Q stated in the referral that his clinical assessment was that there was a "high suspicion of cancer", and noted Patient C's unexplained weight loss, pulmonary embolism (PE), elevated PSA, and abnormal DRE. Dr Q noted:

"[Patient C] was referred for assessment by [Dr R] and the priority has come back as routine. I wonder if this is a mistake. He would seem to be at high risk of having prostate cancer with a history of unexplained and unintentional weight loss and recent admission with confirmed PE — no specific trigger for this identified."

170. Dr Q noted in the referral that he considered that an underlying malignancy would need to be excluded sooner than the four-month priority currently given. Patient C then received notification of an earlier appointment for 14 June 2016. He noted that his wife's enquiry and/or the second GP referral were the likely cause for the earlier appointment.

Appointment 14 June 2016

171. On 14 June 2016, Patient C was seen by surgical registrar Dr S. In her reporting letter to Dr Q, Dr S wrote that a DRE had indicated that Patient C had a nodule on the upper aspect of the right lobe of his prostate. She noted that she had discussed with Patient C the need for a TRUS biopsy of his prostate. Dr S added:

"[H]owever, since he has only had a PE two months ago, I discussed it with [Dr L] and he has advised to wait three months before coming off the Dabigatran and having the TRUS biopsy. I have put him on the waiting list for this today."

172. Patient C did not see Dr L at the appointment.

173. Patient C stated that, at that stage, he had complete faith in the Urology Department, and the general lack of urgency about his condition conveyed to him that there was nothing to be anxious about.

Appointment 17 August 2016

174. On 17 August 2016, Patient C was seen by respiratory physician Dr T for a follow-up regarding his PE. Southern DHB stated that Dr T advised the Urology Department that it was possible to biopsy Patient C's prostate while he was on dabigatran, so long as the usual protocols were followed. Dr T wrote to the Urology Department stating that Patient C should be treated with Clexane for three or four days prior to the TRUS biopsy, and recommenced on dabigatran afterwards. Dr T wrote:

"It is likely I suspect that the pulmonary embolism was apparently a paraneoplastic⁴⁶ phenomenon related to his prostate ... I would be very grateful for your assistance in getting [the] TRUS done in a timely manner."

TRUS arrangements

175. On 25 August 2016, Patient C was sent a letter stating that his TRUS biopsy had been scheduled for 14 September 2016 under Dr L's team. Enclosed with the letter was an information pamphlet, "Trans Rectal Ultrasound Guided Prostate Biopsy (TRUS biopsy)". Patient C said that he was given no instructions about the management of his anticoagulation, and the information pamphlet stated: "It is recommended that you stop all blood thinning drugs 7 days before the biopsy."
176. Patient C said that he was aware that he might require Clexane, and he thought that some information had inadvertently not been included in the letter. Consequently, he followed the advice in the letter that stated: "If you have any questions please call us." Patient C said he called and left a message requesting more information about the protocols for coming off dabigatran.
177. Patient C stated that at 1.07pm on 30 August 2016, he received a call from a person he assumed was part of the clinical team, but who he now knows to have been the department secretary, Ms U. He stated that at that time, he was standing in the street and unable to write down information, so it was arranged that they would speak again at 8am the following day.
178. At 8am on 31 August 2016, Ms U called Patient C and identified herself as "[Dr L's] secretary". Patient C said that she then attempted to pass on information that "she said [Dr L] had instructed her to relay to [Patient C] about how the change from Dabigatran to Clexane and back to Dabigatran was to be managed". Patient C stated that the information was unclear, for example whether he was to start the Clexane on the same day on which he stopped the dabigatran.

⁴⁶ Paraneoplastic syndromes are a group of rare disorders that are triggered by an abnormal immune system response to a cancerous tumour. Paraneoplastic syndromes are thought to occur when cancer-fighting antibodies or white blood cells (known as T cells) mistakenly attack normal cells in the nervous system.

179. Patient C said that Ms U told him that he was to have no Clexane on 14 September and “3/2” to restart the dabigatran. Patient C said that Ms U told him that she did not understand that instruction, and would get back to him with an explanation. Patient C said she told him that she would fax the information to him, and when he said that he did not have a fax, she said that she would fax it to his GP.
180. Patient C said that he then asked that the information be emailed to him, but Ms U said that she did not email anybody because she got “hate mail”. Subsequently, the conversation became acrimonious. Patient C said that he asked Ms U to “Shut up and listen”. He said that she then “launched a verbal counter-assault” and banged down the phone in his ear. On 31 August 2016, a fax clarifying the medication instructions was sent to Patient C’s GP.

TRUS biopsy

181. Patient C stated that his experiences had shaken his confidence in the Dunedin Hospital Urology Department, and so he organised to have the TRUS biopsy done privately by a urologist.
182. Patient C said that he stopped the dabigatran, and the urologist prescribed Clexane in preparation for the TRUS biopsy. The TRUS biopsy was performed on 30 September 2016. Four of 10 samples showed adenocarcinoma,⁴⁷ with a Gleason score of 4 + 5 = 9. On 6 October 2016, Patient C had a CT scan, which showed no evidence of metastatic disease or cancer in his lymph nodes.

Radiation oncology

183. On 7 October 2016, a radiation oncologist saw Patient C in another centre. The radiation oncologist recorded in his reporting letter to the urologist that they had discussed the options available, including surgery or radiation with neoadjuvant (before surgery) and adjuvant (after surgery) hormones for a total of two years. The radiation oncologist also discussed the possibility of radiation in the future should Patient C have surgery. The radiation oncologist noted that Patient C wanted to have his treatment in Dunedin, so no further appointments were made for him.
184. On 26 October 2016, the radiation oncologist referred Patient C to the Radiation Oncology Service at Dunedin Hospital for consideration of external beam radiation therapy. The radiation oncologist noted in the referral that Patient C had a localised high-risk prostate cancer.
185. On 17 November 2016, a radiation oncologist reviewed Patient C at Dunedin Hospital, and it was planned that he would commence radiotherapy in April 2017.

⁴⁷ Adenocarcinoma is a type of cancer that forms in mucus-secreting glands. Cancer that forms in the prostate gland is typically an adenocarcinoma, which makes up 99% of all prostate cancers.

Complaint

186. On 10 November 2016, Patient C made a complaint to Southern DHB covering the issues set out in this opinion. After Patient C provided further details of his concerns, Southern DHB responded on 5 December 2016.
187. Patient C was dissatisfied with the investigation and, in response to his concerns, Southern DHB's Medical Director of Patient Services prepared a complaint report dated 26 June 2017. The report states that Dr L knew from the first presentation that Patient C's prostate was malignant, and did not require a biopsy to make the diagnosis. It states that Dr L felt that the dangers of performing a biopsy in an anticoagulated patient were far greater than any delay with regard to treating Patient C's cancer, and that Dr L considered it to be important for Patient C to complete the full course of anticoagulation for his PE. Southern DHB stated that Dr L did not feel that ongoing monitoring of Patient C would add to the diagnosis or subsequent treatment.
188. The report states that there was a significant communication gap between what Dr L was thinking and what Patient C thought was happening.
189. The Southern DHB report states that Patient C was correct in considering that it was inappropriate for a non-clinical member of staff (Ms U) to advise him about his anticoagulation management. The report states that the process has now been changed, so that if a patient contacts the department to obtain advice about anticoagulation, the patient will be referred to the clinical nurse specialist or surgical registrar. The report also states that "hanging up" on a patient is not appropriate behaviour, and that in such situations the patient would now be referred to the service manager.
190. In response to the report, Patient C noted that he had never been examined by Dr L, nor had he had any written or spoken communication with him and, accordingly, there had been no misunderstanding on his (Patient C's) part. Patient C expressed concern that Dr L did not speak to respiratory physician Dr T about the advisability of, and process for, stopping the dabigatran.
191. Patient C also stated that as Dr L had not examined him, Dr L was not in a position to predict the future development of the tumour. Patient C said that because the tumour was not monitored, its rapid growth was not detected. As a result, the tumour reached the stage where surgery was not the best option, and radiation treatment would need to be longer to take account of the likelihood of the cancer having spread to his lymph nodes. Patient C said that it is not known whether the three- to four-month delay caused by not proceeding directly with the biopsy will affect his long-term outcome.
192. Patient C also expressed concerns about the Southern DHB complaints process. He said that the Southern DHB website did not set out the process, so he contacted the Patient Affairs department, but the person to whom he spoke could not explain the process.
193. The report states that Patient C was correct in expressing frustration about the complaint process. It notes that on assessment, the main issues with the website were:

- There was nothing on the website describing the approach to complaints.
- There was no guidance to submitting a complaint other than an email address and telephone numbers.
- There was no information about how complaints were handled once they were received.
- There was nothing with regard to other options such as HDC.

194. Southern DHB stated that it was undertaking an upgrade of the website to make it easier and more user friendly for patients and complainants.

Patient C

195. Patient C considers that RN O should not have triaged his referral, because the wider clinical picture of his unexplained PE and weight loss was outside the bounds of the standard triage scenario.

196. Patient C's view is that if the Dunedin Hospital Urology Service was not able to meet the demand for urology services, it should have prioritised people with abnormal DREs, as they were more likely to have aggressive cancer.

197. Patient C stated that the decision to delay his biopsy because he had had a PE two months previously and was on dabigatran displayed a lack of understanding of dabigatran, the attendant risks of undertaking a surgical procedure for someone two months after having a PE, and how to manage such a patient appropriately. Patient C noted that Dr L did not seek advice from Dr T or a haematologist at the time of the 14 June 2016 appointment, but instead made his decision based on his own knowledge and skill set.

198. Patient C stated that Dr L should have discussed with him the pros and cons of carrying out the biopsy following the 14 June 2016 appointment, or delaying it until he had completed the dabigatran course.

199. Patient C said that there is no documentation in his clinical notes about the use of Clexane prior to having a biopsy. In addition, Patient C considers that it was not appropriate for Dr L to instruct a non-clinical member of staff to give him clinical information.

Southern DHB

200. Southern DHB stated that referrals to the Urology Department exceeded its capacity to manage them, despite attempts to tighten triage criteria and reduce referral volumes.

Responses to provisional opinion

201. Southern DHB stated that the practice of the departmental secretary providing clinical advice was "totally inappropriate" and should not have been allowed by the clinicians and service management.

202. Patient C provided HDC with a letter from Southern DHB signed by Ms G, Dr E, the Nursing Director, and the Allied Health Director that states:

“Anticoagulant advice prior to prostate biopsy is clearly documented and usually sent to patients by the urology secretary. We accept that in instances such as this it should be the responsibility of the clinical nurse specialist.”

203. Patient C said that Southern DHB’s initial reluctance to do a thorough investigation of his concerns “points to a culture of problem avoidance in relation to complaints”.

Opinion: Southern DHB — breach

Care of Patient C

204. On 27 April 2016, Patient C was referred to the Urology Department at Dunedin Hospital because he had a mildly elevated PSA and an abnormal prostate on DRE. RN O triaged the referral on 28 April 2016 as “to be seen within 6 weeks”.
205. Dr Masters stated that the triage was appropriate and followed the Southern DHB Urology nurse referral triage guidelines. He noted that Patient C was originally booked for a clinic appointment on 2 August 2016, which was then changed to 17 August 2016. Dr Masters said: “This is clearly not acceptable. It would seem that there was no expectation that the department would be able to fulfil its own referral guidelines.”
206. Patient C was seen on 14 June 2016, after his wife had contacted RN O, and Dr Q had made a second referral questioning why there was a four-month wait for an FSA. Had this not happened, the appointment in August would have remained, which would have been four months from the referral. Dr Masters advised that it was not appropriate for it to necessitate a second GP letter for Patient C to be seen within an appropriate timeframe. Dr Masters opined:

“If the hospital knows it is not meeting its own referral guidelines then it needs to take proactive action to sort this out. It needed good management and co-operation between the clinicians and management to sort this out and that was not adequate hence a moderate departure.”

