MidCentral District Health Board

Capital and Coast District Health Board

A Report by the

Health and Disability Commissioner

(Case 07HDC20199)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

In December 2006, Mr B was diagnosed by MidCentral DHB general surgeon Dr C as having carotid artery disease that required specialist surgery. Dr C referred Mr B to Capital and Coast DHB vascular surgeon Dr D on 6 December 2006.

On 17 October 2007 Mr B attended his GP, who realised that Mr B had not yet been assessed by a vascular surgeon. Accordingly, the GP contacted Dr C's registrar, who sent a second referral to Dr D on 5 November 2007.

Capital and Coast DHB has no record of receiving either referral.

This report considers the standard of care provided to Mr B at MidCentral DHB, the responsibility of a referring DHB to ensure that a referral to another DHB is followed up, and the responsibility of a receiving DHB to log, acknowledge and monitor referrals.

Parties involved

Mr A	Complainant/Consumer's son
Mr B	Consumer
Dr C	General surgeon (MidCentral DHB)
Dr D	Vascular surgeon (Capital and Coast DHB)
Dr E	Registrar (MidCentral DHB)
Dr F	Consumer's GP
Dr G	Medical officer (Horowhenua Hospital)
MidCentral DHB	Provider
Capital and Coast DHB	Provider

Complaint and investigation

On 15 November 2007 the Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided to his father, Mr B, by MidCentral District Health Board. The following issue was identified for investigation:

The appropriateness of the care provided by MidCentral District Health Board to Mr B from December 2006 to December 2007, in particular the management of Mr B's referral to Capital and Coast District Health Board.

An investigation was commenced on 27 March 2008. Information was received from Mr A, Dr E, Dr F, MidCentral DHB, Capital and Coast DHB, and the Ministry of Health. Independent expert advice was obtained from vascular surgeon Professor Justin Roake.

Information gathered during investigation

After a small stroke in August 2006 at the age of 72, Mr B was referred on 3 August by his general practitioner at a medical centre, Dr F, to MidCentral DHB's Elder Health outpatient clinic at Horowhenua Hospital for further investigations. (He had not required admission to hospital.)

On 14 August 2006, Mr B was reviewed at Horowhenua Hospital by medical officer Dr G, who ordered a CT scan of the head, echocardiogram and ultrasound scan of the carotid arteries. On receipt of the results of these investigations, Dr G referred Mr B on 9 November 2006 to the vascular surgeon at Palmerston North Hospital.[1] Subsequently, Mr B was reviewed at Palmerston North Hospital by general surgeon Dr C on 5 December 2006. Dr C stated:

> "I saw [Mr B] in my Surgical Outpatient Clinic on 5 December 2006. He suffered a [stroke] a few months prior to that visit. He had left sided hemiparesis [paralysis] from which he had made a reasonably good recovery. Subsequent Duplex scan of his carotid arteries revealed right sided internal carotid artery stenosis of 70–80% on the right and 50–70% on the left side.
>
> I had a thorough discussion with [Mr B] regarding the … findings and referred him on to the Vascular Unit at Wellington Hospital for further management. We do not do carotid surgery … at Palmerston North Hospital, hence the referral. [Mr B], in the meantime, was on Aspirin and Persantin to decrease the risk of further strokes."

Dr C sent a letter on 6 December 2006, referring Mr B to vascular surgeon Dr D at Wellington Hospital, and requesting "further intervention for carotid artery stenosis".[2]

Capital and Coast District Health Board (CCDHB) has no record that this referral for vascular surgery was received, and Dr F did not receive a copy of the referral letter at the time.

[1] The referral letter was copied to Dr F.

[2] Carotid artery stenosis: A narrowing of the carotid artery.

Mr B consulted Dr F on 4 April 2007 on an unrelated matter and mentioned that he had not yet received an appointment from Wellington Hospital. The practice nurse was asked to follow this up, and subsequently sent an email back to Dr F which stated: "… apparently on list in Wellington for surgery no time line for this yet". Following a specific request from the medical centre in mid-April 2007, MidCentral DHB sent Dr F a copy of the December 2006 referral letter to Wellington Hospital.

