District Health Board

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC00116)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary 1
Complaint and investigation 2
Information gathered during investigation 2
Opinion: District health board 9
Opinion: Ms B — adverse comment 13
Changes made since events 15
Recommendations 16
Follow-up actions 17
Appendix A: Independent clinical advice to Commissioner 18

Executive summary

1. This report concerns the care provided to a six-year-old boy by the ophthalmology service at a district health board. In particular, it highlights the long waiting times and delays that occurred before the boy was seen by the service after he began to experience symptoms of reduced vision. He waited six months for an appointment before being seen by a private ophthalmologist and subsequently being diagnosed with a brain tumour.

Findings

2. The Deputy Commissioner found multiples issues in the care the DHB provided, in particular:

- His initial referral was missed because eligibility needed to be checked, and referrals were accepted on the date on which eligibility was confirmed. This led to a delay of nearly a month in being placed on the waitlist;
- Both his referrals were graded incorrectly by an orthoptist, against referral management guidelines that did not provide guidance around red flag symptoms, and without the direct supervision of an ophthalmologist; and
- The DHB failed to meet the Ministry of Health's Patient Flow Indicators, which stipulate that all patients accepted for a first specialist assessment (FSA) should be seen within four months of the date of the referral.

3. The Deputy Commissioner found that all of these issues led to an unacceptable delay in the boy being seen by an ophthalmologist at the DHB, and considered that the issues were a result of a service delivery failure. Accordingly, she found that the DHB breached Right 4(1) of the Code.

4. The Deputy Commissioner was also critical of the individual errors made by the orthoptist when grading two referrals. However, the Deputy Commissioner considered that the system in which the orthoptist was working at the time was flawed, and appropriate guidelines and supervision to support her practice were not in place.

Recommendations

5. The Deputy Commissioner recommended that the DHB provide HDC with an independent evaluation of the systems in place to identify and prioritise overdue FSA ophthalmology patients; undertake a random audit of paediatric ophthalmology referrals over a three-month period to ensure that they have been graded appropriately; and consider the independent advisor's comments regarding alternative care options.

6. The Deputy Commissioner recommended that the orthoptist undertake further training through the DHB on the new grading guidelines.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided to her son, Master A, by a district health board (DHB). The following issue was identified for investigation:

- *Whether the DHB provided Master A with an appropriate standard of care in 2019.*

8. The parties directly involved in the investigation were:

Mrs A	Complainant/consumer's mother
DHB	Provider

9. This report is the opinion of Deputy Health and Disability Commissioner Dr Vanessa Caldwell, and is made in accordance with the power delegated to her by the Commissioner.

10. Further information was received from:

Ms B	Orthoptist
Private practice eye clinic	
The Ministry of Health	

11. Ophthalmologist Dr C is also mentioned in this report.

12. Independent expert advice was obtained from an ophthalmologist, Associate Professor Shuan Dai (Appendix A).

Information gathered during investigation

Background

13. This report concerns the care provided to Master A (aged six years at the time of events) by the DHB ophthalmology service. In particular, it concerns the long waiting times and delays in being seen by the service when Master A began to experience symptoms of reduced vision. He waited six months for an appointment before being seen by a private ophthalmologist and subsequently being diagnosed with a brain tumour.

First referral — 6 June 2019

Receipt of referral

14. On 6 June 2019, Master A's general practitioner (GP) sent an electronic referral for an outpatient paediatric ophthalmology appointment at a main centre public hospital, as Master A had worsening eye symptoms. The referral was then forwarded to another DHB, as the family lived within its catchment. The referral stated:

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

> "Right eye amblyopia [reduced vision in one eye] — appreciate your review of this 6 year old male with right eye amblyopia on lateral/horizontal gaze.[1] Mother had noted this develop over last 1 year but more severe in past 1–2 months. Denies any reduction in [visual acuity]. [Visual acuity right eye] 6/6,[2] [visual acuity left eye] 6/6 …"

15. The DHB told HDC that an eligibility report process should have been carried out upon receipt of the referral to ensure that Master A was eligible for publicly funded health care, as he was residing in New Zealand on an overseas passport. However, this did not occur owing to an "administrative oversight".

16. The DHB stated that initially Master A's referral was flagged for the eligibility report process when the referral was received, but, possibly because of the volume of work at the time, Master A's name was missed by the eligibility team. As a result, Master A was not placed on the waitlist for an appointment at this point.

Grading of referral

17. On 8 June 2019, the referral was graded by an orthoptist,[3] Ms B,[4] as a "P3" (priority three), meaning that Master A was to be seen within 12 weeks. Ms B told HDC that this was based on the limited information available on the referral, that the referral stated that there were concerns regarding reduced vision in one eye (amblyopia) despite Master A's visual acuity (as tested at the GP) being good in both eyes, and that the symptoms had been present for at least one year. On receipt of Master A's second referral (discussed below), it was discovered that the GP had meant "crossed eyes" (strabismus) rather than amblyopia.

18. The Clinical Head of Ophthalmology at the DHB told HDC that it is normal practice for orthoptists to assess referrals, and he had no concerns regarding Ms B's ability to assess and grade referrals appropriately. He noted that given the length of time the symptoms had apparently been present (one year), this referral contained no other red flags to indicate that Master A needed to be seen urgently, and he considered that the grading of P3 was appropriate.

19. Ms B noted that referral grading in many public hospitals is done by orthoptists, owing to the limited availability of paediatric ophthalmologists and because paediatric ophthalmologists are not available on a daily basis to grade referrals. She stated that the DHB has two orthoptists and one paediatric optometrist so that all paediatric referrals are graded in a timely manner. She told HDC that if there are any uncertainties about a referral, she seeks advice from a paediatric ophthalmologist.