207. I agree with this comment. RN O triaged the referral on 28 April 2016 as “to be seen within 6 weeks”.
208. Patient C was informed that he had an appointment booked at the Urology Department for 2 August 2016. Subsequently he received a letter changing the appointment to 17 August 2016. Patient C was concerned about the delay, and consulted Dr Q, who made a further referral to the Urology Department on 9 May 2016. Dr Q stated in the referral that his clinical assessment was that there was a “high suspicion of cancer”, and noted Patient C’s unexplained weight loss, pulmonary embolism, elevated PSA, and abnormal DRE.
209. It is concerning that despite being triaged as “to be seen within 6 weeks”, the first date for the FSA that Patient C was offered was over four months after the referral. This delay caused concern for Patient C. I agree with Dr Masters that it should not have required the intervention of Dr Q for Patient C to be seen within an appropriate timeframe.

Initial decision to defer biopsy until course of anticoagulation medication completed

210. When Patient C was seen on 14 June 2016, Dr L decided to delay Patient C's biopsy because he had had a PE two months previously and was on dabigatran. Dr Masters advised that it was within the expected range of management and treatment in New Zealand to defer the biopsy until Patient C had completed the course of dabigatran, and that this would apply unless a patient had high-grade cancer. Dr Masters indicated that in New Zealand it would be unusual to perform a biopsy without stopping dabigatran because of the attendant risk of bleeding.
211. Dr Masters said that the decision to wait until the anticoagulant treatment for the PEs had been completed is within normal practice in New Zealand, because it is difficult to prove that early intervention improves outcomes with prostate cancer, and if stopping anticoagulation may pose a risk to the patient and the treatment is for a defined time period, it is reasonable to wait until the treatment has finished.
212. I accept this advice. However, Patient C stated that Dr L should have discussed with him the pros and cons of undertaking the biopsy following the 14 June 2016 appointment, or delaying it until he had completed the dabigatran course.
213. Dr Masters advised that communicating the risks and benefits and timing of prostate biopsies on anticoagulated patients is complex, and requires communication of the relative risks. In my view, Dr L or Dr S should have had a detailed conversation with Patient C regarding the timing of his biopsy and the management of his anticoagulation, including the options and risks.

Communication

214. Following an appointment with Patient C on 17 August 2016, Dr T advised the Urology Department that it was possible to biopsy Patient C's prostate while he was on dabigatran, so long as the usual protocols were followed. Dr T said that Patient C should be treated with Clexane for three or four days prior to the TRUS biopsy, and recommenced on dabigatran afterwards.
215. On 25 August 2016, Patient C was sent a letter saying that his TRUS biopsy had been scheduled for 14 September 2016. Enclosed with the letter was an information pamphlet, "Trans Rectal Ultrasound Guided Prostate Biopsy (TRUS biopsy)". Patient C said that the only instruction he received about the management of his anticoagulation was in the information pamphlet, which stated: "It is recommended that you stop all blood thinning drugs 7 days before the biopsy." Patient C contacted the Urology Department seeking clarification.
216. Dr L delegated to the department secretary the task of advising Patient C about the management of his anticoagulation. The instructions she gave were unclear to Patient C, and Ms U was unable to answer all his questions.
217. Dr Masters advised that the change from dabigatran to Clexane and back to dabigatran is complex, and requires clinical knowledge and clinical input from a nurse or doctor,

preferably with clear written instructions. In addition, administering Clexane injections requires appropriate advice, and may need the input of district nurses or the GP practice.

218. Dr Masters advised that to delegate this task to a clerical support person was not acceptable or appropriate. I agree with Dr Masters that it was unreasonable to expect Ms U to perform that role, and I note that her inability to answer Patient C's questions led to an acrimonious conversation. Dr Masters stated that he would regard this as a moderate departure from the expected level of care. I agree with this advice.
219. Furthermore, Patient C said that he asked Ms U to "Shut up and listen", and that she then "launched a verbal counter-assault" and banged down the phone in his ear. I consider that Ms U's action in hanging up on Patient C was unprofessional, but possibly a reflection of the pressure under which she was working, and the task she had been given to perform.
220. I accept that this experience contributed to Patient C's lack of confidence in the level of care he was receiving from Southern DHB.

Summary

221. The date that Southern DHB offered to Patient C for the FSA was not within an acceptable timeframe. A further GP referral was necessary in order to expedite the appointment, and this was not appropriate. In addition, while I accept that it was reasonable to wait until the treatment for Patient C's PEs had been completed before carrying out the biopsy, I consider that DHB staff should have had a detailed conversation with Patient C regarding the timing of his biopsy and the management of his anticoagulation, including the options and risks.
222. Given the possible risks of a further PE, Patient C should have been provided with effective information regarding the change from dabigatran to Clexane and back to dabigatran by a member of the clinical staff. It is not appropriate that the role of communicating this information was delegated to a non-clinical staff member who did not understand the information and was unable to answer Patient C's questions. This led to an acrimonious discussion in which Ms U hung up on Patient C before later sending his GP the information by fax.
223. District health boards are responsible for the operation of clinical services they provide, and are responsible for service-level failures. For the above reasons, I consider that Southern DHB failed to provide services to Patient C with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Complaints process — adverse comment

224. On 10 November 2016, Patient C made a complaint to Southern DHB covering the issues set out in this opinion. Patient C also expressed concerns about the Southern DHB complaints process. He said that the website did not set out the process, so he contacted the Patient Affairs department, but the person to whom he spoke could not explain the process. After Patient C provided further details of his concerns, Southern DHB responded

on 5 December 2016. Subsequently, the Medical Director of Patient Services prepared a complaint report dated 26 June 2017.

225. Right 10(1) of the Code provides that every consumer has the right to complain about a provider in any form appropriate to the consumer. Patient C clearly found the Southern DHB complaints procedure difficult and frustrating to negotiate. His concerns were upheld when the Medical Director of Patient Services' team attempted to access the complaints procedure, as set out in the complaint report. Dr Masters noted that ease of access and prompt and courteous handling are invaluable if good results and resolution of complaints are to be achieved. I am critical that the information publicly available about the complaints process did not facilitate the making of complaints. I consider that DHBs should have complaints processes that are easy to access and understand. In Patient C's case, this was not achieved.
-

Patient D⁴⁸

Factual background

Introduction

226. In 2014, Patient D (then aged 43 years) underwent a double mastectomy for breast cancer and axillary clearance (removal of lymph nodes).

Urinary retention

227. In 2015 and 2016, Patient D was seen in the Southern DHB Urology Clinic because of presentations to the Emergency Department (ED) with urinary retention. On 12 May 2016, RN O referred her for urodynamics⁴⁹ to investigate her bladder function.
228. On 9 June 2016, Patient D was seen by a urologist, who reported to the Dunedin Hospital Urology Service that it appeared that the cause of Patient D's retention was a degree of detrusor⁵⁰ failure, which might be secondary to a large floppy bladder. The urologist stated:

“I think if she has not done so that she requires a cystoscopy⁵¹ to ensure there is no other abnormality in her bladder especially in light of her history of [breast] cancer with possible disease spreading to the lungs.”

⁴⁸ Case 18HDC00326. The parties directly involved in the investigation were Patient D, Southern DHB, and consultant urologist Dr P. Further information from consultant gynaecologist Dr U was also reviewed. Independent expert advice was obtained from Dr Masters (Appendix E).

⁴⁹ Urodynamic testing or urodynamics is a study that assesses the storing and releasing of urine by the bladder and urethra.

⁵⁰ The detrusor muscle is smooth muscle found in the wall of the bladder. The detrusor muscle remains relaxed to allow the bladder to store urine, and contracts during urination to release urine.

⁵¹ Examination of the lining of the bladder and the urethra. A hollow tube (cystoscope) equipped with a lens is inserted into the urethra and advanced into the bladder. There are two types of cystoscope — flexible and

Urology appointment 19 July 2016

229. On 19 July 2016, Patient D saw urology registrar Dr W at Dunedin Hospital Urology outpatients clinic. Dr W noted that the underlying problem seemed to be detrusor failure. He booked Patient D for a flexible cystoscopy, and she was placed on the waiting list.

Breast reconstruction

230. On 8 August 2016, Patient D had a bilateral breast reconstruction at a private hospital in Dunedin.

Further referrals

231. On 22 December 2016, Patient D attended the breast follow-up clinic and saw a Breast Care Services clinical nurse specialist, who referred her to Women's Health (Gynaecology) because Patient D was experiencing what was thought to be vaginal (PV) bleeding. On 27 January 2017, an ultrasound of Patient D's pelvis showed masses in her bladder.
232. On 31 January 2017, Patient D attended Women's Health and saw consultant gynaecologist Dr V, who sent an "urgent referral" of Patient D to the Urology Service. Dr V stated that the bleeding observed was possibly haematuria.⁵² The referral states that an ultrasound a few days earlier had shown two irregular soft tissue masses within the bladder that were suspicious for malignancy, and added: "I would be very grateful if you could see [Patient D] urgently to investigate the possible bladder tumours." Dr V noted that Patient D had heard nothing further after being placed on the waiting list for a flexible cystoscopy in July 2016, and added: "She is now upset about this, given the ultrasound is suggestive of bladder tumours."
233. On 2 February 2017, Patient D presented to the Dunedin Hospital ED with lower back pain and urinary retention that required an indwelling urinary catheter (IDUC). An ultrasound undertaken in the ED showed a bladder mass.
234. On 3 February 2017, RN O triaged the referral from Dr V as "Urgency (1) Faster cancer wait patient", and under the cancer flagging heading ticked, "There is a high suspicion of cancer". On 8 February 2017, Patient D was discussed at a Urology X-ray meeting and booked for an urgent transurethral resection of the bladder tumour (TURBT).⁵³
235. On 20 February 2017, urologist Dr P saw Patient D in the Urology outpatients clinic. Dr P reported to Patient D's GP that the ultrasound suggested a bladder lesion. Dr P noted that Patient D had been waitlisted for a flexible cystoscopy for evaluation of her urinary retention, but that this had not occurred. Dr P's plan was for Patient D to have a CT scan of her abdomen and pelvis, and a flexible cystoscopy.

rigid. A flexible cystoscope is a fibre-optic tube that can move around bends in the urinary system. It is about the thickness of a pencil, and generally is used to assist diagnosis or to evaluate treatment. A rigid cystoscope is a solid, straight tube with a light at one end. Although both types of cystoscope have side channels where other instruments can be inserted, a greater variety of instruments can be used with the rigid cystoscope.

⁵² Blood in the urine.

⁵³ A TURBT is a procedure to remove bladder tumours from the bladder wall. A scope with a special cutting instrument is inserted into the bladder through the urethra to remove the tumour.

236. Patient D underwent a CT scan on 28 February 2017.
237. On 16 March 2017, the GP replied to Dr P: "Patient still waiting to be contacted: she is anxious to be seen."
238. On 23 March 2017, Dr M reported to the GP that Patient D's imaging had been reviewed at the Urology X-ray meeting. Dr M noted:

"She was booked for a flexible cystoscopy back in February. Unfortunately due to waiting lists and a lack of resources this hasn't happened yet. She presented to the Emergency Department recently with urinary retention and I have booked her to the next available general anaesthetic list for TURBT. On imaging today she does have lesions in the bladder which almost certainly are urothelial carcinoma.⁵⁴"

239. On 27 March 2017, Patient D underwent a rigid cystoscopy and TURBT performed by a urology registrar assisted by Dr L. The registrar recorded in the operation note that two separate tumours approximately two centimetres in diameter were found on the right lateral anterior wall of the bladder.
240. Patient D has since had further cystoscopies and, in December 2017, was found to have a recurrence of bladder cancer requiring a further TURBT.

