Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
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Ms. Patricia Kingsnorth
Acute and Social Care Governance
C/O Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

27 March 2023

Dear Madam,

**Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust**

**Provision of a Section 21 Notice requiring the provision of evidence in the form of a written statement**

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant



Issued by the Urology Services Inquiry on 27 March 2023. Annotated by the Urology Services Inquiry.

information required to provide the witness statement required now or at any stage throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you are aware the Trust has already responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and/or has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or the Trust's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.



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Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit you must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by the USI

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

Personal Information redacted by USI

**Anne Donnelly**
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI



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**THE INDEPENDENT PUBLIC INQUIRY INTO**
**UROLOGY SERVICES IN THE**
**SOUTHERN HEALTH AND SOCIAL CARE TRUST**

# Chair's Notice

## [No 2 of 2023]

## Pursuant to Section 21(2) of the Inquiries Act 2005

**WARNING**

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

**TO:** **Patricia Kingsnorth**
**Acute and Social Care Governance**
**C/O Southern Health and Social Care Trust**
**Headquarters**
**68 Lurgan Road**
**Portadown**
**BT63 5QQ**



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## IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

## WITNESS STATEMENT TO BE PRODUCED

**TAKE NOTICE** that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 28th April 2023.**

## APPLICATION TO VARY OR REVOKE THE NOTICE

**AND FURTHER TAKE NOTICE** that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

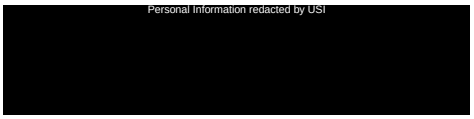
If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 21st April 2023.**



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Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 24th March 2023

Signed: 


**Christine Smith QC**
Chair of Urology Services Inquiry



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**SCHEDULE**

**[No 2 of 2023]**

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include:

   (i) an explanation of your role, responsibilities and duties, and

   (ii) a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns or governance issues arising.

   It would greatly assist the inquiry if you would provide the above narrative in numbered paragraphs and in chronological order.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the Urology Services Inquiry ("USI"). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.

Please also address the following questions. If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person. There may be some repetition in your answers to these questions and your narrative. The key is to ensure that you address the questions asked below, whether in this section or in your general narrative in reply to Q1.

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3. During your tenure, who did you understand to be in charge of governance and risk within (1) acute services, and (2) urology services?

4. What was your understanding of the way in which governance issues might be brought to your attention? What is your view of the efficacy of those methods of identifying governance concerns?

5. Please explain your understanding as to whom you were expected to report? To whom did you actually report and how often did these reports/meetings occur? If meetings, did they have an agenda and were they minuted? If so, please provide all minutes and agendas.

6. Did you have any meetings or discussion with anyone regarding governance issues or concerns within urology? If yes, and not set out in your previous answers, please set out all details of such meeting and discussions, including dates, times, locations, those present, and details of what was discussed and any follow up actions or reviews to decisions made. Please include all relevant documentation.

7. If any actions were taken as a result of these meetings, how, if at all, did you assess the effectiveness of these actions?

8. Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.

9. What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known? If not your role, whose role was it to do this?

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10. Were you ever involved in briefing, either in person or in writing, the Senior Management Team when issues of governance and risk were being reported or discussed? If yes, please provide all details. If no, who was responsible for providing such briefings?

11. Were you aware if any issues you raised regarding governance and risk were brought to the Senior Management Team? If yes, please explain in full. If no, what were the issues, and how are you aware they were not brought to the Senior Management Team?

12. Did you ever feel that issues of governance and risk you raised were not dealt with properly or at all?

    1. If yes, please provide all details, including the names of those to whom you spoke about the issues.

    2. If no, how did you assure yourself that issues raised by you were properly addressed?

13. Are you aware of any issues of governance, either raised by you or others, being brought to the attention of the Board and/or any of the Board Committees?

14. Please detail all systems of oversight and monitoring used and/or developed by you in response to concerns or risks. How did these differ from what previously existed?