20. Ms B did not seek advice about the grading of this referral.

---

[1] Looking to the right or to the left in the horizontal plane.

[2] 6/6 vision means that a person can see at a distance of 6 metres what an average person also sees at the same distance, and is the New Zealand equivalent of "20/20".

[3] Orthoptists specialise in the evaluation and treatment of eye movement problems and binocular vision.

[4] Ms B has been an orthoptist for many years. She told HDC that on average, she grades 2,000 referrals per year.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Confirmation of eligibility

21. The DHB told HDC that to identify anyone who may have been missed (flagged for the eligibility process but not yet completed), the eligibility report is re-run each month. This was next done on 26 June 2019, and the report identified that Master A had been missed from the process.

22. On the same day, a letter was posted to Mrs A requesting documents to confirm Master A's eligibility for publicly funded health care. Mrs A told HDC that she is a New Zealand-born citizen, and the family resides in New Zealand permanently. She stated that upon receiving the letter questioning Master A's eligibility, she went to the DHB the following day (1 July 2019) to provide all the relevant documents, including passports, birth certificates, and marriage certificates.

23. The DHB told HDC that the date on which eligibility is confirmed is used as the date of acceptance of the referral (the starting date used for the waitlist), and that this is standard practice. As such, despite the referral having been made on 6 June 2019, the date of acceptance and start date for the waitlist was 1 July 2019.

24. On 4 July 2019, a further letter was posted to Mrs A confirming receipt of the referral for an Ophthalmology appointment. The referral stated:

> "You have been referred to the Ophthalmology team. The Specialist has given your referral a priority of 3 and the approximate wait time for an appointment is 5 weeks."

Second referral — 26 August 2019

25. By 26 August 2019 (approximately 11 weeks from the date of the first referral and over seven weeks from the date on which eligibility was confirmed), the family had not heard from the DHB and had not been given an appointment. They saw another GP, and a second referral was sent to the main centre public hospital, which in turn was forwarded to Master A's DHB. This referral stated:

> "4/12 [four months] ago noted eyes convergent. Saw GP, saw Optometrist, back to GP, [referred to the DHB]. Referral acceptance delayed by 6/52 [six weeks] for Eligibility proof letter as is on [overseas] Passport. Past 2/12 [two months] getting occipital headaches[5] 2–3x a month … New squint. New occipital headaches …"

26. The referral was received by the DHB on 28 August 2019. It was re-graded by Ms B as a "P2" (to be seen within four weeks) as per the DHB's referral management guideline at the time, which stated that for a child aged between three months and eight years with a squint, the priority should be a P2. The guideline did not contain detail about what to do if there were any accompanying red flags such as headaches or double vision. Ms B did not seek advice about the grading of the second referral.

[5] A distinct type of headache characterised by piercing, throbbing, or electric-shock-like chronic pain in the upper neck, back of the head, and behind the ears, usually on one side of the head.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

27. No letter was sent to Mrs A to advise her of Master A's new priority status.

28. The Clinical Head of Ophthalmology at the DHB told HDC that this second referral had red flags in terms of the headache and worsening squint, despite apparent lack of refractive error[6] (as Master A had normal vision without glasses). As such, he considered that it would have been justified to re-grade the referral as a P1, to be seen within two weeks, owing to the red flags and the delays that Master A had already experienced.

29. Ms B acknowledged to HDC that the grading for the second referral was incorrect, and that it should have been a P1. She apologised sincerely for the oversight.

30. Mrs A told HDC that Master A's GP called the DHB every couple of weeks to check when the next appointment would become available. She said that they were told that the Ophthalmology Service was fully booked and there was a huge backlog for paediatric ophthalmology, and it was not even possible to provide an estimate on how long they would be waiting. She stated:

> "We were just another number, no care from the health department whatsoever. [Master A] was suffering headaches, double vision and [was] also being teased at school because he looked 'scary'."

31. The DHB told HDC that regrettably, owing to the pressures on the service at this time, patients who were graded as P2 were not being seen within the four-week timeframe.

Private appointment — 3 December 2019

32. On 27 November 2019, Mrs A and Master A presented to their local optometry clinic. Mrs A noted that Master A was struggling to read books, squinting and closing the left eye, and feeling the right eye turning in. Master A was seen by an optometrist, who noted a large right eye esotropia (a type of eye misalignment in which one or both eyes turn inward) for both distance and near reading.

33. The optometrist documented: "[A]fter discussing with [Mrs A], she would like to see a specialist privately first due to the long waiting list for the public system." A referral was then made by the optometry clinic to a private specialist eye clinic.

34. An ophthalmologist at the clinic, Dr C, saw Master A on 3 December 2019. Dr C noted that Master A had a six-month history of a squint and constant right eye esotropia, and that he had been experiencing moderate headaches every two weeks for the past five months.

35. Dr C considered that Master A was a little older than most children who present with esotropia, and so arranged for him to have an urgent CT[7] head scan at the DHB to rule out any sinister pathology.

[6] When the eye cannot focus clearly on images from the outside world.

[7] A computed tomography (CT) scan is a medical imaging technique used to obtain detailed images of the body.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

36. At this point, an appointment at the DHB had not yet been made for Master A. An appointment (for 18 December 2019) was scheduled on 9 December 2019 after it was initiated by Dr C (who was also a part-time ophthalmologist at the DHB). As Dr C had already seen and assessed Master A, Dr C requested that Master A be booked in for the first available appointment. In this case, the first available appointment was with an orthoptist, rather than an ophthalmologist.

37. The DHB stated that often there is more availability of orthoptic appointments, and therefore at times a child will be booked into one of these clinics as a first specialist assessment (FSA). This allows an initial triage and then prompt review by an ophthalmologist should there be any features of concern. The DHB considered that this was an appropriate action to take in the circumstances.