Southern DHB

241. Southern DHB stated that the flexible cystoscopy requested by Dr W on 19 July 2016 was considered to be non-urgent, as at that time, Patient D had no documented bladder tumour. Southern DHB stated that at the time (19 July 2016), flexible cystoscopies were not performed in the outpatient area. Southern DHB said that the referral was not lost, but the procedure was not performed because of a lack of resource.
242. Southern DHB noted that it changed its procedure, and flexible cystoscopies are now performed in the outpatient "one stop" setting. It stated that current waiting times for flexible cystoscopy are from two weeks for urgent priority, to four months for routine priority.
243. Southern DHB stated that the second referral, on 31 January 2017, was prioritised as FCT after the work-up by the Gynaecology Service identified on ultrasound that there were probable bladder masses. Southern DHB said:

"We do apologise for the delay in the initial cystoscopy, which may have identified the tumours sooner. [Dr L], consultant urologist, has reviewed [Patient D's] case and has reported that the tumours were of low grade and earlier identification would not have changed the need for ongoing recurrent cystoscopies and treatment as this is standard for all patients identified with a removed bladder tumour."

⁵⁴ A type of cancer that typically occurs in the urinary system. Treatment for localised carcinomas is surgical resection of the tumour, but recurrence is common.

244. Southern DHB stated:

“The wait list event was cancelled and replaced with a transurethral resection of bladder tumour (TURBT) procedure due to positive ultrasound results. The wait time was 204 days.”

Complaint management

245. Patient D stated that the initial complaint she made to the DHB in March 2017 met with no response from Southern DHB and so, on 3 May 2017, the Health and Disability Advocacy Service wrote a letter to Southern DHB on her behalf. On 31 May 2017, Southern DHB responded agreeing that Patient D’s waiting times for appointments and treatments were longer than the DHB “would have expected”, and apologised for this and the “associated distress”.

246. Patient D was not satisfied with the response. She stated that over a five-week period in June and July she tried to contact the Service Manager, Mr J, but was unsuccessful. Patient D then wrote to Southern DHB asking for her complaint to be reviewed. A response letter from Southern DHB, dated 21 August 2017, said that Mr J would work with the advocate to arrange a meeting. Consequently, on 11 September 2017, the advocate emailed a meeting agenda to Mr J. Patient D said that Mr J did not provide a time to meet, and did not respond to further contacts. Southern DHB provided no further response to the complaints.

247. Southern DHB said that when Mr J was no longer the Service Manager, there was a handover to his replacement, but this failed to manage the transfer of Patient D’s complaint effectively. Southern DHB stated that monitoring at the senior leadership team level also failed. However, it said that recently considerable work has been undertaken to improve its responsiveness to overdue complaints.

248. The Southern DHB CEO stated:

“The management of [Patient D’s] complaint is totally unacceptable and I continue to reinforce with my team of the importance of ensuring that all complaints are carefully reviewed, and the complainant receives a response that clearly addresses the issues they have raised within the shortest possible timeframe. I intend to use this complaint as a paradigm case with my team.”

249. Southern DHB apologised for the distress experienced by Patient D because of the way in which her complaint was handled.

Opinion: Southern DHB — breach

250. Patient D was treated for breast cancer in 2014. In 2016, she developed urinary retention, and was referred for urodynamics, which took place on 9 June 2016. The urologist recommended that Patient D have a cystoscopy.

251. On 19 July 2016, Patient D saw Dr W at Dunedin Hospital's Urology outpatients clinic, and Dr W booked her for a flexible cystoscopy. Dr Masters advised that the appointment in the clinic six weeks after the urodynamic study was reasonable, as was the referral for a flexible cystoscopy. He noted that at that stage there was no test result or symptom that suggested a bladder tumour, and he considers that the standard of care was met.
252. However, the flexible cystoscopy had not been performed by the time consultant gynaecologist Dr V at Women's Health made an "urgent referral" on 31 January 2017. Dr Masters advised that the routine flexible cystoscopy should have been performed within six months of Dr W's referral, and he regards the failure to do so as a significant departure from the expected standard of care. I agree.
253. By failing to perform a timely flexible cystoscopy within six months of Dr W's referral, Southern DHB failed to provide services to Patient D with reasonable care and skill, and breached Right 4(1) of the Code.
254. Southern DHB stated that Dr W's referral was not lost, but the procedure was not performed because of a lack of resource. Dr V's "urgent referral" of 31 January 2017 states that an ultrasound a few days earlier had shown two irregular soft tissue masses within the bladder that were suspicious for malignancy, and added: "I would be very grateful if you could see [Patient D] urgently to investigate the possible bladder tumours." On 3 February 2017, RN O triaged the referral from Dr V as urgency 1, faster cancer wait patient, and noted that there was a high suspicion of cancer. Patient D was admitted for a rigid cystoscopy on 27 March 2017.
255. Dr Masters advised that at that stage a very high standard of care was achieved. A referral was made within four days, and Patient D's case was discussed in a multi-disciplinary team meeting on 8 February 2017. Her outpatient appointment was on 20 February 2017, which was within four weeks of referral. A CT scan was ordered and performed within eight days, and surgery (TURBT and rigid cystoscopy) was performed on 27 March 2017, within six weeks of the outpatients appointment. I accept this advice.

Complaint management

256. Right 10(3) of the Code states that every provider must facilitate the fair, simple, speedy and efficient resolution of complaints. However, Patient D's initial complaint to the DHB in March 2017 met with no response from Southern DHB. I am very critical of this.
257. On 3 May 2017, an advocate wrote a letter to Southern DHB on Patient D's behalf. On 31 May 2017, Southern DHB responded agreeing that Patient D's waiting times for appointments and treatments were longer than the DHB "would have expected", and apologised for this and the "associated distress". The letter stated:

"The urology service is experiencing a significant increase in referrals and ongoing care which has unfortunately meant we have not been able to see all patients within the intended timeframe. We are currently working on reviewing our processes to improve these to avoid delays going forward."

258. Southern DHB's letter of 31 May 2017 invited Patient D to contact Mr J. Patient D made multiple unsuccessful attempts to contact him, and subsequently it transpired that he was no longer employed by Southern DHB as Service Manager. Dr Masters advised:

“This is really very poor communication on behalf of the DHB when they are already dealing with someone who was upset with regards to (perceived) delays in the management and treatment of her bladder tumour. Surely someone knew that this offer to contact [Mr J] was never going to work and the DHB could have done better than this.”

259. Southern DHB agreed that the management of Patient D's complaint was totally unacceptable, and apologised for the distress experienced by Patient D from the way in which her complaint was handled.

260. In my view, this was very poor management. Patient D clearly found the Southern DHB complaints procedure unresponsive and frustrating. Southern DHB's complaints process should be easy to access, and complaints should be handled in an appropriate manner. In Patient D's case, this was not achieved. By failing to respond to the initial complaint; by advising that a meeting with an advocate would be arranged after Patient D expressed dissatisfaction with the DHB's response to the complaint, and taking no further action on the complaint after the Service Manager, Mr J, left that role; and by not providing any further responses to Patient D, Southern DHB failed to facilitate the fair, simple, speedy and efficient resolution of Patient D's complaint and, accordingly, breached Right 10(3) of the Code.

Conclusions: Southern DHB

Introduction

261. Southern DHB has a responsibility to provide appropriate care to its consumers that complies with relevant standards, including the New Zealand Health and Disability Services (CORE) Standards,⁵⁵ which are designed to enable providers to be clear about their responsibilities for safe outcomes.

262. In this investigation I have focused on the inability of Southern DHB to meet the demand for urology services, particularly from 2016. The effect of this is demonstrated by the group of patients who complained to this Office about delays and difficulties they experienced with obtaining the urology services they needed from Southern DHB (discussed above).

263. There had been concerns within the DHB at least since 2014. Following the system quality review final status report in 2016, the tracking of patients on the FCT pathway resulted in

⁵⁵ NZS 8134:2008.

early improvement in the median time between making the decision to treat a patient, and the patient's first treatment. In November 2016, 2.6% of Urology patients were not being treated within the ESPI5 target.

264. By July 2017, 37.8% of Urology patients were not being treated within the ESPI5 target. Urology Service managers and clinicians raised their concerns with management. In addition, from 1 January 2016 a number of patient complaints were made to the DHB about the Urology Service. However, the external review did not begin until June 2017.
265. Southern DHB said that referrals to the Urology Service exceeded its capacity to manage them despite attempts to tighten triage criteria and reduce referral volumes.⁵⁶ I consider that when the system was unable to meet the demand, the DHB was slow to act in a way that was cohesive and would bring effective, sustainable improvement. The external review report of August 2017 states that Southern DHB's management had limited knowledge of the demand the Urology Service needed to meet in the context of changing demographics, and there was little planning for urology services across the entire DHB.
266. It is essential that providers assess, plan, adapt, and respond effectively to the foreseeable effects that changing demographics in their population will have on systems and demand. In the context of resource constraint, appropriate waiting list and appointment management systems are vital to managing risk. With increasing demand, capacity needs to be monitored. Having mechanisms to monitor wait times and make these transparent to both the public and to referrers is essential.⁵⁷ Organisations also need to consider initiatives such as different models of care to reduce the gap between capacity and demand.
267. I accept that Southern DHB had a prioritisation tool that specified the timeframes within which patients should expect to receive services. Thereafter, the time within which the patients actually received the services depended on the practice of considering clinical need, length on the waiting list (those who had been waiting longest received their appointment first, provided that no other factors were involved), and whether the patient required a procedure or not. There was no policy or overall monitoring of this system. It appears that as different clinicians booked their patients for urgent procedures, the system became overloaded.
268. The DHB was unable to meet the timeframes provided for in the prioritisation tool, and many patients waited with no treatment and no information about when they would be treated. The individual cases discussed above provide some examples of this.

⁵⁶ See 17HDC01385, discussed above.

⁵⁷ See the discussion in Opinion 15HDC01667, 16HDC00035, and 16HDC00328 (1 May 2018).

269. As I commented previously in a case related to Southern DHB's Ophthalmology Service,⁵⁸ prioritising more patients as urgent when there is insufficient capacity has the effect of grid-locking the system. In that case, I noted:

“An effective consumer-centred system must be able to respond to clinical concerns raised by patients, document these, and have an escalation pathway in place that staff can follow where clinically indicated.”

270. In some of the cases discussed in this report, patients were not seen because the referral or follow-up request for appointments were “lost in the system”. In my view, the service should have in place a robust process for tracking and accounting for all referrals and requests for follow-up.

271. Until late 2016, the urologists had picked up extra lists. In addition, some Dunedin patients were treated at a private hospital, and Southland SMOs came to Dunedin and took some outpatient clinics and day-surgery theatre lists. From November 2016, there were a number of changes in Urology Service managers. As the system became strained, relationships between clinicians and management were impaired, and the urologists became less willing to undertake extra clinics or operating lists. The urologists attempted to communicate to management their concerns about the clinical risk caused by the lack of capacity.

272. From 2016, the urologists emphasised the need to increase the SMO resource available. However, as stated above, there were also a number of other problems, including the physical layout at the Dunedin site, and the fact that the Dunedin and Invercargill sites did not work together. The urologists were told that there were insufficient funds for the additional 0.5 FTE urologist that was requested, but management accepted that a review was needed. The urologists were told that there would be a review in the New Year, but as discussed above, this did not commence until June 2017.