Ten months later, on 17 October 2007, Mr B attended the medical centre and was reviewed by another doctor, who noted that Mr B "still has postural [low blood pressure] and dizziness". The doctor also noted that Mr B had not been contacted by the vascular surgeons at Wellington Hospital. Accordingly, on 18 October 2007 the doctor wrote to the surgical outpatients clinic at Horowhenua Hospital (part of MidCentral DHB):

> "Thank you for seeing [Mr B] with bilateral internal carotid artery stenosis. He has been seen by Surgery last … December and they were going to refer him to a vascular surgeon. He hasn't heard anything from them since then. I will appreciate if you can advise us on the progress of his referral or further management."

On 2 November 2007, Dr C's registrar, Dr E, wrote to Dr F:

> "Thank you very much for bringing to our attention that [Mr B] is still awaiting a vascular opinion in Wellington. I have chased up the paperwork and we note that [Dr C] had referred [Mr B] to [Dr D] in December 2006.
>
> We have organised to send another copy of this letter as it may have been lost in the system. We hope that [Dr D] can see [Mr B] on an urgent basis."

In a letter dated 5 November 2007, Dr E wrote to Dr D repeating the referral of 6 December 2006.[3] Dr E asked that Mr B be seen urgently because of the delay caused by the earlier referral having been lost. CCDHB has no record that this second referral was received.

On 11 November 2007, Mr B was admitted to Palmerston North Hospital having suffered a further stroke that affected the right side of his body.

Complaint

Mr B's son, Mr A, complained to HDC in November 2007. In his letter of complaint, Mr A asked:

> "…

[3] The referral letter of 5 November 2007 was copied to Dr F.

- How can such important communications be lost in transit on two occasions? Why is there no process in place to ensure such communications are received by the intended recipient?

- Why did Palmerston North Hospital wait a full 10 months to follow up the first letter? Surely if they did not hear after a few weeks, they should have sent an email or placed a call directly with the intended recipient.

- How can Wellington Hospital not commit to performing the potentially life saving surgery on my father now that it is obvious that there has been such a catastrophic failure on the part of the health system?

- How can the Palmerston North Hospital not commit to providing my father with the best available rehabilitation given that they jointly must shoulder the responsibility for my father's predicament?"

Mr A stated:

"My father, and indeed all New Zealand residents, are clients of the New Zealand health system … Given that my father is now severely disabled and now presumably has a much shortened life expectancy as a result of this failure on the part of the health system, I make the following recommendations:

1. The health system as a whole is declared culpable for the failure that has resulted in my father's current predicament.

2. Individual parties within the health system are identified and held accountable for this culpability.

3. A recommendation is made for my father to receive extensive compensation due to this failure.

4. An initiative is undertaken to put in place a reliable booking and messaging system within the health system that delivers an electronic message brokering system whose functional requirements include:

    - Persistence and guaranteed delivery of messages and service requests in the face of any form of failure.

    - Continued presence of said messages in each individual's work queue until the item has been completed."

District health board responsibilities

MidCentral DHB (MCDHB) has no system to check that a referral made to another district health board is received and actioned. MCDHB stated:

> "Across all services, MidCentral Health assumes that a written referral has been received. The only process that provides confirmation is when a surgeon makes direct contact with the receiving consultant, or the surgeon requests a follow-up appointment with the patient at his clinic, requested at the time of referral. …
>
> MidCentral Health receives written confirmation from the DHB once a patient has been seen or treatment completed.
>
> In order to ensure receipt of patient referrals by tertiary centres, either MidCentral Health would need an electronic flag system that raised an alert to prompt a manual investigation, or the receiving DHB would have to adjust their processes to return confirmation."

CCDHB advised HDC that all referrals come through a Booking Centre, and are registered within 24 hours of receipt before they are sent to the service for prioritisation. Once prioritised, the referrals are sent back to the Booking Centre and acknowledgement letters are sent to the patient and GP (but not the referring DHB) within 10 days.