38. In response to the provisional opinion, the DHB stated that this appointment was also arranged to assess any changes in visual acuity and strabismus, and to fit a prism if needed to alleviate Master A's double vision while waiting for further investigation (such as the CT scan). The DHB stated that Dr C was available on the same day and could be consulted immediately, leaving appointments in Dr C's clinic available for other patients.

39. The DHB said that all investigations required by a paediatric ophthalmologist at a first visit had already been performed by Dr C at the private appointment, and therefore the orthoptic appointment was a follow-up rather than an FSA.

40. A letter was sent to the family to let them know that an appointment was available for 18 December 2019. By this time, it had been 28 weeks since the initial referral had been made, and 16 weeks since the second referral.

Subsequent events

41. The CT scan of Master A's head was undertaken on 20 December 2019, and a solid mass lesion (measuring 3.5cm x 3.5cm x 3.3cm) was found in the back of his brain.

42. Surgery was undertaken on 30 December 2019 for complete removal of the lesion. The lesion was sent for testing, and fortunately was found to be a benign, slow-growing tumour,[8] and no further treatment was required.

Further information

The family

43. Mrs A told HDC that she was upset that the referral process took so long, and that she had to take "a roundabout way" to get Master A seen. She stated:

> "I could have lost my son due to negligence of the system, if it wasn't for the [two people who] pushed for [Master A] to be seen I don't know what could have happened and we would probably still be waiting now."

[8] A pilocytic astrocytoma.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

44. Mrs A said that she believes things need to change, as no one deserves to be treated like just another number.

DHB

45. The DHB told HDC:

> "We apologise unreservedly for the delay [Master A] experienced in getting an appointment and for the obvious distress and frustration caused by this delay. We were pleased to hear the tumour was benign, completely excised and [Master A] has made a steady recovery from his surgery."

46. In response to the independent advice obtained by HDC (set out in Appendix A), the DHB stated that the Ophthalmology Service agrees that there has been a departure from the expected standard of care owing to the delays that occurred. The DHB acknowledged that the initial referral (dated 6 June 2019) prioritisation should have been graded as a P2, but noted that there was confusion around the clinical signs described by the GP.

47. The DHB also agreed that the second referral (dated 26 August 2019) and the extra information provided should have alerted the triaging clinician and increased the priority to P1 given the length of time since the initial referral, and knowledge of the delays that were being experienced.

48. The Ministry of Health's Patient Flow Indicators[9] stipulate that all patients accepted for an FSA should be seen within four months of the date of the referral. The data for the end of the financial year 2021 (June 2021) showed that 3.3% of patients waited longer than the required four months for their first appointment within the Ophthalmology Service at the DHB.

49. In response to a previous HDC case that raised concerns similar to Master A's case, the DHB intended that by the end of June 2019, no more than 5% of ophthalmology patients (follow-ups) would wait 50% longer than clinically recommended. The DHB stated that regrettably, despite its best efforts, this target was also not met, and over the past 12 months, 13% of people have been waiting 50% longer than recommended.

50. The DHB said that these compliance targets were not able to be met for the following reasons:

1) There is a well-recognised national ophthalmologist shortage, and an increased demand for ophthalmology services across the country due to the aging population. The DHB noted that it was unable to recruit to its budgeted FTE owing to the current COVID-19 pandemic and border lockdowns.
2) Capacity constraint within the facility. The DHB stated that expansion of its ophthalmology facilities is planned to be completed by mid-2023, and the service has

[9] https://www.health.govt.nz/our-work/hospitals-and-specialist-care/elective-services/elective-services-and-how-dhbs-are-performing/latest-summary-elective-services-patient-flow-indicators-espis.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

increased its capacity by offering weekend and evening clinics as a temporary measure until the facility expansion has been completed.

51. As a result of these events, the DHB made many changes to its Ophthalmology Service, as discussed in detail from paragraph 99. The DHB stated:

> "We trust this provides the Commissioner with some confidence that [the DHB] has taken the resourcing pressures in the ophthalmology service seriously and has taken a number of steps to address these issues. Across the … region, we are making key improvements to adapt and respond effectively to the foreseeable effects that skills shortages in the health sector will have. We will continue to strive to make improvements in this regard so that we can meet the health needs of our community."

Ms B

52. Ms B told HDC:

> "The mistakes and delays made were very unfortunate and although not an excuse, the work pressure the ophthalmology services is under and the limited availability of trained paediatric ophthalmologist and orthoptist, have contributed to the delay in care for [Master A].
>
> I hope that with some changes to our processes as discussed above, we can prevent anything like this from happening again."

The Ministry of Health

53. During this investigation, HDC wrote to the Ministry of Health (the Ministry) to raise concerns about the DHB's Ophthalmology Service, as highlighted by this case. The Ministry responded that it shares the concerns about the risks associated with long wait times for ophthalmology services at the DHB, and noted that the Ministry has been working closely with the DHB to improve waiting times for care.

54. The Ministry told HDC that the DHB has provided it with a recovery plan, which outlines plans to streamline the cataract journey, extend technician-led testing clinics, and run weekend and evening outpatient clinics, to facilitate increased access for all patients on the waiting list. The Ministry stated that this plan, in conjunction with additional funding from both the 2020 budget, and funding for the 2021/22 financial year, will support improvements and waiting list recovery in ophthalmology and other services at the DHB.

55. The Ministry stated: "Thank you for bringing this complaint to our attention, and we will continue supporting DHBs to improve ophthalmology waiting times."

Responses to provisional opinion

56. The family was given the opportunity to comment on the "information gathered" section of the provisional opinion, and had no further information to add.