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15. If you were involved in developing systems in response to concern or risks, please set out in full the reasons why you felt it necessary to develop such systems, what the aim of those systems were and how effective you considered them to be. How did you assess or assure yourself of their effectiveness? Were these systems subject to review? Please explain your answers in full.

16. If these systems were introduced in response to SAIs, please explain why you think the risk and governance issues those systems were designed to address were not flagged before SAI stage? What was wrong with the systems existing at that time that the issues were not identified? If they were identified by existing systems, why were they not addressed?

17. During your tenure as Acute Clinical and Social Care Co-ordinator, did you consider, that you were adequately supported by your line managers and other staff? Please explain your answer in full, with names, roles and examples as relevant.

18. During your tenure, where you offered any support for quality improvement initiatives? If yes, please explain and provide any supporting documentation.

19. What, in your experience, was *the culture* within (i) Acute Services and (ii) urology, regarding governance? For example, do you think there was enough time to properly manage and respond to governance issues? Did you feel that governance concerns raised by or through you were adequately addressed?

20. What is your overall view of *the effectiveness* of governance systems within –
    1. Acute services generally, and

    2. Urology service in particular

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Do you think the governance arrangements, overall, were and are fit for purpose?

21. What, in your opinion, could have improved the effectiveness of the governance structures and systems in place during your tenure?

22. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

23. If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.

**NOTE:**

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

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**UROLOGY SERVICES INQUIRY**

**USI Ref: Notice 2 of 2023**

**Date of Notice: 24th March 2023**

**Note: An addendum amending this statement was received by the Urology Services Inquiry on 02 June 2023 and can be found at WIT-96809 to WIT-96827. Annotated by the Urology Services Inquiry.**

**Statement of: Mrs Patricia Kingsnorth**

**I, Patricia Kingsnorth, say as follows:-**

1. **Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include:**

**(i) an explanation of your role, responsibilities and duties, and**

1.1 I qualified as a General Nurse in June 1986 and as a Registered Midwife in February 1991.

1.2 I began working as a Midwife (Band 6) in the Southern Health and Social Care Trust (Legacy Newry and Mourne Trust) in November 1997.

1.3 I was appointed as a Clinical Risk Midwife (Band 7) in May 2011.

a. This was a new Role within the Trust and I was tasked with developing the Governance processes within the Integrated Maternity and Women's Health Division (IMWH).

b. I was provided with training in Serious Adverse Incident Reviews using a Root Cause Analysis process. I attended training in Human Factors and Risk Management and medico-legal issues in Women's Health Care. I also attended online courses regarding Risk Management and Patient Safety.

c. I worked with two Consultant Obstetricians from the Craigavon Site and two Consultant Obstetricians from the Daisy Hill Site. Together

we developed a process for reviewing all Datix based on the Royal College of Obstetrician and Gynaecologist (RCOG) 'Trigger List'. The Trigger List provided staff with guidance about which incidents constituted adverse events requiring a Datix submission. An example of this was a postpartum haemorrhage greater than 1500mls, the rationale being that, if a woman bleeds significantly, the care needs to be reviewed to assess how the haemorrhage was managed. The ensuing learning resulted in the introduction of a postpartum haemorrhage box and simulated training for staff. This supplied staff with easy access to equipment and drugs to prevent any delays and simulated practice to manage obstetric emergencies, thus improving patient care. Please see:

1. Royal College of Obstetrics and Gynaecology Trigger List.

d. I was involved in Serious Adverse Incident (SAI) Reviews and in providing support for patients through the process and feeding back the outcome of the reviews. This was a very open and transparent process which clearly identified any missed opportunities and which generated learning. We would frequently have openly offered apologies when things went wrong and put measures in place to reduce the risk of recurrence.

e. I was able to have oversight of any adverse events across Maternity and Gynaecology on both sites and was made aware of any serious incidents by the Lead Midwives and Obstetricians which would then have been escalated through the management structures. Although the system wasn't perfect and had many resource issues it did formulate the foundations of a better system later.