The Ministry of Health advised HDC that, as part of its national service specification for DHB elective services, there is no specific requirement for a service receiving a referral to acknowledge receipt if the referrer is not the patient's primary care practitioner. The Ministry also advised that DHBs are required to "appropriately acknowledge and process all patient referrals within 10 working days".

Independent advice to Commissioner

The following expert advice was obtained from vascular surgeon Professor Justin Roake:

> "I have been asked to provide independent expert advice to the Health and Disability Commissioner about whether MidCentral DHB provided an appropriate standard of care to [Mr B] (Ref 07/20199).
>
> I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> My qualifications are MBChB (Otago), DPhil (Oxon), FRACS(Vasc), FRCS, and I have training and experience in the theory and practice of peripheral vascular surgery. I was consultant vascular surgeon at the John Radcliffe Hospital, Oxford, UK from 1992 to 1997. In September 1997 I was appointed to the Chair of Surgery, Christchurch, NZ, and have practised as a consultant vascular surgeon at

Christchurch Hospital continuously since my appointment. … I am vocationally registered in general and vascular surgery in New Zealand.

I have no conflict of interest with respect to this complaint.

[At this point Professor Roake lists the information provided to him and a précis of the case. He also lists the questions asked of him, which are repeated in his report. This information is omitted from this report for the purpose of brevity.]

Opinion

1. Please comment generally on the care provided to [Mr B] by MidCentral DHB.

- The care provided by MidCentral DHB appears to have been of an appropriate standard. [Dr C] made an appropriate referral to [Dr D] as a result of the consultation on 5 December 2006. He recognised that [Mr B] might benefit from surgical treatment of his carotid artery broadly in line with clinical evidence (summarised below) obtained from randomised controlled trials.

- The most reliable evidence for management of symptomatic carotid artery stenoses is obtained from the combined analysis of two large multicentre randomised controlled trials (NASCET and ECST) published in the Lancet by Dr Peter Rothwell in 2003 and 2004 (Lancet 2003; 361: 107–16 and Lancet 2004; 363: 915–24). This evidence is important for understanding whether or not appropriate care was delivered in [Mr B's] case. The clinical trials show that carotid endarterectomy can significantly reduce the risk of stroke related to a carotid stenosis if:

    - The degree of stenosis exceeds approximately 50% *and*

    - The procedure is performed within a relatively short time of a sentinel event — a stroke or transient ischaemic attack (TIA) referable to the stenosed artery. In a male this would generally be within 12 weeks of an event related to a >70% stenosis or within 2 weeks of an event related to a 50–70% stenosis

    - The clinical benefit of carotid endarterectomy for asymptomatic stenoses or temporally remotely symptomatic stenoses (more than 3–6 months) is either small or non-existent.

- This evidence leads to management of carotid artery disease that may appear to be counterintuitive — urgent management if there have been recent symptoms but non-urgent management if with the passage of

time there have been no further symptomatic events related to the carotid disease.

- At the time [Mr B] was seen by [Dr C] he had had a stroke referable [to] a 70–80% stenosis in the right carotid artery 3 to 4 months earlier. Technically this falls just outside the window where substantial benefit from surgery might be expected. Nevertheless referral to a specialist vascular surgeon was appropriate.

- In general mail is a reliable means of communication. Given the volume of clinical correspondence it is not feasible for DHBs to keep track of all correspondence. However, as in this case, the GP and patient have a role in ensuring that action occurs in a timely fashion.

2. Please comment on the adequacy of the actions taken by MidCentral DHB medical staff once they became aware that the referral of 5 December 2006 had not been received by Capital and Coast DHB. In particular, please comment on the time taken to act following alert by the GP, and whether there should have been more urgent communication with CCDHB, such as by telephone.

    - When MidCentral DHB medical staff became aware that the first referral had not been received by Capital and Coast DHB it was 10 months after [Mr B's] original consultation with [Dr C] and 13–14 months after the sentinel event leading to the referral to [Dr D].