57. The DHB and Ms B were provided with the opportunity to comment on the provisional opinion, and their comments have been incorporated in the report where relevant.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Opinion: District health board

Introduction

58. In June and August 2019, two referrals were sent to the DHB from Master A's GP to request an appointment for worsening eye symptoms. Despite initially being triaged with the aim to be seen within 12 weeks, and then re-prioritised following the second referral to be seen within four weeks, Master A did not receive an appointment, and so was taken by his mother to be seen by a private ophthalmologist in December 2019. The private ophthalmologist arranged for Master A to have an urgent CT head scan to rule out any sinister pathology. The scan revealed a solid mass lesion in the back of his brain, which subsequently was removed and found to be benign.

59. The DHB told HDC that there is a well-recognised national shortage of ophthalmologists and an increased demand for ophthalmology services across the country due to the aging population, and noted that this caused delays in the system.

60. My independent clinical advisor, ophthalmologist Dr Shuan Dai, acknowledged that there is chronic pressure in the provision of ophthalmology services in the DHB, especially in the area of paediatric ophthalmology. He stated that this is due to a combination of factors, namely population growth and the shortage of trained paediatric ophthalmologists in the workforce. Dr Dai advised:

> "Unless there is significant investment in the work force this unfortunate incident [is] likely to repeat.
>
> In [Master A's] case the delay was not acceptable by today's standard[s], and there are obviously system issues that can be improved."

61. As this Office has stated previously, the Ministry of Health has a role, with DHBs, to recognise the effect of pressures on the system, and plan accordingly. However, the existence of systemic pressures does not remove provider accountability in addressing such issues. A key improvement that all DHBs and the Ministry of Health must make, now and in the future, is to assess, plan, adapt, and respond effectively to the foreseeable effects that issues such as population change will have on systems and demand.

62. This is not the first time HDC has investigated matters relating to delays in the DHB's ophthalmology services that have impacted negatively on a consumer. It is concerning that, despite the changes made as a result of this earlier matter, we are still seeing negative impacts on consumers because of delays in the service. It is clear that there are still systems issues at the DHB that need to be addressed.

Care provided to Master A — breach

Processing of Master A's referral

63. Master A's initial referral from his GP was sent on 6 June 2019. The DHB told HDC that an eligibility process should have been carried out on receipt of the referral, to ensure that Master A was eligible for publicly funded health care. However, Master A's name was missed

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

by the eligibility team, and the DHB noted that this may have happened because of the volume of work at the time. The omission was discovered on 26 June 2019 during a re-run of the eligibility report, and Master A's eligibility information was provided to the DHB on 1 July 2019.

64. The DHB told HDC that the date on which eligibility is confirmed is used as the date of acceptance (the date on which the waitlist starts), and that this is standard practice. As such, despite the referral having been made on 6 June 2019, the start date for the waitlist was 1 July 2019.

65. Dr Dai advised that this practice exposes patients to unnecessary risks, given that potential delays in processing referrals cannot be avoided entirely. He considers that it would be better to accept the referral where all necessary documentation is provided, or reject the referral if information or documentation is missing. Dr Dai stated that this way, the referring doctor or the patient will take appropriate action sooner, such as seeking alternative care or providing the DHB with the required documentation.

66. I agree with this advice, and consider that with delays already occurring in the system owing to demand and capacity issues, the DHB's eligibility process risked creating further delays for patients. In this case, despite Master A being eligible for publicly funded health care, the administrative oversight by the DHB meant that Master A's referral was not actioned for 20 days. This was then compounded by the DHB's standard practice of using the date on which eligibility is confirmed as the date of acceptance. Despite Mrs A providing the required documents the day after being notified that they were needed, the process created almost a month's delay in Master A being placed on the waitlist.

67. I note that the eligibility process at the DHB has since been changed (discussed below), and it now allows for patients to be graded and waitlisted at the same time, and potentially to be seen while awaiting eligibility checking. I consider this appropriate.

Priority of referrals

68. Both of Master A's referrals were graded by an orthoptist, without the direct supervision of an ophthalmologist. Dr Dai noted that it is an acceptable practice to use orthoptists for referral triaging in many public hospital paediatric eye services across Australia and New Zealand. However, he said that there needs to be clearly defined protocol or guidelines that outline which paediatric eye conditions should be classified as which priority. He stated:

> "I recognise both public and private health systems are under immense pressures due to the ever increasing demand. Appropriate utilisation of allied health work force, e.g. orthoptists, is the right approach to help with such demand, however supervision and strict protocols must be followed to safeguard patients' wellbeing in the execution of such a model of care."

69. Master A's initial referral from his GP noted that Master A had right eye amblyopia on lateral/horizontal gaze, which had become more severe over the past one to two months.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

70. On 8 June 2019, the referral was graded by Ms B as a "P3" (priority three), to be seen within 12 weeks. Ms B told HDC that this was based on the limited information available on the referral, and the fact that the referral stated that there were concerns regarding amblyopia (reduced vision in one eye) despite Master A's visual acuity (as tested by the GP) being good in both eyes. Subsequently it was discovered that Master A's GP meant "strabismus" (crossed eyes) instead of "amblyopia".

71. Dr Dai considered that, had an ophthalmologist graded this referral, they would not have interpreted "a right eye amblyopia on lateral/horizontal gaze" to mean amblyopia rather than strabismus. He stated that "this difference merely reflects the depth of knowledge between an ophthalmologist and an orthoptist". Dr Dai advised that this referral should have been graded as a P2, rather than a P3.

72. On 28 August 2019, the DHB received another referral from Master A's GP. This referral stated that Master A's eyes had been noted to be convergent four months previously, and that acceptance of the referral had been delayed. The referral noted that Master A was getting new occipital headaches, and had developed a new squint.