1.4 I was appointed Lead Midwife (Band 8A) for Community Midwifery Services in December 2014. This was a managerial role responsible for delivering safe and effective care. I was responsible for the delivery of care to



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patients in 5 geographical locations within the Trust and this involved the development and improvement of Maternity / Obstetric community clinics in accordance with the recommendations for the Northern Ireland Maternity Strategy (2012-2020). I managed 65 staff members including two Band 7 Team Leaders and Community Midwives and Maternity Support Workers. My role also involved the oversight and development of the home birth services and providing obstetric emergency training for midwives attending home births.

1.5 I was appointed Acting Clinical and Social Care Governance Coordinator (Band 8b) and took up post on 21st January 2019.

a. I believe this to be the role I occupied that may be of direct relevance to the Inquiry's Terms of Reference. Please see:

   1a. Acute Governance Coordinator Job Description

b. My role was to provide clinical and social care governance within the Acute setting. This included Medicine and Unscheduled Care, Emergency Department, Surgery and Elective Care (including Urology), Maternity and Women's Health, Diagnostics, and Cancer Care. This was a vast remit which included management of complaints, incident reporting, SAIs, equipment management, and Standards and Guidelines within all of Acute Services (some of which Standards and Guidelines were relevant for the whole Trust).

c. I had a number of teams to manage. There was a Complaints Team comprising a Band 6 Complaints Manager, a Band 5 Complaints Officer, a Band 3 Complaints Assistant and a Band 2 Administrative Assistant. I was also responsible for a Band 7 Standards and Guidelines (S&G) Manager, a Band 5 Governance Officer for Standards and Guidelines, and a Band 7 Equipment Manager. There was also the SAI Team which initially included a Band 6 Governance Nurse and Band 5 Governance Officer (administrative support) and



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myself until two recently recruited Band 7 Governance Managers came into post in March and May 2019.

d. My general role encompassed general oversight of incident reporting, complaints, Ombudsman complaints and action plans. It included the development of Trust Guidelines following recommendations from adverse incidents, for example, the "Conscious Sedation Guideline". I was responsible for maintaining and updating the Directorate and Divisional Risk Registers (the Corporate Risk Registers were managed at Trust Board level). A report of the Risk Registers was included in monthly governance papers for the Acute Clinical Governance Meeting and for the Acute Governance Meeting for each Assistant Director and their relevant Divisions. Within these governance papers, a report on current complaints, including Ombudsman complaints and any outstanding complaints, was provided to ensure that the Divisional Assistant Directors were aware of any delays or backlogs in complaints responses.

e. I was also involved in providing responses to the HSCB and RQIA as part of my assurance role.

f. Compliance audits were carried out, for example, on surgical site infections and hand washing. Reports of these audits were presented bimonthly.

g. Reports were generated for the monthly Acute Governance Meeting to advise of the complaints position, the number of Datix, and the themes of incidents including the number of moderate to catastrophic incidents.

h. Regarding incident reporting, I had oversight of all Datix submissions. These Datix submissions were graded from minor to catastrophic. All



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major and catastrophic incidents were checked with the relevant Head of Service for that clinical area for more detail. For example, there was an occasional Datix submission from a staff member to recorded as major or catastrophic when perhaps it was only a minor incident. Therefore, it was important to check the detail of the Datix first before escalating it. If a Datix was major or catastrophic it would be escalated to the next available Divisional Screening meeting or to the "Hot Debrief" meeting, whichever came first. A screening meeting is a meeting held weekly for a particular Division. In attendance would be the Divisional Assistant Director, an Associate Medical Director and a number of Clinical Directors as well as myself and a governance manager (Band 7). A governance officer (Band 5) would record the outcomes and actions from the meetings on an Excel spreadsheet. There would be no minutes of the meetings kept. At the screening meeting, discussions occurred as to the detail of the incident and to determine if the Datix required a more in-depth review than a Datix response. For example, if more detail was required about an incident, a round table discussion with the staff involved in the incident may be convened or, if the incident met the requirement for an SAI review, then this would be agreed at a screening meeting and a notification would be sent to the HSCB advising it of the SAI and of the level of same.

i. Any major complaint or any Ombudsman complaints were also brought to screening meetings for discussion. The outcome of this may be a meeting with the complainant in order to address the issues promptly or, in some instances, the decision may be made to conduct an SAI review into the management and care provided.

j. Incidents that were reported to me directly through the operational teams may also have been brought to the screening meeting for discussion; an example of this was a patient who was assaulted by another patient in a ward.