    - As noted above any clinical urgency had dissipated through the passage of time and the actions of the medical staff involved appear to have been entirely appropriate. There was no particular need for a telephone referral.

3. In the circumstances where the first referral had been 'lost', should any additional actions have been taken by the referring clinicians to ensure the second referral of 5 November 2007 was received?

    - There was no particular reason to suppose that the second referral would be lost. As noted above the mail system is generally reliable and in this case the second referral was less urgent than the first.

4. Any other comments you wish to make

    - It is difficult to understand how clinical correspondence to Capital and Coast DHB could be 'lost' on two occasions. It is clear that the correspondence was sent from MidCentral DHB on each occasion — copies were received by [Mr B's] GP. Although Capital and Coast DHB claim to have reliable systems to deal with incoming referrals the

failure to receive correspondence on two occasions calls this into question.

Summary

It is unfortunate that [Mr B] suffered a second [cerebrovascular accident] without first having the benefit of a specialist opinion. However the actions taken by MidCentral DHB medical staff appear to have been appropriate. It is difficult to understand how clinical correspondence to Capital and Coast DHB could be 'lost' on two occasions and this raises questions on the effectiveness of their systems for handling incoming referrals."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

…

(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Opinion: Breach — MidCentral District Health Board

Overview

Mr B suffered a stroke in November 2007 that *may* have been prevented had he been assessed in a timely manner by a specialist vascular surgeon at Wellington Hospital. Although the original referral had been made eleven months earlier, because of inadequate systems at MidCentral DHB that failed to check that the referral had been received and was being actioned by Capital and Coast DHB, Mr B fell through the cracks in the system.

Mr A is right to ask, "How can such important communications be lost in transit on two occasions? Why is there no process in place to ensure such communications are

received by the intended recipient?" The simple answer is that there should have been such a process and his father's referral should never have been lost. This case highlights the need for the development of a single electronic health record and record management system in New Zealand, which could provide automatic electronic tracking of referrals and appointments together with the capacity for all health providers (including GPs and patients) to view the progress of referrals in the system and appointments made.[4]

I repeat what I have stated in another case investigated concurrently with Mr B's: this case should be a wake-up call for all district health boards to improve their systems for handling inter-DHB referrals. Leadership at a national level will be essential for this to occur. Changes are clearly needed to referring and receiving practices if boards are to fulfil their duty of care for patients.[5]

Duty of care — general principles

District health boards owe patients a duty of care in handling outpatient referrals, under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code). This duty applies no less to referrals from other DHBs (inter-DHB referrals) than to those from GPs within their district. A specific aspect of the duty of care is the duty to co-operate with other providers to ensure continuity of care, under Right 4(5) of the Code.

In meeting this duty of care, it would seem necessary for a referring district health board to: (1) copy all referrals to the patient and their general practitioner, and (2) have a system in place to ensure that a referral has been received (and follow it up in the absence of confirmation of receipt) and that care of the patient has been accepted by the receiving district health board.

Receiving district health boards owe referred patients a duty of care to: (1) acknowledge receipt of the referral, (2) prioritise it,[6] (3) arrange for patients to be seen in a timely fashion, in their assigned priority,[7] and (4) keep the patient and his or her GP informed whether, and if so when, the patient will be seen.

As I noted in a concurrent case:[8]

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[4] This point was made by Auckland DHB in case 07HDC19869 (3 October 2008).

[5] See Opinion 07HDC19869 (3 October 2008).

[6] As noted in the Southland urology case 04HDC13909 (4 April 2006), prioritisation systems should be "fair, systematic, consistent, evidence-based and transparent" (citing "Statement on safe practice in an environment of resource limitation" (Medical Council of New Zealand, 2005)).

[7] As noted in the Southland urology case, district health boards have a duty to appropriately manage and monitor their waiting lists. See http://www.hdc.org.nz/files/hdc/opinions/04hdc13909urologist,dhb.pdf (4 April 2006), page 13.