73. On receipt, Master A's referral was re-graded by Ms B as a "P2" (to be seen within four weeks) as per the DHB's referral management guideline at the time, which stated that for a child aged between three months and eight years with a squint, the priority should be a P2.

74. Dr Dai advised that this referral should have been graded as a P1, given the worsening convergent strabismus and new symptom of a headache. The Clinical Head of Ophthalmology at the DHB and Ms B have both reflected on this grading, and agreed that it would have been justified to re-grade the referral as a P1, to be seen within two weeks, due to the red flags (headaches and worsening squint) and the delays that Master A had already experienced.

75. I note that at the time of the events, the DHB's referral management guideline stated that for a child of Master A's age with a squint, the priority should be a P2. There was no guidance around red flag symptoms such as headaches.

76. I acknowledge that it is acceptable practice to use orthoptists for referral triaging, but I consider that thorough guidelines were needed to ensure that referrals were being graded appropriately.

77. In addition, I consider that greater supervision by ophthalmologists was needed for this referral process. I note Dr Dai's comments that the incorrect grading of Master A's referrals reflected the difference in depth of knowledge between an ophthalmologist and an orthoptist. While Ms B is an experienced orthoptist, and she told HDC that if she had any uncertainties about a referral, she would ask advice from a paediatric ophthalmologist, this process relied on the orthoptist always recognising the limits of their knowledge and being able to identify when something is in need of escalation. Put simply, if you do not recognise an issue, you do not know to ask.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Timeframe for an FSA

78. As stated above, Master A's initial referral was graded as a P3, with the aim for him to be seen at the DHB (as a first specialist appointment) within 12 weeks. Master A was placed on the waitlist on 1 July 2019. Based on the P3 triage for the initial referral, Master A should have been seen by the end of September 2019. However, despite a second referral being sent, which alerted the DHB to worsening symptoms and red flags, and a reprioritised grading of his referral, Master A had not been offered an appointment by December 2019. He was finally offered an appointment for 18 December 2019 at the request of Dr C, whom he had seen privately.

79. By this time, it had been 28 weeks since the initial referral had been made, and 16 weeks since the second referral.

80. The Ministry of Health's Patient Flow Indicators stipulate that all patients accepted for an FSA should be seen within four months of the date of the referral. The DHB failed to meet this timeframe for Master A.

81. I am very critical of the length of time it took for Master A to be seen at the DHB for an FSA, noting that Master A's symptoms could well have been indicative of a health issue that was time sensitive. It is unclear when he would have received an appointment had Dr C not intervened, and concerning to consider how long Master A may have continued to wait for an FSA at the DHB had Mrs A not taken him to see a private ophthalmologist in December 2019.

Conclusion

82. As set out above, many aspects of the care provided to Master A by the DHB fell below accepted standards. Overall, this led to an unacceptable delay in Master A being seen by an ophthalmologist at the DHB.

83. Dr Dai advised that, in his view, there was a moderate departure from the accepted standard of care in the clinical management of Master A's case, owing to a number of delays, including the eligibility checks, triaging, and clinical appointment time.

84. I agree. It is concerning that in order to receive treatment within a reasonable timeframe, Master A's family had to seek care privately. While I acknowledge that demand for this service exceeds capacity, the key concerns in this case also relate to the way in which the service is run.

85. I consider that in this case, the issues were a result of a service delivery failure, for which, ultimately, the DHB is responsible. Accordingly, I find that the DHB breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[10]

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

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

18 December 2019 appointment — other comment

86. On 3 December 2019, Master A saw ophthalmologist Dr C at a private clinic. Dr C was concerned about Master A's symptoms considering his age, and arranged for him to have an urgent CT head scan at the DHB to rule out any sinister pathology. Dr C then requested that Master A be seen by the DHB's Ophthalmology Service and that he be booked in for the first available appointment. In this case, the first available appointment was with an orthoptist, rather than an ophthalmologist.

87. In response to the provisional opinion, the DHB stated that this appointment was also arranged to assess any changes in visual acuity and strabismus, and to fit a prism if needed to alleviate Master A's double vision while waiting for further investigation (such as the CT scan). The DHB said that Dr C was available to be consulted that day, and Dr C had completed all required investigations privately, and therefore this appointment was a follow-up rather than an FSA. The DHB told HDC that it considered this to have been an appropriate action in the circumstances.

88. However, my independent advisor, Dr Dai, considers that the DHB appointment with an orthoptist rather than with a paediatric ophthalmologist was not appropriate given Master A's worsening symptoms of strabismus and headaches. He stated:

> "I think it is appropriate for an orthoptist to see patients first if they were triaged to the level of knowledge and skill sets of the orthoptist. In [Master A's] case the December appointment with an orthoptist was not appropriate as the child obviously had a potential condition requiring clinical skills beyond what an orthoptist can safely offer."

89. I have considered this advice, as well as the explanation given by the DHB in relation to this appointment. I am mindful that at this point, Master A had already been seen by a private ophthalmologist and work was underway to have his symptoms investigated properly. The purpose of this appointment was not to investigate further or respond to Master A's worsening symptoms of strabismus and headaches — it was to assess any changes and alleviate symptoms while these were being investigated. I consider this action appropriate.

Opinion: Ms B — adverse comment

90. Ms B was the orthoptist at the DHB who graded both of Master A's referrals in this case. Ms B is an experienced orthoptist and told HDC that on average she grades 2,000 referrals per year.

91. Master A's first referral was graded as a P3 by Ms B on 8 June 2019. Ms B told HDC that her decision to grade the referral as a P3 was based on the limited information available on the referral, the fact that the referral stated that there were concerns regarding amblyopia (reduced vision in one eye) even though Master A's visual acuity had been noted to be good in both eyes, and that the symptoms had developed over the last year. The DHB has since

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

acknowledged to HDC that this initial referral prioritisation should have been a P2, but noted that there was confusion around the clinical signs described by the GP ("amblyopia" when he meant "strabismus" (crossed eyes)).