273. The cases considered in this report are concerning examples of information being available but not actioned appropriately within the Southern DHB system, and having a direct impact on the timeliness of consumers receiving appropriate care. The delays in being treated, and the poor communication, frequently led to frustration and distress for patients.

274. In a previous report⁵⁹ relating to a different DHB, my independent expert advisor, Dr Iwona Stolarek, provided the following comments, which I consider are also relevant to these cases:

“Waiting list and appointment management problems are not unique to [this] DHB. With increasing demand, capacity needs to be monitored. Having mechanisms to monitor wait times and make these transparent to both the public and to referrers is

⁵⁸ Opinion 16HDC01010 (12 March 2018), available at www.hdc.org.nz.

⁵⁹ Opinion 15HDC01667 (1 May 2018) available at www.hdc.org.nz.

key. Transparency allows referrers to provide additional clinical information to improve the prioritisation and triage process, and for alternative provider options to be sought. Organisations also need to consider initiatives such as different models of care to reduce the gap between capacity and demand ...

Referral systems are complex with many stages from initial referral through grading/triage to the appointment, whether for first specialist appointment or follow-ups. There are different transition points and handovers between staff ...

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

275. Southern DHB owed consumers who required urology services a duty of care to ensure that their referrals for specialist assessments and diagnostic services were managed appropriately.⁶⁰ To meet its duty of care, Southern DHB needed to:

- Appropriately assess and prioritise the consumers’ levels of need using relevant standards and/or guidelines; and
- Promptly and clearly inform the consumers and the referrers about:
 - a) The decision and the reasons for it;
 - b) Management options, including the option of seeking private treatment and the risks (if any) of no treatment; and
 - c) The need to monitor their condition and notify the DHB of any deterioration.

276. The Ministry of Health publication “About the Electives programme”⁶¹ acknowledges that there are not enough resources to meet everybody’s needs immediately, and states that the resources available must be given out in a way that is fair to all. It states that all patients have the right to know what will happen to them regarding their treatment and when it will happen. All patient referrals should be assessed within 15 calendar days once received by the DHB, and the patient and referrer advised within that period whether an FSA will be available.

277. If a patient is accepted for an FSA, the FSA should occur within four months, and if the specialist decides that further specialist treatment is required, the patient should receive a priority score according to the level of need and ability to benefit from the treatment compared to other people. If the patient’s priority score is high enough, given available resources, treatment should be provided within four months of confirmation that it is available.

⁶⁰ See case 09HDC00891 (31 March 2010) and 16HDC01010 (12 March 2018), available at www.hdc.org.nz.

⁶¹ www.health.govt.nz.

278. The Ministry of Health requirements are that DHBs fulfil ESPI2 — that new referrals must be seen within four months, and ESPI5 — that patients booked for surgery must have the operation within four months. Those patients whose condition is not yet urgent enough to need specialist care within four months, but may get worse, should be given the status of Active Review. While in the category of Active Review, patients should receive a clinical assessment every six months. In the cases considered above, those targets were not met.

Demands on the Urology Service

279. I am fully cognisant of the complex resourcing pressures and associated demographic factors at play affecting urology treatment in New Zealand, including the demands on the system. I am also mindful of the external review and subsequent actions taken by Southern DHB to address the deficiencies identified.
280. From 2016, clinical prioritisation was undertaken by clinical nurse specialists. My expert advisor, urologist Dr Jonathon Masters, advised that this was appropriate. He noted that the triage nurse followed the Southern DHB departmental triage guidelines, which follow the nationally agreed referral guidelines for urological referrals. Dr Masters stated: “In general triage nurses with appropriate guidelines are better than medical colleagues at triaging appropriately.”
281. Even though there was an appropriate referral triaging system that indicated the expected period in which the patients who had been referred to the Urology Service would be seen for an FSA, and a system to identify the order in which the services would be provided, this is of little efficacy if there are insufficient appointments available to provide services within the prioritisation dates. During the period under consideration, the Urology Service at Southern DHB lacked capacity, in that the available clinics did not have enough appointments for the number of patients needing to be seen. In addition, the physical layout at the Dunedin site was unsuitable in that there was limited space in the consulting rooms and, as a result, in Dunedin, second appointments for the procedures were required. The capacity issues related to doctors, nurses, and physical space, especially clinic rooms, equipment, and clerical support staff. The inability to provide timely services resulted in stressed staff,⁶² multiple complaints from patients to Southern DHB, and, regrettably, the cases considered in this report.
282. Despite the increasing backlog, it appears that it took until 2016 for management to fully appreciate the clinical risk. As stated above, it was agreed in late 2016 that a review of the service was needed. There was then a substantial delay until the review was commenced in June 2017. Although Southern DHB organised an external review to help to resolve the issues in the Urology Service, that did not occur before the situation had become critical.
283. There was an inadequate response to the growing demand for urology services. As noted earlier in this report, the organisation was clearly struggling to respond to increasing

⁶² Demonstrated by the communications to management from urologists and service managers, and also discussed in Patient C’s case.

pressure. Clinical staff attempted to communicate to management the concerns regarding the growing problem. When this occurred, relationships became strained, and a collaborative and cohesive approach was not taken. Although some actions were undertaken, I consider that until the external review in June 2017, the clinical risk caused by the lack of capacity was not addressed adequately.

284. Southern DHB failed to ensure that a system was in place that effectively managed patients waiting for urology services during the period in question. Members of the public and clinicians came to expect delays, as was noted by Dr N in Patient B's case. In my view, delays became normalised. These are issues of central importance for all DHBs that, if not recognised and acted on, can have severe consequences for patients. In this case, Southern DHB's inadequate response failed each of the patients discussed in this report.

Complaints

285. HDC obtained 38 complaints made by patients to Southern DHB about the Urology Service from 1 January 2016. Attempts by patients to find out about their appointments or obtain an appointment are described in the complaints to the DHB and in the complaints to HDC. It is clear that the responses received from Southern DHB often caused considerable frustration to patients. I also note the example in one of the individual cases discussed above where the patient had an acrimonious conversation with the departmental secretary who had been tasked with the role of relaying clinical advice about management of the patient's medication.⁶³ I am concerned about the level and clarity of information consumers received from the Urology Service about their care.
286. With regard to the complaints to HDC, as discussed earlier I have found Southern DHB in breach of the Code in the following respects:
- Patient A — His time to treatment was almost double the target timeframe. This was compounded by a failure to keep him informed about a likely date for his surgery. Southern DHB failed to provide his services with reasonable care and skill, and breached Right 4(1) of the Code.
 - Patient B — There was an unacceptable delay in Patient B receiving treatment. He was graded as priority 3 (expected to be seen within six weeks), but he was not seen until over five months after his initial referral. It was then a further seven weeks until his biopsy was performed, even though the booking form was marked urgent, with multiple circles and a star to emphasise the urgency. Southern DHB failed to provide his services with reasonable care and skill, and breached Right 4(1) of the Code.
 - Patient C — Despite being triaged as "to be seen within 6 weeks", the first date for the FSA that Patient C was offered was over four months after the GP's referral. Subsequently the appointment was brought forward after his GP made a further referral noting the "high suspicion of cancer", unexplained weight loss, pulmonary

⁶³ 17HDC01385.

embolism, elevated PSA, and abnormal DRE. Information regarding the change from dabigatran to Clexane and back to dabigatran was conveyed by a member of the non-clinical staff. Southern DHB failed to provide Patient C's services with reasonable care and skill, and breached Right 4(1) of the Code.

- Patient D — On 19 July 2016, Patient D was booked for a flexible cystoscopy, but it was not performed until after a gynaecologist made an “urgent referral” on 31 January 2017. Southern DHB failed to provide Patient D's services with reasonable care and skill, and breached Right 4(1) of the Code. In addition, Southern DHB failed to facilitate the fair, simple, speedy, and efficient resolution of Patient D's complaint, and breached Right 10(3) of the Code.

287. These are incidents of suboptimal performance that fit within the pattern demonstrated in this report.

Governance and culture

288. The sites at Dunedin and Invercargill are physically isolated from each other, and arose from different organisations (Otago and Southland DHBs). When Southern DHB was first formed, they continued to function as two different entities with different systems, ways of working, and management structures. There was a significant difference in the access to care between patients on the Dunedin site, and those being treated in Southland. In Dunedin, the facilities were inadequate. By contrast, the facilities in Southland Hospital were modern and more satisfactory.

289. By 2016, Southern DHB had been aware of its inability to meet demand for urology services for some time. Although Southern DHB management was aware of this, the external review demonstrated that it had limited knowledge of the demand the Urology Service needed to meet in the context of changing demographics, and there was little planning for urology services across the entire DHB. There was a concerning level of clinical risk because of the long waiting period for patients on the Dunedin site.

290. In response to the provisional opinion, Southern DHB stated that managers were presented with considerable challenges in regard to the clinicians' lack of willingness at times to work together to find solutions to the problems within the service, other than to provide an additional urologist.

291. It is evident that relationships within Southern DHB became stressed. In my view, effective service delivery requires collaborative and mutually accountable relationships, and no party to this relationship can step away from the mutual accountability and responsibility to work constructively to solve the complex challenges that are an inevitable part of the health and disability sectors. It is necessary that there is an integrated approach that results in clinicians and management being collectively responsible for the delivery of effective services.

292. The learnings from this case — the need for clear processes, effective communication, collaborative working, and collective ownership of the challenges — are self-evident.
293. I commend the Chief Executive and his team for the work that has been undertaken, in particular over the last two years. The “mega-clinic” weekends are an excellent example of the clinical support and organisational commitment that has been utilised to address the challenges faced by the Urology Service. HDC will continue to monitor progress.
-

Recommendations

294. I recommend that within three months of the date of this report, Southern DHB provide HDC with:
- a) An independent evaluation of the systems in place to identify and prioritise Urology patients who have overdue appointments. This should include the use of clinically based patient acuity scores, so that patients with higher acuities are prioritised, and patients identified as high risk do not have appointments delayed.
 - b) A quantitative and qualitative audit of the management of Urology Service referrals and follow-ups since September 2017, to be certain that tracking systems are in place and all referrals are responded to in a timely manner.
 - c) A review of the mechanisms in place to monitor wait times, and the processes to make these transparent to the public and referrers, including allowing referrers to provide additional clinical information to improve the prioritisation and triage process.
 - d) A report on the steps taken to build departmental capacity, responsiveness, and adaptability, including regular accurate measurement and reporting of demand and capacity, using objective agreed criteria that account for actual and projected increases in demand, as well as details regarding:
 - Steps taken to improve the relationship between management and clinical staff;
 - Training and implementation of nursing staff and ancillary and non-specialist staff;
 - Progress with relocating the Dunedin Urology Service to more appropriate physical space;
 - Progress with recruiting staff, as recommended in the external review; and
 - The redefined roles and responsibilities of those involved in the management of the Urology Service.
295. I recommend that Southern DHB arrange routine telephone access to clinical staff so that Urology Service patients, across both centres, can contact the Urology Service readily, speak to an appropriately trained person when clinical concerns are raised, receive an

appropriate response, and have this recorded in their clinical notes. Southern DHB is to report back to HDC on the actions taken, within three months of the date of this report.