[8] Case 07HDC19869 (3 October 2008).

> "It is not for HDC to prescribe the correct solution to these problems. But it is my job to state the obvious: whatever referral system is operating between district health boards, it has to work for patients, who should have justified confidence that referrals will lead to action in sufficient time to treat preventable problems that the public system undertakes to treat."

Clinical care

My independent vascular surgery advisor, Professor Justin Roake, advised that the clinical decisions made by the medical staff at MidCentral DHB regarding Mr B's care were of an appropriate standard. The decision to refer Mr B for vascular surgery was correct, and the referrals were properly made. Professor Roake advised that, counterintuitively, once it was realised that the first referral had been lost, there was no clinical reason to make the second referral in a more urgent fashion (given the passage of time without further symptomatic events related to the carotid artery disease). I accept Professor Roake's advice and, in relation to Mr B's clinical care, I conclude that MidCentral DHB did not breach the Code.

Referral

Although the actual clinical care provided was of an appropriate standard, I am concerned by the failure of MidCentral DHB to take follow-up action when a vascular surgery review did not eventuate within a reasonable time following the referral of 6 December 2006.

Mr B was referred for vascular surgery on 6 December 2006 by the MidCentral DHB surgeons. The referral was apparently never received by Capital and Coast DHB. There is no system at MidCentral DHB for tracking referrals to another DHB to ensure they have been received and that care of the patient has been accepted. Since Capital and Coast DHB does not send an acknowledgement of receipt of the referral to the referring DHB, it was not known (and should not have been assumed) by the referring MidCentral DHB surgeons that the referral had been received.

The Ministry of Health advised HDC that it imposes no requirement on district health boards to track the progress of referrals for elective services. Furthermore, it is apparently the norm in New Zealand for a DHB to have no system to track a referral to another DHB.

The absence of any contractual specification is not determinative of the extent of a DHB's duty of care. Nor does the fact that 21 DHBs fail to track referrals make this an appropriate standard of care. In the same way that individual providers such as GPs are responsible for ensuring that referrals are received, and care of the patient accepted,[9] so too DHBs owe patients a duty of care to follow up referrals to other DHBs. I accept my expert's point that GPs and patients themselves have a

[9] See discussion below in relation to a GP's responsibility.

responsibility to see that "action occurs in a timely fashion",[10] although they can hardly "ensure" action. In any event, it should not be left to them to ensure that a referral from one DHB to another has been received and care accepted. That responsibility lies with the referring DHB.

MidCentral DHB failed to follow up the December 2006 referral and check that it had been received and was being actioned by Capital and Coast DHB. MidCentral DHB had no system in place to track its referrals to other DHBs. As a consequence, MidCentral DHB failed to coordinate the provision of Mr B's care with Capital and Coast DHB in handling the referral. In these circumstances, MidCentral DHB breached Rights 4(1) and 4(5) of the Code.

MidCentral DHB accepts that it breached the Code, and will be apologising to Mr B. It is currently reviewing its system for handling referrals to other DHBs.

Other comments

Responsibility of receiving DHB

It is surprising that Capital and Coast DHB apparently received neither of Mr B's two referrals. It may be that the first letter (in December 2006) was not sent, since a copy was not received by Mr B's GP at that time. However, it seems probable that the second referral (in November 2007) was sent, since a copy was received by Mr B's GP at that time. Even though Capital and Coast DHB has no record of receiving the referrals, it is difficult to believe that neither referral arrived.

Capital and Coast DHB advised that had the referral letters been received, they would have been registered within 24 hours of arrival before being prioritised, and an acknowledgement letter sent to Dr F and Mr B. This did not happen.

I share Professor Roake's view that this case raises questions about the effectiveness of the systems used at Capital and Coast DHB for handling incoming referrals. In my view, receiving DHBs owe a duty of care to referred patients to have an efficient and reliable system in place to electronically log referrals, acknowledge receipt from the referrer, and monitor referrals from all sources, including other DHBs.