92. On receipt of Master A's second referral, on 28 August 2019, Ms B re-graded Master A's priority from a P3 to a P2 (to be seen within four weeks) as per the DHB's referral management guideline at the time.

93. The Clinical Head of Ophthalmology at the DHB told HDC that it would have been justified to re-grade the referral as a P1, to be seen within two weeks, due to the red flags (headaches and worsening squint) and the delays that Master A had already experienced. Ms B acknowledged to HDC that the grading for the second referral should have been a P1, and sincerely apologised for this oversight.

94. My independent ophthalmology advisor, Dr Dai, considers that the first referral should have been graded as a priority 1 or 2, and that the second referral should have been flagged as a priority 1, given the worsening symptoms and the new symptom of a headache. Dr Dai stated:

> "Appropriate utilisation of allied health work force, e.g. orthoptist, is the right approach to help with such demand, however supervision and strict protocols must be followed to safeguard patients' wellbeing in the execution of such a model of care."

95. I accept this advice. Ms B told HDC that if there are any uncertainties about a referral, she will seek advice from a paediatric ophthalmologist. However, despite the confusion created by the wrong terminology in the initial referral, Ms B does not appear to have sought advice. Dr Dai said that an ophthalmologist would not have interpreted the initial GP referral as amblyopia rather than crossed eyes (which would have triggered a P2 categorisation), and noted that "this difference merely reflects the depth of knowledge between an ophthalmologist and an orthoptist".

96. Regarding the grading of the second referral, I acknowledge that at the time, the DHB's referral management guideline stated that for a child aged between three months and eight years with a squint, the priority should be a P2. Ms B told HDC that her grading was based on this guideline. However, I note that the guideline did not contain information on red flags. Although the guideline has since been amended to state that if there are any red flags (such as headaches, double vision, or a child aged five years or above), the grading will be P1, I consider that this information should have been in place at the time of events.

97. I am critical of the individual errors made by Ms B when grading Master A's two referrals. However, I have carefully considered the system in which she was working at the time, and, in my opinion, this was flawed. I consider that appropriate guidelines and supervision to support Ms B's practice were not in place at the time, and, as such, I do not find her in breach of the Code for these errors. I do, however, expect her practice to include increased oversight and review of decisions to support her ongoing learning and reduce future errors.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Changes made since events

98. Following these events, the DHB made a number of changes, which are outlined below.

Process of eligibility checks

99. Since these events, the DHB has agreed to adopt the same process for eligibility checks as another DHB, in which patients are graded and waitlisted at the same time, and can potentially be seen while awaiting eligibility checks. A new eligibility process was defined, and has been in place at the DHB since 2021.

Grading guidelines

100. The grading guidelines were updated in 2021, and the priority rating for a child with a squint is now P2 (as opposed to a P2 for ages three months to eight years, and a P3 for ages eight years and above). The revised guidelines also state that if there are any red flags such as headaches, double vision, and a child aged five years or above, the grading will be P1.

Triaging of second referrals

101. Two paediatric ophthalmologists will now be responsible for reviewing and triaging all paediatric re-referrals at the DHB. In addition, the Paediatric Ophthalmology team is developing a process to audit the referral grading to ensure consistency and safety.

Overdue paediatric appointments

102. As a result of Master A's experience, all overdue paediatric referrals were reviewed and re-triaged immediately to identify any patients at risk. Six additional custom paediatric clinics were set up in 2019 to clear the waitlist.

Communication to referrers, patients, and family

103. All clinic consultation outcome letters (sent to referrers and patients) were revised to advise patients of delayed follow-up appointments and what to do should their vision deteriorate or should they have any concerns regarding their vision. The DHB will explore whether this information should also be added to the Wait List Acknowledgement letters.

104. The DHB told HDC that almost 50% of all correspondence to patients/families is now done via text messaging and emailing, and that this number is increasing yearly. It stated that as a backup, when an email is sent and not opened within five days, this is detected and a printed letter is automatically mailed out. It advised that all internal and external referrals are electronic, and the response and advice to the referrer is immediate.

Demand and available resources

105. The DHB noted that it is aware that demand exceeds the available resources, and that there is no quick fix for this. In order to address the present demand, the Ophthalmology Service has been running additional weekend clinics (with approximately 600 patients being seen over the two days), and running additional clinics during the week, including evenings. It has increased the number of clinics on the DHB site, with up to three clinics running five days a week.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

106. Over the period of December 2019 to March 2020, more optometrists and ophthalmologists commenced employment at the DHB.

107. In response to the provisional recommendations, the DHB provided HDC with a detailed update report on the progress of the work being done alongside the Ministry. In this report, the DHB outlined that it had made further changes to its workforce; implemented a new "Cataract Pathway", which has reduced the average waiting time for cataract surgery; it will be initiating a community-based eye clinic, which it anticipates will free up the DHB for more complex patients; it is currently reviewing potential options to extend "Technician-Led Clinics" to cope with the increasing demand for eye care; and it has arranged additional theatre sessions for surgery.

Referrals from GPs

108. GPs have since received training from one of the DHB's paediatric ophthalmologists on how to improve the quality of referrals. In addition, the DHB told HDC that it now accepts only e-Referrals, and that there is an ability to request additional information from the referrer in the event that the referral form lacks clarity and/or detail. The DHB stated:

> "If, despite our best efforts to obtain clarification from the referrer [and] the appropriate grading is still in doubt, we err on the side of caution and accept the referral."