296. In relation to shared learning, I recommend that Southern DHB:
- a) Arrange regular forums involving Urology Service staff and management, to include discussion and planning to assist development of treatment protocols in the context of an ageing population. Southern DHB is to report back to HDC on the actions taken, within three months of the date of this report.
 - b) Confirm that the external review report was discussed with all other DHBs via their Chief Medical Officers, to ensure that any patient risk arising from similar circumstances is identified and controlled.
297. I recommend that Southern DHB arrange for the Urology Service and its facilities to undergo regular credentialling. Southern DHB is to report back to HDC on the actions taken, within three months of the date of this report.
298. I recommend that Southern DHB continue to provide HDC with three-monthly updates on the implementation of the recommendations of the external review, until December 2019.
299. I recommend that Southern DHB undertake a review of its complaints management processes, including its website, with a view to improving the accessibility and responsiveness of its complaints management. Southern DHB is to report back to HDC on the outcomes of the review, within three months of the date of this report.
300. I recommend that Southern DHB provide separate formal written apologies to Patient A, Patient B, Patient C, and Patient D. The apologies are to be sent to HDC for forwarding, within three weeks of the date of this report.
301. I recommend that the Ministry of Health consider conducting a national discussion on urology service priorities and national reporting of overdue urology appointment statistics, and report to HDC on the outcome of its consideration.
-

Follow-up actions

302. A copy of this report with details identifying the parties removed, except Southern DHB, Southland Hospital, and Dunedin Hospital, will be sent to the Health Quality & Safety Commission, the Urological Society of Australia and New Zealand, the National CMO Group, and the Central Technical Advisory Service (TAS), and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner — Patient A

The following expert advice was obtained from Dr Jonathan Masters:

“My name is Jonathan Masters. My Medical Council Number is 26350. I am an Urologist and Honorary Senior Lecturer and my specialist interests are in prostate and bladder cancer. I do not have any conflicts of interest in this case.

You have asked me to consider whether the care [Patient A] received was appropriate in the circumstances and in particular to comment on:

- 1) Whether the referral by [Dr L] was adequate.
- 2) Whether the timeliness of [Patient A’s] treatment was within acceptable standards.
- 3) Whether the communication with [Patient A] was appropriate.
- 4) Whether it was appropriate to fail to provide a clinic letter to [Patient A] and his GP.
- 5) Whether [Patient A] was adequately monitored while waiting for surgery.
- 6) Any other matters in this case that you consider warrant comment.

I have been provided with a letter of complaint dated [...] with supporting information, Southern DHB’s response to HDC dated 14 September 2017 and the clinical records covering the period from February 2017 to August 2017.

- 1) Whether the referral by [Dr L] was adequate

I believe that referral from [Dr L] was more than adequate. Contrary to the letter signed by [the] Chief Executive Officer there are in fact 2 booking forms completed for [Patient A] by [Dr L] the first dated 4 April 2017 is circled as faster cancer tracking which means a diagnosis is established at referral. The second (where the top is cut off on photocopying such that I can not see the date of form completion) is marked as ‘A’ Urgent. At a maximum the wait time from referral to treatment should be 62 days for faster cancer treatment times. In reality [Patient A] confirmed his decision about treatment on 3 April 2017 by email. The public booking form was completed by [Dr L] 4 April 2017. This booking form was acknowledged by fax 4 April 2017 by [the Urology secretary] who scheduled both assessments by the continence service and a letter was sent to [Patient A] on 5th April for his anaesthetic pre assessment on 13 April 2017. This means that it was very clear to the schedulers in the public system what the intentions were for this patient and I think it is a remarkable effort that all the necessary bookings and appointments were sorted out by [Ms U] the secretary within 24 hours.

- 2) Whether the timeliness of [Patient A's] treatment was within acceptable standards

[Patient A's] surgery was outside the Southern DHB's and the Ministry guidelines for cancer treatment and so this aspect of his care falls short of the expected standard of care and I would consider this a moderate departure from accepted standards. In fact in [Patient A's] case the delay was unlikely to do him harm physically as he had a low PSA and only an intermediate grade (Gleason 4+3 ISUP grade 3) cancer. This is supported by the fact that his final specimen showed organ and specimen confined cancer. However this does not excuse the DHB for failing to meet theirs and the Ministry's target times for definitive treatment for the cancer. The psychological stress for [Patient A] must have been considerable with a delay of over 4 months from referral to treatment.

- 3) Whether the communication with [Patient A] was appropriate

The communication with [Patient A] was of a very high standard up to the point where [Patient A] was simply sitting on a waitlist for surgery with no update as to when the surgery may be. When [Patient A] phoned the hospital in July to try and confirm a date for surgery he was led to understand that there were 10 people more urgent than him and that no date had been set. Given that the Southern DHB at that point in time were not in a position to provide surgery due to inadequate resourcing in urology I am not sure how much communication could have been improved to relay this information to [Patient A]. After completing both the anaesthetic and continence assessments I believe communication then fell below an acceptable level but this would be a mild departure from an acceptable level of care.

- 4) Whether it was appropriate to fail to provide a clinic letter to [Patient A] and his GP.

I am not clear what this refers to. [Dr L's] letters from his private clinic were sent to the GP and the plan was clear. Certainly the dealings with the Urology department in the public hospital initially were outstanding. [Patient A] had passed through both his anaesthetic assessment and his continence assessment for which there is a clinic letter. I am not clear how many more letters the HDC were expecting to be sent. Where [Patient A] has attended clinics there are letters written. I believe the written correspondence is of an acceptable level of care.

- 5) Whether [Patient A] was adequately monitored while waiting for surgery.

It is not necessary to monitor men waiting surgery for treatment for prostate cancer assuming that they will get surgery in an appropriate length of time. The problem here is not one of monitoring it is the problem of the long wait times.

- 6) Any other matters in this case that you consider warrant comment

I would like to comment on the letter signed by [the CEO]. The GP recommended that [Patient A] have the biopsies done privately because he felt (correctly at the time) that

the provision within the DHB for prostate biopsies was inadequate. Contrary to what is intimated in the letter signed by [the CEO] there was no delay or confusion because the patient was referred in from the private system. He had both his anaesthetic assessment and continence assessment without difficulty or delay. One of the 2 forms is marked as urgent the other is faster cancer tracking and so as mentioned in the letter from [the CEO] (paragraph 10) he should have had treatment within 62 days maximum. The most pertinent sentence is that at the bottom of paragraph 5 namely 'Unfortunately [Patient A] then experienced delay in his treatment due to problems being experienced by our Urology Service.' Ultimately as Chief Executive Officer this is [his] responsibility. To his credit an external review was organised to help resolve these issues in the Urology Department but not before the situation had been allowed to become critical.

Jonathan Masters

NZMC number 26350

February 12 2018"

Appendix B: Independent advice to the Commissioner — Patient B

The following expert advice was obtained from Dr Masters:

“My name is Jonathan Masters. My Medical Council Number is 26350. I am an Urologist and Honorary Senior Lecturer and my specialist interests are in prostate and bladder cancer. I do not have any conflicts of interest in this case. You have asked me to consider whether the care [Patient B] received was reasonable in the circumstances and in particular to comment on:

- 1) Whether the timeliness of [Patient B’s] progression through the following stages was within acceptable standards
 - First visit with specialist following referral from GP (20 February 2017)
 - Biopsy performed (20th April 2017)
 - Prostatectomy performed (6th July 2017)
- 2) Whether the standard of communication with [Patient B] was appropriate
- 3) Whether the standard of communications among the clinicians involved in [Patient B’s] care was appropriate
- 4) Any other matters in this case that you consider warrant comment

I have been provided with a letter of complaint dated [...] with supporting information, Southern DHB’s response to HDC dated 28 September 2017 and the clinical records covering the period from September 2016 to November 2017 and the clinical records from [the medical centre] and the external review of Southern DHB Urology services from June 2017.

1) Whether the timeliness of [Patient B’s] progression through the following stages was within acceptable standards

a. First visit with specialist following referral from GP (20 February 2017)

[Patient B’s] referral was faxed on 12th September 2016 and triaged by the triage nurse using the Otago triage system (which conforms to the national guidelines for urology from USANZ) to be seen within 6 weeks. This is entirely appropriate and the letter was triaged in a timely fashion without delay. Around New Zealand some but not all DHBs would have triaged this man directly for a prostate biopsy rather than a clinic appointment as he was clearly going to need a biopsy thus reducing the wait to diagnosis. Whilst a wait of up to 6 weeks is a reasonable wait to be seen, in this case [Patient B] was not seen for 5 months and it took a further 7 weeks for biopsies to be performed.

This delay significantly impacted the quality of [Patient B’s] life in that he had gone into chronic retention with associated pain by the time he was seen on 20 Feb 2017.

The delay will almost certainly impact his longevity due to a delay in the treatment for his prostate cancer. I would consider this a substantial departure from the expected level of care in New Zealand.

Biopsy performed (10th April 2017)

The delay between the first clinic appointment and the biopsy was 7 weeks. In a man who clinically was thought to have prostate cancer and significant symptoms (retention) this delay is a moderate departure from the expected level of care.

The booking form was marked urgent with multiple circles and a star on it to emphasize the urgency and yet it still took 7 weeks.

The practice in Otago of performing the biopsies as day case theatre procedures is unusual and inefficient and this will not have helped in the 7 week wait for biopsies. In most DHBs the biopsies are done as outpatient procedures.

Prostatectomy performed (6th July 2017)

From a clinical perspective deciding on the correct form of management for [Patient B] is a significant challenge. He had a very high grade locally invasive prostate cancer and was also unable to void requiring a catheter. He was discussed at MDM meetings twice. On the first occasion the MRI had not been completed (2 May 2017). On the second occasion (6 June 2017) a decision to proceed with surgery was confirmed though this was likely to be palliative rather than curative given the extensive local involvement.

The operation proceeded on the 6th July. I think this delay between MDM and surgery is a little long but I do not know how frequently the MDMs are held (? Once a month). I do agree that this case needed discussion at the MDM. I also note there is a letter May 23 suggesting he was booked for surgery at this time. I would regard the delay between biopsy and surgery as just acceptable compared with other units in New Zealand.

Whether the standard of communication with [Patient B] was appropriate

[Patient B] did not receive any communication with regard to his first appointment for the best part of 5 months. This, despite the fact he was triaged correctly to be seen within 6 weeks. This delay without explanation is unreasonable but arises because of the excessive delay in being seen. Once [Patient B] was seen in the clinic and was under way then I think the standard of communication with [Patient B] was appropriate.

Whether the standard of communications among the clinicians involved in [Patient B's] care was appropriate

I feel the standard of communication between clinicians in this case is good. Multiple different urologists have been involved in his care and in addition the radiation and

medical oncologists. Given the situation they found themselves in I feel that the clinicians have worked hard to formulate a plan and then provide the best support for the patient including completing an ACC form as [Patient B] was not able to work preoperatively and still cannot work now.

Any other matters in this case that you consider warrant comment

I believe that [Patient B's] long term prognosis and the quality of his life has been affected by the very long wait from referral to diagnosis at the time of the biopsy. This was the best part of 7 months. This is not an acceptable wait time for a man who should have been seen and processed by 6 weeks given that he had a high suspicion of cancer.

To its credit the DHB did organise an external review of the urology service in Dunedin and Southland DHB in June 2017. That there was a significant problem in the urology department had been abundantly clear for some time before June 2017 and sadly [Patient B] is in many ways a victim of the Southland DHB's inability to get its own house in order. I very much hope, as [Patient B's] complaint eloquently states, that the complaint means 'it doesn't happen to anyone else'.

Jonathan Masters

NZMC number 26350

February 22 2018"

Appendix C: Expert Advice from Dr David Maplesden — Patient B

The following expert advice was obtained from general practitioner Dr David Maplesden:

“1. Thank you for the request that I provide clinical advice in relation to the complaint from [Patient B] about the care provided to him by Southern DHB. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner’s Guidelines for Independent Advisors. I have reviewed the information on file: complaint from [Patient B]; response from manager [medical centre]; GP notes [medical centre]; response and clinical notes Southern DHB (Dunedin Hospital — DH).