The Ministry of Health requires DHBs to "appropriately acknowledge and process all referrals within 10 working days". In my view, a receiving DHB should acknowledge receipt of the referral, promptly notify the patient (with a copy to the patient's GP and to the referring DHB) of an approximate timeframe for an appointment, and then

[10] Involving patients at all stages of the communication process provides a valuable safeguard to prevent communications going astray.

notify the patient (again, with a copy to the GP and referrer) of a specific appointment time.

If the referring DHB also has a system to routinely check that there are no outstanding referrals, this will close the loop and should ensure that referrals do not go astray. I comment in more detail on a receiving DHB's responsibility in a concurrent case.[11]

Responsibility of general practitioner
This case involves the referral of a patient from one DHB to another. It also provides a salutary reminder that GPs have a key role to play in following up referrals to check that they are actioned promptly. For most patients, their GP is the health care provider who is best placed to keep an overview of their care. As noted in the Southland urology case, the referring GP "retains a duty of care for the ongoing clinical management of the patient pending specialist assessment".[12] An aspect of this duty is actively following up a referral for a patient who is still awaiting a further specialist assessment. Although primary responsibility for such follow-up lies with the referring DHB, I consider that the GP retains a residual responsibility to monitor the progress of the patient through the system.

Dr F, Mr B's GP, pointed out that in this case the referral made by her (in August 2006) and followed up by another GP from the medical centre (in October 2007) was directed to the surgical outpatients clinic at Horowhenua Hospital (part of MidCentral DHB). Medical officer, Dr G, at Horowhenua Hospital undertook various investigations and on-referred Mr B to Palmerston North Hospital (another part of MidCentral DHB). This in turn led to the two referrals by MidCentral DHB to Capital and Coast DHB (in December 2006 and November 2007).

I accept Dr F's point that:

> "[t]he number of referrals between Elder Health Horowhenua Hospital, Surgical Outpatients, Palmerston North Hospital radiology departments and Wellington Vascular Surgeons are numerous. The logistics required for a non-referring general practice to actively follow up these referrals are vast. [Our] practice did not have any knowledge of the December [2006] referral until we requested it in mid-April. At that time the delay in seeing surgeons in Wellington was not out of the ordinary."

However, even when there are intermediate referrals, I consider that a patient's GP retains a residual responsibility to monitor the progress of the patient through the system.

[11] See 07HDC19869 (3 October 2008).

[12] See footnote 5.

In this case, the medical centre did take some steps to monitor and expedite Mr B's referral to the Wellington vascular surgeons.

Ethical responsibility of DHBs
In his complaint, Mr A suggested that MidCentral and Capital and Coast DHBs should "commit to providing my father with the best available rehabilitation given that they jointly must shoulder the responsibility for my father's predicament".

Although it cannot be proved that the delayed referral caused Mr B's second stroke, there is no doubt he was badly let down by the poor systems in place at MidCentral and Capital and Coast DHBs. In my view, MidCentral and Capital and Coast DHBs have an ethical responsibility to ensure that he receives all appropriate health care from this point onwards.

Recommendations

- I recommend that MidCentral DHB apologise to Mr B for its breaches of the Code.
- I recommend that MidCentral DHB review its referral system in light of this report, and advise HDC of the outcome of its review by **31 January 2009**.
- I recommend that Capital and Coast DHB review its system for handling incoming referrals in light of this report, and advise HDC of the outcome of its review by **31 January 2009**.
- I recommend that the Ministry of Health review the current system of inter-DHB referrals, and advise HDC of the outcome of its review by **31 January 2009**.

Follow-up actions

- A copy of this report, with details identifying the parties removed (other than MidCentral District Health Board, Palmerston North Hospital, Horowhenua Hospital, Capital and Coast District Health Board, Wellington Hospital and HDC advisor Professor Roake), will be sent to the Minister of Health, the Quality Improvement Committee, the Health Information Strategy Action Committee, the Director-General of Health, the Royal Australasian College of Surgeons, the Royal New Zealand College of General Practitioners, and all district health boards, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.