Apology letter

109. On 2 April 2020, the DHB provided a formal written apology letter to the family for the events of this case.

Recommendations

110. In response to the proposed recommendations, the DHB provided HDC with a detailed update report on the progress of the work being done alongside the Ministry. In addition, I recommend that the DHB:

a) Provide HDC with an independent evaluation of the systems in place to identify and prioritise overdue FSA ophthalmology patients. Evidence that this has been planned is to be sent to HDC within three months of the date of this report. The DHB is to send HDC the outcome of this evaluation once available.

b) Undertake a random audit of the paediatric ophthalmology referrals over a three-month period immediately preceding the date of this report, to ensure that they have been graded appropriately. The outcome of this audit is to be sent to HDC within six months of the date of this report. Where the outcome of the audit does not show satisfactory compliance with the DHB's updated grading guidelines, the DHB is to report to HDC on further changes it will make to address this.

c) Consider my independent advisor's comments that given the current pressure of workforce shortages, it may be worthwhile to advise parents in a timely fashion that alternative care options are available (such as private providers, or other public facilities for semi-urgent or urgent referrals). The DHB is to report back to HDC on the outcome of this consideration, and any changes made as a result, within three months of the date of this report.

111. I recommend that Ms B undertake further training through the DHB on the new grading guidelines. Evidence that this has been done is to be sent to HDC within three months of the date of this report. In response to the provisional opinion, the DHB advised that training will also be provided to other orthoptists and paediatric optometrists, and a regional level training session is also being arranged.

Follow-up actions

112. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Royal Australian and New Zealand College of Ophthalmologists (RANZCO), the Ministry of Health, the Royal New Zealand College of General Practitioners, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from an ophthalmologist, Associate Professor Shuan Dai:

"**RE: Complaint: the DHB**

Our ref: C20HDC00116

My name is Shuan Huai Dai, and I am a fully qualified Medical Practitioner, Vocationally registered with the New Zealand Medical Council in the branch of Ophthalmology (NZ Medical Council 22582) and the Australian Health Practitioner Registration Authority (AHPRA MED0002190278).

I am a Fellow of the Royal Australian and New Zealand College of Ophthalmologists, a Member of the American Academy of Ophthalmology and a Member of the American Association of Paediatric Ophthalmology and Strabismus. I serve as the current president of the Australian & New Zealand Strabismus Society. I am the current Director of Ophthalmology at Queensland Children's Hospital, Brisbane, Australia and an Associate Professor, School of Medicine, University of Queensland.

I have a special interest and clinical expertise in paediatric ophthalmology & adult strabismus surgery. I am one of only a few fellowship trained paediatric neuro-ophthalmologists (brain disease & eye) in the world. I was the lead paediatric ophthalmologist in Auckland, New Zealand for the last 13 years prior to moving to Brisbane in late 2018. …

I do not have a personal or professional conflict of interest in this case. When preparing this report, I understand that my overriding duty is to HDC. I have read HDC's Guidelines for Independent Advisors for expert witnesses and I agree to be bound by it.

In the process of preparation of this report I have had access to the following documents:

1. Letter of complaint dated 15 January 2020
2. [The DHB's] response dated 2 April 2020
3. Clinical records from [the DHB] covering the period of June–December 2019
4. [The DHB's] Eligibility Process

Background history:
[Master A] was referred to [the DHB] Ophthalmology on 6 June 2019 with 'a right eye amblyopia on lateral/horizontal gaze' (I suspect that was meant to say strabismus) with a gradual onset over a 12 month period, worsening in the proceeding 1–2 months. [Master A] was reported to have good visual acuity (6/6 each eye).

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The referral was triaged by an orthoptist as P3 (which indicates a clinic appointment within 8 weeks according to [the DHB] triage & appointment process) on the 8th June 2019.

[Master A] was not added on the waiting list until 1st of July 2019 due to 3 weeks delay in his eligibility assessment process which we now know was an administrative error.

[Master A] hadn't received any appointment letter so a second referral was made by his GP on the 26th August 2019 with the information of 'worsening convergent strabismus and headache'. [Master A's] waiting list was upgraded to P2 on the 29th August 2019.

[Master A] was seen in an orthoptist clinic on the 18th of December 2019 and by then he had already been seen privately by an ophthalmologist in early December 2019 and a CT scan had been organised for 20 December 2019. The CT scan identified a posterior fossa tumour with enlarged 4th ventricle and he subsequently was urgently referred to Starship where he had successful surgery for removal of the brain tumour. I believe [Master A] made a speedy recovery afterwards with no visual loss.

Comments:
In my view there has been ***a moderate departure from standard care*** in the clinical management of [Master A's] case due to a number of delays. These include the eligibility checks, triaging and clinical appointment time.

Firstly the delay in the processing of his referral due to an administrative error in eligibility clearance which later was confirmed to be an administrative error.

Secondly [Master A's] strabismus should have been considered as acquired strabismus given he had nil strabismus before age 5 & this should have been a 'red flag', therefore to be considered as priority 2, or 1, instead of Priority 3 in my experience.

The re-triage after the second referral on the 26th August should clearly be flagged out as Priority 1 given the 'worsening of convergent strabismus' and new symptoms of 'headache'.

Lastly, there is a significant delay in allocating a clinic appointment for [Master A]. Even based on the initially triaged priority P3 (1st July 2019), which means that [Master A] should have been seen at least before the end of September 2019. However his appointment only occurred on the 18th of December 2019. Further, the [DHB] appointment provided for [Master A] on the 18th of December 2019 was an orthoptist appointment, rather than a paediatric ophthalmologist and this was not appropriate given [Master A's] worsening of symptoms 'worsening convergent strabismus, headaches'. Had [Master A's] family not taken him to see a private ophthalmologist there would have been a further delay in [Master A's] diagnosis & subsequent management.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Specific comments:

1. The triaging and grading of the referral when it was first received in June 2019 and whether the consumer should have been seen earlier.