2. [Patient B] complains about delays in the DHB actioning a referral sent in by his GP in September 2016 in relation to lower urinary tract symptoms and an abnormal prostate examination. [Patient B] was eventually seen by the DHB urology service in February 2017 when he had a catheter inserted and was told he required an urgent biopsy. The biopsy was not performed for another two months and showed advanced prostate cancer. [Patient B] underwent a radical prostatectomy on 6 July 2017. His cancer was advanced and had a poor prognosis and post-op radiotherapy was required. [Patient B] has been left with significant sequelae from the radical surgery he required and is concerned that earlier treatment might have resulted in a better prognosis and less radical surgery required.

3. GP notes have been reviewed from January 2016. [Patient B] was aged 62 years at the time his diagnosis of prostate cancer was confirmed on biopsy. He had a positive family history of the disease. On file is a PSA result dated 16 September 2015 — 0.9 µg/L (reference range given as 0.0–4.4). I am unable to determine from the available information if this was a routine screening test or if [Patient B] had previously complained of lower urinary tract symptoms (LUTS).

4. First consult in 2016 is 18 January (repeat regular medications, reference to knee symptoms). Next consult was 12 September 2016 at which [Patient B] presented a history of LUTS (precise duration not evident) as per the referral below. Notes include: *no significant back pain, no persistent leg pain ... afebrile P 80/min, abdo soft non-tender no LKKS no palpable bladder. Rectal exam hard firm prostate — large right lobe larger than left and more tender with ridge feeling to the right. Assessment: Prostatic hypertrophy Plan: refer urology — urgent as sounding like he is obstructing. Doxazosin was commenced and a referral letter was sent.*

5. DHB urology service e-referral sent by [Dr N] on 12 September 2016 was as follows (original bolding):

Request: Clinic assessment

High suspicion of cancer

LUTS with hard craggy ridge right side of the prostate.

Thank you for seeing [Patient B]. He has had LUTS for some time and has progressed significantly over the last 12 months with frequency 1–2 hourly and urgency and nocturia 3–4 times at night.

His prostate is large with a craggy ridge on the right lobe. His PSA twelve months ago was 0.9.

I have repeated his PSA and MSU and will forward when they are available.

Thank you for your opinion.

Relevant personal medical information was attached as was blood test results from September 2015. Results dated 12 September 2016 showed PSA of 2.4 µg/L and clear MSU.

6. On 23 September 2016 [Dr N] evidently received notification from the DHB that the referral had been received and notes include: *Urology — Semi urgent within 6 wks* (which would be by around 4 November 2016).

7. Next consultation was 11 October 2016 for review of a back lesion. Notes include: Also has had a good response from doxazosin, flow is better, up only once at night, had some backache week before last, now better. Also says ... has [family member who] has had prostatectomy for ca prostate.

8. [Dr N] reviewed [Patient B] on 29 November 2016 (now about nine weeks since grading letter received) with symptom of pressure behind the eyes since starting doxazosin. Focussed neurological examination was normal and decision made to trial terazosin instead of doxazosin. Notes include the comment await flow studies implying [Dr N] was expecting [Patient B] to be undergoing urodynamic studies.

9. On 6 December 2016 [Patient B] spoke with the practice nurse regarding deterioration in his LUTS since stopping doxazosin. After discussion with [Dr N], [Patient B] was advised to increase his dose of terazosin but restart doxazosin if this was ineffective. On 15 December 2016, [Patient B] contacted the practice nurse to advise he had restarted the doxazosin which was effective and requesting a repeat prescription. He also described back pain since a recent injury and was advised to see [Dr N] regarding this.

10. On 17 December 2016 [Patient B] saw [a healthcare provider at a medical centre] who noted history of back injury three weeks previously with symptoms and assessment findings suggestive of a right L5 radiculopathy. [Patient B] was advised to continue the osteopathic treatment he had already commenced, naproxen and codeine as analgesia and review in a few weeks if ongoing power and sensation problems re referral to GPSI. He was advised to have blood tests related to his usual

medication (lithium) which was done the following week. There is no reference to complaint of urinary symptoms or discussion regarding his urology appointment. This was the last recorded direct contact [Patient B] had with [medical centre] GPs until after his first specialist assessment by the DHB urology service.

11. Report from urologist [Dr P] dated 20 February 2017 notes [Patient B's] attendance for first specialist assessment. Clinically he was suspicious [Patient B] had an advanced prostate cancer and recorded: He needs an immediate prostate biopsy. Post-void ultrasound indicated [Patient B] was in chronic urinary retention and a urinary catheter was inserted with concurrent referral to the continence service. PSA repeated 21 February 2017 (ordered by an urologist) showed PSA 2.6 µg/L.

12. Prostate biopsy was performed on 10 April 2017 with outpatient follow-up scheduled for two weeks. At outpatient review on 23 May 2017 (following biopsy results and MRI scan), [Patient B] was informed he had an advanced high-risk prostate cancer, and he was offered a radical prostatectomy with likely need for post-op radiotherapy. Management was discussed further at the Urology X-ray meeting on 24 May 2017 with surgery confirmed. There was apparent further discussion of [Patient B's] case at the DHB Genito-Urinary Multi-Disciplinary Meeting on 6 June 2017 with a report to the GP stating the outcome of the meeting could be viewed in this patient's Clinical Documents section in iSOFT HealthViews.

13. [Patient B] finally underwent radical prostatectomy and bilateral lymph node dissection on 6 July 2017. [Patient B] was seen by [a radiation oncologist] on 14 August 2017 with plan made for radiotherapy to the prostatic bed but acknowledgement the cancer carried a poor prognosis and was of the type that advanced rapidly if untreated (with reference to the lengthy wait between referral and treatment). An ACC claim for treatment injury was submitted by [Dr N] on 21 August 2017.

14. Response from [the medical centre] includes the following points:

- (i) [Dr N] referred [Patient B] on the 12 September 2016 the same day he presented with symptoms of frequency and urgency and referral agreed. [Patient B] had no symptoms of back pain or symptoms suggestive of cauda equina. [Dr N's] rectal examination suggested the possibility of a prostatic malignancy. [Patient B's] PSA was less than 4 at 2.4 on the 22 September 2016.
- (ii) [Dr N] followed the 'Prostate Cancer Management and Referral Guidance' published by the Ministry of Health in September 2015. He raised the 'high suspicion of cancer flag' on his referral and the expectation was that there would be a 6–8 week wait. It was understood at that time that the Urology Department at Dunedin Public Hospital were having capacity issues.

- (iii) On the 23 September 2016 the practice received correspondence from Dunedin Public Hospital indicating that [Patient B] would be seen semi-urgently within 6 weeks. This was recorded in [Patient B's] notes. The guidance recommends the referral be classified as routine and up to 8 weeks wait.
- (iv) [Patient B] was seen again for follow up on 11 October where his symptoms had improved following the introduction of doxazosin and he had no bone pain suggestive of advanced disease. No further correspondence was deemed necessary to the hospital by [Dr N] as it was clear from their correspondence that the referral had been received by Dunedin Public Hospital. The content of the referral had been acknowledged i.e. 'the high Risk of cancer' and the triaged urgency to be seen was within the timeframe outlined by the guidance. It should also be noted that the time frames initially indicated by Dunedin Public Hospital for patients to be seen are frequently not met and the Urology Department was known to be under pressure and not meeting current recommended triage times.

15. Comments

- (i) [Dr N] undertook a conscientious assessment of [Patient B] on 12 September 2016 [and] made an appropriate and timely referral after detecting an abnormal feeling prostate. The combination of presence of LUTS and abnormal feeling prostate was suspicious for prostate cancer irrespective of the normal PSA reading. There is some discrepancy in the available guidance (see Appendix 1 & 2) regarding urgency of referral with the 2009 'Suspected Cancer' guidelines indicating urgent referral is required while the 2015 'Prostate Management and Referral' guidance suggests routine referral (although should be seen within 6–8 weeks). The referral contained the relevant information required for the DHB to prioritise [Patient B's] management and there was a clear indication from [Dr N] this was a high suspicion of cancer referral. It appears the positive family history of prostate cancer came to light after the referral was sent but as [Patient B] already fulfilled the criteria for review within 6–8 weeks I do not think this piece of information would/should have altered his prioritisation for review.
- (ii) [Dr N's] clinical notes for 12 September 2016 are somewhat less clear than the referral letter with respect to his high suspicion of cancer. There is no reference to query of diagnosis of cancer but rather the comments: *Assessment: Prostatic hypertrophy Plan: refer urology — urgent as sounding like he is obstructing*. For another provider scanning the notes, this might give the impression that the main concern was benign prostatic hypertrophy causing obstructive symptoms, and the prescribing of doxazosin and response to that medication might further reinforce that perception, although abnormal DRE findings suspicious for cancer were documented. This has some relevance with respect to [Patient B's] review by another provider in December 2016 (see later comments) and while I think the overall standard of clinical documentation was not unreasonable, I think it would have been wise for [Dr N] to have clearly documented in the clinical notes (not

just in the referral letter) that there was a high suspicion of cancer. The content of a referral letter is not readily apparent to another provider viewing the consultation notes.

- (iii) The precise nature of what was discussed with [Patient B] following his assessment by [Dr N] on 12 September 2016 is not apparent from the available documentation. While [Patient B] was aware an urgent urology referral was being made, it is unclear whether he understood that suspicion of cancer was the main reason for the referral as opposed to risk of obstruction. The discussion of possibility of cancer diagnosis with the patient requires balancing the perceived likelihood of the diagnosis against the risks of making a patient unduly anxious or stressed. On the other hand, provision of information regarding suspicion of a cancer diagnosis enables the patient to consider alternative access arrangements such as first specialist assessment in private rather than waiting for a public hospital appointment, and I think would be inclined to heighten the patient's awareness of expected time frames for review and make it more likely for them to question any perceived delay in review. I think if [Dr N] genuinely believed there was a high suspicion that [Patient B] had an underlying prostate cancer (as indicated in his referral and appropriately considered given the assessment findings) this should have been discussed with [Patient B] on 12 September 2016 and I would be mildly critical if it was not. However, given the information provided in the referral letter I do not believe there was any reason the referral would be prioritised as other than urgent and that [Patient B] would be seen in a timely manner.
- (iv) The issue of 'tracking' of the referral has not been addressed in the [the medical centre] response. Comments on expected practice in this regard are outlined in Appendix 3. Given the high suspicion of cancer it would have been prudent to have used a PMS task reminder to ensure the referral had been received and actioned in a timely manner. On 23 September 2016 confirmation of receipt of the referral, prioritisation and expected waiting time was received from the DHB (actual letter not on file) and transcribed into the clinical notes. Expected waiting time was within six weeks. The [medical centre] response includes the comment: [the DHB] *Urology Department was known to be under pressure and not meeting current recommended triage times*. In this situation, and with the benefit of hindsight, it might have been prudent for a reminder to have been set to ensure [Patient B] was actually seen within the time frame allocated. However, I think it should be possible to have some faith in the DHB system and to expect that if a delay outside the recommended time frame was likely from the outset or became apparent later, such information would have been conveyed to the GP (and the patient) with a recommendation that the patient might like to consider private referral. I am unable to establish from the available documentation whether such information was made available to [Dr N], or to [Patient B], but it does not appear so. Taking into account this discussion, I think once the DHB had provided [Dr N] with the information that [Patient B] would be seen within six weeks, and

assuming there was no additional information provided regarding likely delays and consideration of private referral, the onus was on the DHB to keep the GP and patient informed of any likely delays in first specialist assessment (FSA). I am therefore not critical if [Dr N] failed to formally track [Patient B's] referral once acknowledgement of receipt of the referral and waiting time had been received from the DHB.