It is an acceptable practice to use orthoptists for referral triaging in many public hospital paediatric eye services across Australia and New Zealand. However there needs to be clearly defined protocol/guideline that defines which paediatric eye conditions should be classified as priority 1, 2, or 3. e.g. referral with failed red reflex should be considered as priority one and to be seen within 1 week and similarly 'acquired strabismus in a child' should be considered priority 1, or 2 at least. Orthoptist triage should be supervised by an appropriate ophthalmologist given not all referrals are straightforward, which is clearly shown in this case.

2. The adequacy and timeliness of eligibility process in this case.

I think the time taken for eligibility check was clearly delayed and one wonders in [Master A's] case if this was necessary given [Master A] was born in NZ to an NZ mother and an [overseas-born] father. By default he is entitled to access to public health care.

3. The re-triaging of the second referral received in August 2019.

See answers above to question 1.

4. Any other matters you consider warrant comment.

I agree with the replies provided by [the CMO and the Director of Ophthalmology] that there is chronic pressure in the provision of ophthalmology services in [the DHB], especially in the area of paediatric ophthalmology. This was due to a combination of factors of the population growth and shortage of trained paediatric ophthalmology work force. Unless there is significant investment in the work force this unfortunate incident will be likely to repeat.

In [Master A's] case the delay was not acceptable by today's standard and there are obviously system issues that can be improved.

I recommend [DHB] Ophthalmology to consider developing a triage guideline for paediatric referrals so conditions that warrant a Priority appointment can be flagged outright from the beginning of the referral process; conduct periodic clinic auditing to ascertain current referral triaging is safe and effective.

Given the pressure of work force shortage is unlikely to ease any sooner it may be worthwhile to advise parents in a timely fashion to seek alternative care options, such as private providers, or other public facilities such as … for semi urgent, or urgent referrals such as [Master A's], to avoid delay in diagnosis of sight and life threatening conditions.

Dr Shuan Dai MBBS, MSc, FRANZCO."

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The following further advice was obtained from Dr Dai:

"**RE: Complaint: [the DHB]**

Our ref: C20HDC00116

Thank you for asking me for further comments on [Master A's] case following extensive case review by [the DHB].

In the process of preparation of this report I have had access to the following documents:

1. Letter of complaint dated 15 January 2020
2. [The DHB's] response dated 2 April 2020
3. [The DHB's] response 21st September 2021
4. [The DHB's] response 21st April 2021 including reply letter from [Ms B]
5. Expert report by Shuan Dai dated 26th December 2020
6. Clinical records from [the DHB] covering the period of June–December 2019
7. [The DHB's] revised eligibility process & triaging flow chart

Firstly I commend the [DHB] for striving to improve its ophthalmology service delivery since [Master A's] case and the most recent reports of demonstrated actions taken in this regard.

I here outline below specific comments to your questions.

1. *Whether the explanation for the December appointment being with the orthoptist changes any aspects of your initial advice;*

I don't think [the DHB's] explanation is sufficient to justify the 'December 2020 appointment being an orthoptist rather than a paediatric ophthalmologist' as I indicated in my previous report, therefore the [DHB] reports don't change my previous advice.

2. *Any comments you wish to make on [the DHB's] statement that the process of using the date of a patient's eligibility being used for the date of acceptance was usual practice at the time of these events (rather than using the date of the referral);*

I think such practice will expose [the DHB] to potential legal liabilities, and patients to unnecessary risks given potential delays in processing referrals can't be entirely avoided. A better way would be either accepting the referral if all necessary documents are provided, or rejecting the referral which states reasons for, e.g, missing information/documentation etc.

This way the referring doctor/patient will take appropriate action sooner including seeking alternative care, or providing [the DHB] with the required documentation. However this is a decision [the DHB] has to make based on their experiences.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

3. *Whether the care provided by [Ms B] was within accepted standards, noting her rationale for grading [Master A's] first referral as a P3;*

[Ms B] is a very experienced orthoptist and she has been working in [the DHB] Ophthalmology for a long time, so there is no doubt about her skills & knowledge in her practice as an orthoptist who usually works alongside an ophthalmologist. That said, I don't think an ophthalmologist would have interpreted 'a right eye amblyopia on lateral/horizontal gaze' in the initial GP referral as amblyopia rather than strabismus which would trigger a 'P2' categorization. This difference merely reflects the depth of knowledge between an ophthalmologist and an orthoptist.

However, I do acknowledge [the DHB] has since made changes to their protocols in triaging paediatric eye referrals with close ophthalmologist supervision.

4. *Any comments you wish to make on [the DHB's] usual process of having an orthoptist see the patients first;*

I think it is appropriate for an orthoptist to see patients first if they were triaged to the level of knowledge and skill sets of the orthoptist. In [Master A's] case the December appointment with an orthoptist was not appropriate as the child obviously had a potential condition requiring clinical skills beyond what an orthoptist can safely offer.

5. *Any comments you wish to make on the relevant [DHB] policies and guidelines;*

I think the [DHB's] revised policies and guidelines demonstrate clear improvements and I advise them to consider my comment in question 2 should they wish to do so.

6. *Any further comments you wish to make on this case;*

No.

7. *Any further recommendations you wish to make on this case, to prevent a similar event occurring again.*

See answers to questions 2 & 3.

I recognise both public and private health systems are under immense pressures due to the ever increasing demand. Appropriate utilisation of allied health work force, e.g. orthoptists, is the right approach to help with such demand, however supervision and strict protocols must be followed to safeguard patients' wellbeing in the execution of such a model of care.

Dr Shuan Dai MBBS, MSc, FRANZCO"

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.