- (v) I am not aware of the DHB practice with respect to notification of patients of expected wait times following referral as this appears to vary between DHBs. If [Dr N] was aware that the DHB did not notify patients of expected wait times, I would expect him to have arranged for [Patient B] to have been notified of the expected 'within six weeks' time frame following receipt of that information from the DHB. [Patient B] might then be regarded as being adequately informed in terms of expected FSA time frames, with the additional expectation that he might inform his GP or the DHB if those time frames were not being met. There is no reference in the clinical notes to the issue of delayed FSA being raised by either party and I am unable to establish if [Patient B] was notified of the expected FSA wait time.
- (vi) [Patient B] was subsequently reviewed by [Dr N] on 11 October 2016 for issues unrelated to his prostate but the family history of prostate cancer was disclosed. The positive family history did place [Patient B] at increased risk of prostate cancer but as this diagnosis was already suspected, and he was apparently due for his FSA within the next few weeks, I do not believe any further action was required by [Dr N] at this point.
- (vii) [Patient B] presented to [Dr N] again on 29 November 2016 with issues related to his doxazosin medication (and therefore related to his prostatic symptoms). It was now 11 weeks since [Dr N] had sent in his 'high suspicion of cancer' referral, and nine weeks since notification had been received of the 'within six weeks' FSA timeframe. It is not apparent the issue of delayed FSA was raised by [Patient B], but I believe it should have been raised by [Dr N]. Noting the cited prostate referral guidance (Appendix 1) which gives an expected FSA time frame of 6–8 weeks, and the assumption (from [the medical centre's] response) that [Dr N] was aware there were some service issues within the DHB urology department, the current delay was perhaps not unexpected but I think at this point, given the 'high suspicion of cancer', there should have been a clear plan in place to ensure the delays did not become 'unacceptable'. If [Dr N] was able to access DHB outpatient appointment schedules through the iSOFT Health Views, it would have been an opportune time to confirm [Patient B] had an imminent appointment. I think at least [Patient B] should have been instructed to report back if an appointment had not been confirmed within the next couple of weeks, and if this was the case for [Dr N] to have contacted the DHB urology service. I think the option of private referral might also have been raised at this point if further delay was not unexpected although I cannot predict if [Patient B] would have accepted this

option. I am mildly to moderately critical that apparently no action was taken at this point to advocate on [Patient B's] behalf, or to put in place some specific plan/reminder, to ensure he received a timely review for his 'high suspicion of cancer'.

- (viii) [Patient B] was next reviewed by another [medical centre] provider on 17 December 2016 in relation to back pain following an apparent injury. There is no reference to presentation of urinary symptoms or discussion regarding the overdue urology FSA. A history of cancer is a potential 'red flag' in a patient presenting with back pain but I feel this diagnosis was not readily apparent from brief review of the notes (see comment in 15(ii)), and [Dr N] had most recently included the comment 'await flow studies' in the consultation of 29 November 2016 again implying the main concern was [Patient B's] obstructive symptoms rather than suspicion of cancer. Under the circumstances, I believe [Patient B's] management on this date was reasonable from a clinical perspective although there was a missed opportunity to determine the wait for his urology FSA was now unacceptably long.
- (ix) It is apparent that [Patient B] did not proactively raise the issue of the delayed FSA with his GP, but this raises the important issue of whether he was adequately informed both of the reason for his initial referral, the expected time frames for review, and what he should do if the expected time frames were not met. If he was under the impression the referral was solely for his obstructive symptoms rather than suspected cancer, and noting he had gained significant relief of his obstructive symptoms with use of doxazosin, his apparent acceptance of the assessment delays might be understandable. The importance of providing a consumer with adequate and appropriate information relevant to their circumstance cannot be overemphasised.
- (x) There did not appear to be any further opportunity to expedite [Patient B's] urology assessment from the time of the December 2016 GP appointment until he was eventually reviewed by the urology service in February 2017. I think had [Patient B] been adequately informed regarding his potential diagnosis and expected time frames for management, and what he should do if those time frames were not met, the unacceptable delays in his FSA might have been recognised somewhat earlier. While the DHB role in this situation must be regarded as most prominent, I believe [Dr N] could have been more proactive in keeping [Patient B] appropriately informed and advocating on his behalf and I am mildly to moderately critical this was not done as discussed above. Responsibility for the subsequent delays in [Patient B] receiving his biopsy and eventual surgery I think rest entirely with the DHB.

Further advice

I have reviewed [Dr N's] response on my original advice. The following points are clarified:

1. [Dr N] did make [Patient B] aware he was concerned about the suspicious findings on prostate examination at the time the 'high suspicion of cancer' referral was made. Any adverse comment in my original advice in this regard is therefore retracted.
2. [Dr N] felt there might be two pathologies occurring concurrently: obstructive symptoms secondary to benign hypertrophy and an abnormal area in the prostate ie the obstructive symptoms were not necessarily secondary to prostate malignancy. This is consistent with recent publications in the medical literature¹ which note a lack of certainty over whether presence of LUTS is associated with increased risk of advanced prostate cancer.
3. [Patient B] would have received notification of the 'likely' wait for his urology FSA (within six weeks) at the same time the practice did.
4. [Dr N] recalls that at the appointment of 29 November 2016 he thinks [Patient B] had received notification of his FSA date (February 2017). Given the time of the year (Christmas holiday period looming) and the historical performance of the DHB with urology FSAs, [Dr N] thinks he probably accepted the delayed FSA as 'normality'. It does not appear the option of private referral was raised at any time with [Patient B].
5. [Dr N] outlines actions he has taken since being aware of [Patient B's] situation including improvements in the PMS automatic 'task monitoring' capability, and an active role advocating on behalf of primary care from a position within the DHB.
6. I do not think a five month wait for a FSA in a patient with high suspicion of prostate cancer, with or without LUTS, can be regarded as acceptable or accepted practice. I think once [Dr N] became aware of the anticipated date of [Patient B's] FSA (apparently 29 November 2016) he might have considered two options on behalf of his patient:
 - (i) Ring the urology department and clarify this patient was high suspicion of cancer and his appointment must be rescheduled for the immediate future (given it had already been 10 or more weeks since the referral was sent), or
 - (ii) Offer the patient the option of private referral
7. I do not think it was reasonable or in the best interests of the patient to accept the DHB 'offer' of a FSA in February 2017. However, I must acknowledge the 'disempowerment' of primary care providers by the DHB in this situation as a significant mitigating factor. [Dr N] had been conscientious and followed

¹ Ostero J et Broderson J. Do men with lower urinary tract symptoms have an increased risk of advanced prostate cancer? *BMJ*. 2018;361:k1202

recommended best practice in his management and referral of [Patient B], including following clinical pathways developed in conjunction with the DHB, yet the DHB was apparently consistently failing to meet expected practice with respect to recommended FSA times and this became accepted as the 'new normal'. This is potentially a dangerous situation and I hope [Dr N] is successful in his attempts to advocate on behalf of primary care from within the DHB. However, I remain of the view that [Dr N's] failure to attempt to expedite [Patient B's] FSA (private or public) on 29 November 2016 represents a mild to moderate departure from expected standards of care."

Appendix D: Independent advice to the Commissioner — Patient C

The following expert advice was obtained from Dr Masters:

“My name is Jonathan Masters. My Medical Council Number is 26350. I am an Urologist and Honorary Senior Lecturer and my specialist interests are in prostate and bladder cancer. I do not have any conflicts of interest in this case.

You have asked me to consider whether the care [Patient C] received was reasonable and why and in particular to comment on:

- 1) Whether the timeliness of [Patient C’s] diagnosis of prostate cancer was within acceptable standards including the priority given to first specialist assessment and the failure to undertake a biopsy
- 2) Whether [Patient C] was appropriately monitored while he was awaiting biopsy
- 3) Whether [Patient C’s] anticoagulation medication was managed appropriately
- 4) Whether it would be expected that [Dr L] would assess [Patient C] before making a diagnosis that [Patient C’s] prostate was malignant.
- 5) Whether the standard of communication with [Patient C] was appropriate
- 6) Whether it was appropriate for the Urology Secretary [Ms U] to give clinical advice to [Patient C].
- 7) Whether [Ms U’s] conduct during the conversation was appropriate
- 8) Whether [Patient C’s] complaint to the Southern DHB was managed appropriately
- 9) Any other matters in this case that you consider warrant comment

I have been provided with complaint dated [...] with supporting information, Southern DHB’s response dated 7 September 2017 and the clinical records covering the period from 3 April 2016 to December 2016.

1. *Whether the timeliness of [Patient C’s] diagnosis of prostate cancer was within acceptable standards including the priority given to first specialist assessment and the failure to undertake a biopsy*

A) Triage and outpatient appointment

[Patient C] was referred by his GP on 27 April 2016. He was referred with a mildly elevated PSA and a palpably abnormal prostate with a concern that his PEs may have been part of a paraneoplastic process consequent to prostate cancer. The letter was triaged appropriately on 28 April 2016 by the triage nurse following the departmental triage guidelines. These guidelines follow the nationally agreed referral guidelines for urological referrals with respect to prostate cancer and in terms of [Patient C’s] presentation he was appropriately categorised by the triage nurse. In general triage nurses with appropriate guidelines are better than medical colleagues at triaging appropriately. I do however note that [Patient C] was originally booked for a clinic appointment for 2 August 2016 which was changed to 17 August 2016. This is clearly not acceptable. It would seem there was no expectation that the department would be able to fulfil its own referral guidelines (indeed [RN O] triage nurse makes

comment that there may be others also waiting longer than recommended for out patients or biopsies). Where the department has required strong and proactive management instead there have been 3 different managers in 18 months this also seems inappropriate and unacceptable in a department that was obviously struggling to meet its clinical commitments. In general it would seem to me that at the time [Patient C] was referred there was little or no attempt on behalf of senior management to help the urology department meet its targets. From the DHB's response it would seem that this has now been tackled. I would regard this as a moderate departure from the expected level of care.

I do realise that [Patient C] was seen on 14 June 2016 but this was as a result of a second referral from the GP questioning why there was a 4 month wait for an FSA. Presumably without this letter the appointment would have been in August (4 months from referral and not the 6 weeks).

B) Failure to undertake a biopsy

A biopsy was scheduled for 9th September 2016. I understand [Patient C's] frustration at what would seem unnecessary delay. I also realise that [the urologist] performed the biopsies without stopping the Dabigatran but this would be unusual practice in New Zealand and not the norm because of the attendant risk of bleeding and the potential irreversibility of the Dabigatran. Again the decision to wait until the anticoagulant treatment for the PEs had been completed is within normal practice in New Zealand. This is because in reality it is surprisingly difficult to prove early intervention with prostate cancer improves outcomes (see PIVOT and PROTECT trials) and so where stopping the anti coagulation may pose a risk to the patient (further PEs in this case) and where the treatment is for a defined time period (here it was 6 months) then it is reasonable to wait until the treatment has finished. Therefore I believe this lies within the expected range of management and treatment in New Zealand.

2) Whether [Patient C] was appropriately monitored while he was awaiting biopsy

The one possible exception to the statement above is where a patient has high grade cancer. In general a PSA is done no more frequently than 3 months and in particular in this case would have been non contributory as the PSA did not reflect the high Gleason score. Regular digital rectal examinations are subjective. Clearly [Patient C] had a palpably abnormal prostate gland but determining that this was different from a prior DRE is difficult and more difficult if the person performing the DRE is changing on each examination. Thus the GP in April, [Dr S] the registrar in June and [the urologist] in September of 2016 all clearly describe a palpably abnormal prostate with a nodule on the right side but on the basis of the correspondence it is not possible to know whether the feel of the prostate has actually changed over this time period. Increasingly in New Zealand an MRI of the prostate will be performed in this circumstance which will provide useful additional information. However the utility of MRI is very much dependent on both the machine and the experience of the radiologist and I cannot comment on how good this service is in Dunedin. In addition

even in the last 12 months this has changed rapidly and so in June 2016 in Dunedin it may not have contributed significantly. Therefore overall I believe that the monitoring (which was no further tests until the biopsy) sits within an acceptable range of practice in New Zealand for 2016.

3) Whether [Patient C's] anticoagulation medication was managed appropriately

The change from Dabigatran to Clexane and back to Dabigatran is complex and requires clinical knowledge and clinical input from a nurse or doctor preferably with clear written instructions. Administering the Clexane injections also needs coordination as the patients may not know how to self inject and district nurses or the GP practice may need to be involved. That this was delegated to a clerical support person was not acceptable or appropriate. It was unreasonable to expect [Ms U] to perform this role and she was clearly not able to answer or manage [Patient C's] questions in regard to exactly what was required and it is this that led to the phone conversations that were so difficult and unpleasant for both [Patient C] and [Ms U]. The plan itself, had it been delivered by the correct person and preferably with written instruction was fine. I would regard this as a moderate departure from the expected level of care.

4) Whether it would be expected that [Dr L] would assess [Patient C] before making a diagnosis that [Patient C's] prostate was malignant.

A digital rectal examination is not a pleasant procedure. Most patients do not wish to have this repeated in the same clinic unless it is vital. This therefore comes down to the degree of trust that [Dr L] had in the clinical acumen of [Dr S] the surgical registrar. [Dr S] clearly felt that a prostate cancer was likely from the clinical examination and she also discussed the case with [Dr L] in the clinic as this is recorded in [Dr S's] letter of 14 June 2016. On reading the correspondence from [Dr S] and the comments made about her she would seem to be a competent trainee doctor whose judgement [Dr L] could reasonably trust. I therefore feel that it is quite reasonable for [Dr L] to state that he believed [Patient C] had prostate cancer though he did not examine [Patient C] but instead relied on the findings presented to him by [Dr S]. Everyone agreed a prostate biopsy should be performed rather it was when this should be performed that has been the issue.

5) Whether the standard of communication with [Patient C] was appropriate

Ultimately if the communication that [Patient C] had with the staff of the urology department had been of an appropriate standard for [Patient C], then [Patient C] would not have been in contact with the HDC. The communication that [Patient C] had with the clerical support person was not appropriate. I would regard this as a moderate departure from the expected norm in New Zealand.

Communicating the risks and benefits and timing of the prostate biopsies on anticoagulated patients is complex. On the part of the clinician there needs to be an ability to communicate relative risks (of stopping the anticoagulation or delaying the

diagnosis of prostate cancer). The information upon which this is discussed is not clear cut and the information is often interpreted differently by different clinicians and from a patient perspective synthesizing this data when there is an overwhelming anxiety about a cancer diagnosis is very difficult. In the end this comes down to trust. I do not believe that the urology department wished [Patient C's] prognosis to be compromised but with the need for 2 referral letters from the GP to be able to get an appointment, and the difficult conversations around anticoagulation [Patient C] simply did not trust he was getting care of an appropriate level in a timely fashion. Therefore for [Patient C] the standard of communication was not appropriate.

6) *Whether it was appropriate for the Urology Secretary [Ms U] to give clinical advice to [Patient C].*

In this circumstance [Ms U] had been asked to give advice around something that she did not fully understand. [Patient C] wanted clarification on exactly when and how the change from Dabigatran to Clexane would happen. I do not believe that [Ms U] was the correct person to be giving this advice as it is clear she did not really understand what she was advising. This role would have been better filled by a nurse specialist and at the very least when the phone conversations were clearly a frustration to both [Patient C] and [Ms U] she should have been able to pass this on to a clinically qualified person. I do not believe that this advice should have been given to [Patient C] by [Ms U]. I would regard this as a moderate departure from the expected norm.

7) *Whether [Ms U's] conduct during the conversation was appropriate*

I have discussed with my departmental secretaries whether they ever hang the phone up on patients and also whether they have ever had any formal training in managing conversations which are stressful and or abusive. None of the secretaries that I spoke to have had formal training. Generally when these conversations arise, the secretaries that I have spoken to feel that it is appropriate that if after warning the patient that the phone will be put down if the hostile tone of the conversation continues, then it is okay to put the phone down. I cannot comment whether this actually occurred during either of the conversations. I do note that [Patient C] has some sympathy for [Ms U] who he felt was compromised by being asked to do tasks beyond her designated role. If [Patient C] had been warned the phone would be put down if the tenor of the conversation did not change then I think it is appropriate. If this did not happen then the behavior was not appropriate but [Ms U] should be allowed to do the tasks within her remit and not tasks such as explaining the intricacies of clexane bridging therapy.

8) *Whether [Patient C's] complaint to the Southern DHB was managed appropriately*

Accessing the complaints procedure was clearly a frustration for [Patient C]. I note [the Medical Director of Patient Services'] comments when his team tried to access the complaints procedure and the issues that he himself noted, namely:

- 1) There is nothing to describe how to approach the complaints on the website.
- 2) There was no guidance in submitting a complaint other than email address and phone numbers.
- 3) There was no information as to how the complaints are received.
- 4) There was nothing noted with regards other options such as HDC.

I have checked the current website and there is still no information immediately available as to how a complaint process will be handled so the complaint needs to be sent first. I believe that if the complaints procedure had been easier to access and the steps that would be taken in order to try and resolve the issues raised were available to him at the beginning it would have helped considerably. Once the complaints process was up and running I believe the DHB worked hard and appropriately to resolve the issues raised including the investigation by [the Medical Director of Patient Services]. However [Patient C] continued to feel at a disadvantage as it was unclear to him what the aim of each meeting and intervention was meant to be. Thus he was enquiring whether he needed legal representation.

Complaints are never easy to make or handle. In my experience there is normally a valid reason a complaint has been made and it should be taken as a learning opportunity such that further patients do not need to go down the same path. Ease of access and prompt and courteous handling are invaluable if good results and resolution are to be achieved.

Jonathan Masters

NZMC number 26350

December 8 2017”

Further advice 20 December 2017

“[The moderate departure] refers to the fact that it took a second letter from the GP for [Patient C] to be seen in an appropriate time frame. This was much faster than the original booking of mid August. If the hospital knows it is not meeting its own referral guidelines then it needs to take proactive action to sort this out. It needed good management and cooperation between the clinicians and management to sort this out and that was not adequate hence moderate departure.”

Appendix E: Independent advice to the Commissioner — Patient D

The following expert advice was obtained from Dr Masters:

“My name is Jonathan Masters. My Medical Council Number is 26350. I am a Urologist and Honorary Senior Lecturer and my specialist interests are in prostate and bladder cancer. I do not have any conflicts of interest in this case.

You have asked me to consider whether the care [Patient D] received was reasonable in the circumstances and in particular to comment on:

- 1) Whether the time taken for [Patient D] to receive the cystoscopy ordered on July 19th was reasonable. In particular, were there any factors which indicated a more urgent referral for cystoscopy
- 2) Whether the actions taken in response to [Patient D’s] CT scan of 28th February 2017 was reasonable in the circumstances. In particular, please comment on the time taken for [Patient D] to receive an appointment for surgery following the CT scan

1) *Whether the time taken for [Patient D] to receive the cystoscopy ordered on July 19th was reasonable. In particular, were there any factors which indicated a more urgent referral for cystoscopy*

The initial referral from the GP (letter not available) was around the difficulty [Patient D] was having in passing her urine. It took just over 11 months for her to be seen in the urology outpatients which is a long wait for a first specialist appointment. However, the wait for urodynamics was less than 1 month which is a remarkably short wait. A urine sample done just prior to the urodynamics was more consistent with infected urine than anything different (such as a bladder tumour). Review in the clinic was 6 weeks after the urodynamics study which is reasonable and at that point a referral was made for a routine flexible cystoscopy which is also reasonable. At no point in this process was there any test or result or reported symptom that suggested the presence of a bladder tumour and so I believe the standard of care was met. However as far as I can tell this request for a flexible cystoscopy was never acted upon.

It was over 6 months from the original request for a flexible cystoscopy before the second referral was made from the gynaecologists who had performed an Ultrasound exam for vaginal bleeding and found a bladder tumour on the scan. A routine flexible cystoscopy should have been performed within 6 months particularly as it was an internal referral by the urology registrar. This request simply appears to have gone missing. This is a departure from the expected standard of care which I would regard as significant. I have been asked to make comment about how this could be avoided in the future. If the clinic had the flexibility just to do the flexible cystoscopy there and then on the spot the delay could have been avoided. Otherwise better systems need to be in place to ensure bookings are made and paperwork is not lost.

2) Whether the actions taken in response to [Patient D's] CT scan of 28th February 2017 was reasonable in the circumstances. In particular, please comment on the time taken for [Patient D] to receive an appointment for surgery following the CT scan

On 27th January 2017 an US scan for a separate issue found an incidental bladder tumour. There is no history of haematuria documented. A referral was made within 4 days and the case was discussed in the MDM meeting (8th February 2017) even before the patient was seen. The outpatient appointment was within 4 weeks of referral (20th February 2017). A CT was appropriately ordered and performed within 8 days and an anaesthetic assessment was made on the same day as the outpatients. Urine cytology also confirmed that this was highly unlikely to be a high grade tumour. Definitive surgery was performed within 6 weeks of the outpatients' appointment. Histology confirmed this to be a low grade tumour.

This second episode is a separate urological issue from the first episode. From referral to treatment including appropriate investigations discussion at the MDM, anaesthetic assessment has been completed within 62 days and I feel a very high standard of care has been achieved. Follow up including regular surveillance cystoscopies and further removals of bladder tumour recurrences if they arise is absolutely standard care.

3) Other Matters

I note the invitation to contact [Mr J] (Service Manager) in the letter to [Patient D] of 31 May 2017 (Ref 80171). I note also the frustration expressed in the letter of 21 July 2017 from [the] patient advocate on behalf of [Patient D] in that multiple attempts to contact [Mr J] by [Patient D] were unsuccessful. Subsequently it transpired that [Mr J] was no longer employed in that capacity after a DHB reorganization. This is really very poor communication on behalf of the DHB when they are already dealing with someone who was upset with regards (perceived) delays in the management and treatment of her bladder tumour. Surely someone knew that this offer to contact [Mr J] was never going to work and the DHB could have done better than this.

Conclusion

The failure to book the flexible cystoscopy to complete the investigations for incomplete bladder emptying falls below the expected standard of care and is a significant departure from the expected standard of care. Patients booked for investigations should have them completed in an appropriate time frame. Had this happened it is conceivable the bladder tumour would have been detected earlier.

The second referral after the US scan and subsequent investigation and treatment and follow up actually represents a high level of care delivered in an appropriate time frame. The ongoing follow up is routine in this type of low grade tumour (as they can recur) and not due to poor or tardy management.

Southern DHB should have done better than to invite [Patient D] to discuss her issues with someone who was no longer employed in that role. This must have been extremely frustrating for [Patient D].

Jonathan Masters

NZMC number 26350

June 5 2018

Addendum

In your report, you note that it took just over 11 months for [Patient D] to be seen in the Urology Outpatients, which is a long wait for a first specialist appointment. You have not stated whether you consider this a departure from the accepted standard of care. Are you able to advise on this?

It is a long wait and I would consider this a mild departure from expected care. However the delay between the appointment and the urodynamic study was remarkably short and so in essence from referral to urodynamic study of around one year is actually reasonable. This lady had an 11 month then 1 month wait rather than the more usual 4 month and then 6 month wait. I hope that answers the question."