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k. I was responsible for facilitating and assisting with Serious Adverse Incident Reviews and Internal Reviews of patient care. When I first took up post there were 35 outstanding reviews (both SAI and Internal) awaiting either commencement or completion. There were also many more SAI added to this list following screening meetings. Please see:

1b. 20161117_Proceedure for the Reporting and Follow up of SAI version1.1. nov 2016

l. My direct involvement with SAI reviews was to facilitate the meetings, set up meetings, advise the review team of the governance processes to ensure a robust report, and record notes of meetings. I would also meet with staff members to interview them for the SAI reviews and I would record those meetings too. It would be my practice in this regard to ask the interviewee to check if I had documented the information correctly and in the proper context. It was obviously important not to misunderstand what had been said.

m. I would have had separate meetings with the Chair of the Review Panel to write up the Review and assist with the administration of it. It was my practice to advise the Chair of the Review Panel if I felt the Review was not robust enough or not sufficiently open and transparent, so that it may be addressed prior to completion of the Review. For example, in my experience some SAI Chairs would make draft recommendations based on their own opinion about 'the right thing to do' whereas, in order to ensure that the Review was robust, I would advise that the recommendation should be founded upon evidence and national guidance. I would therefore recommend that the team follow the most up to date clinical guidance to ensure that the recommendations in the report were robust.



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n. Performance Management and professional practice was the remit for the operational Assistant Directors and Associate Medical Directors and Clinical Directors. They were responsible for competencies of registrants (whether nursing, midwifery or medical).

o. The Governance Team was tasked with providing information regarding complaints, Datix or SAI involving a staff member. A limitation of this was often that the relevant staff member's name was not provided in the Datix or complaint submission which made it difficult to identify certain staff members.

p. I would never have been made aware of any MHPS or GMC / NMC investigation regarding a staff member.

q. In my previous Role as a Risk Midwife, I would have been made aware of NMC investigation regarding a midwife, I would have been given their name only, with no further details. Nonetheless, this would have allowed me to check if the staff member in question had been involved in any other incidents or SAI Reviews. I would not, however, have been made aware of any medical investigation.

r. In respect of my role in relation to the Urology Services Inquiry Terms of Reference, I first became aware of an SAI Review being carried out by Dr Johnston. This was being facilitated by Mrs Trudy Reid, my predecessor and now Assistant Director of Governance, and therefore it went off my radar as I already had a backlog of 35 SAI Reviews (not including the Dr Johnston Urology SAI Review) to complete and I knew that Mrs Reid was facilitating the Dr Johnston SAI. I didn't know any of the detail of the Review except that it had to do with Mr O'Brien and triage of patients' letters. I had asked my line manager, Dr Tracey Boyce, sometime during the summer of 2019 (possibly around August 2019, but I cannot be sure), if there were any clinical concerns regarding Mr O'Brien and was advised that the



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issues were around triage of letters and storage of notes but that, once a patient was seen by him, the care given was “gold standard”. This was very reassuring as I thought at least the patients were safe.

s. Around September 2019, prior to going on [redacted] leave, I had updated Mrs McClements that there was still no progress from the Dr Johnston urology SAI Review and this prompted correspondence to Mrs Reid to see how the SAI was progressing and if it was nearly finalised. I believe Mrs McClements escalated my concerns about the delay to the Medical Director, Dr O’Kane, and contacted Mrs Trudy Reid seeking an update.

t. The SAI Review chaired by Dr Johnston involved 5 patients and was almost completed when I was on [redacted] leave in December 2019. I was made aware of an email sent to my replacement, Mrs Connie Connelly, in December 2019 from Mr O’Brien which detailed questions about the accuracy of the SAI Review and, I recall, citing his workload as being a mitigating factor in the issues around triaging of letters. The email was shared with Dr Johnston for his consideration. Please see:

2.-4. 20191211 SAI [redacted], A1-A2

u. As the SAI Review Report by Dr Johnston contained 5 patients’ details there was a collective decision to try to separate each patients’ details into an individual report so that each patient could receive a copy of their own individual report but this was not possible and, following discussion at the Acute Clinical Governance meeting on 14th February 2020 (at which Dr Maria O’Kane was present), it was agreed to send out individual letters to the patients affected and to let them know the outcome of the SAI. Mr Haynes agreed to compose the letters. Please see:



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v. There was never any indication of which I was aware that there were concerns regarding Mr O'Brien's clinical practice until he retired in approximately June 2020. I was asked by Dr Damian Gormley, Deputy Medical Director, to bring two Datix relating to two urology patients dated, respectively, 14 and 27 July 2020, to the Screening Meeting for discussion on 31 July 2020. At the Screening Meeting, Mr Haynes advised the screening team that he had discussed concerns with the Medical Director, Dr O'Kane, about inappropriate treatment of some of Mr O'Brien's patients after he (Mr Haynes) had reviewed them at his own Urology Clinic. He advised that there possibly could be more Datix submitted for screening and that the Trust would be looking into the care that the patients received. I was made aware that there were ongoing discussions between the operational urology team and the Trust Senior Management Team about how best to address these concerns and how to identify how many patients were affected. I wasn't included in these discussions but was aware, once Datix were submitted, which patients would be included in an SAI Review. I was also aware that the HSCB and the Department of Health ('DOH') were advised of the concerns at the same time (31st July 2020).

w. As more Datix were submitted the agreement at screening was that each of the patients involved in the Datix reviews would be spoken to by a Consultant Urologist at a review clinic appointment to be advised that there were concerns regarding the care they received and that the Trust would be carrying out a review into their care. At this point, in mid-August 2020 (I do not currently recall the exact date), we were still identifying patients who met the criteria for a SAI Review. I was asked to recruit a Chair for an SAI Review from the Leadership Centre. The specifications were to have an experienced



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Chair, preferably at Medical Director level, with experience of the workings of Cancer Services. Dr Dermot Hughes met those requirements. Myself and Stephen Wallace (Assistant Director for Governance) met with Dr Hughes to explain the concerns regarding inappropriate treatment given to Urology patients. I advised that there would be a number of patients involved (at that point, we didn't know how many) and that we were still working through the numbers. I advised that this was to be a high-level review and that the HSCB and DOH were aware that it would be taking place. I cannot remember our exact conversations and I don't believe there was any record of our discussion kept either by Stephen Wallace or myself. Dr Hughes and I did discuss who else would be required on the Review Team and it was agreed that we would need a specialist nurse and consultant urologist from outside the Trust, possibly from Great Britain.

x. Our first preliminary Review meeting occurred on 10 September 2020. The purpose of the meeting was to scope out what additional information would be required in order to conduct the Review. At this point, I was still unaware that there had been a MHPS with Mr O'Brien. Four patients had been identified [Patient 1], [redacted], [Patient 5], and [Patient 9]) with the possibility of a fifth [Patient 101] in respect of whom we didn't have enough information (on the basis of the Datix alone) to assess whether or not they met the criteria for SAI Review. It was identified that the case in question would need to be shared with an expert urologist.

y. On 12 October 2020 a second Review Team meeting occurred with all of the Review Team including Mr Hugh Gilbert, Consultant Urologist, from England. At this meeting, Dr Hughes expressed concern that we had commenced a Review and that more patients were still being added to it (at this point there were eight patients). I fed this back to Mrs Melanie McClements who agreed to discuss it



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with the Medical Director. I was then invited by Mrs Melanie McClements to attend a Urology Oversight Meeting on Tuesday 15th September 2020 to provide an update on the SAI process, how to proceed with informing family members, and the recruitment of a Consultant Urologist for the Review Team. Please see:

6. 20200915 meeting
7. 20210208 Datix [redacted]
8.20191031 Datix incident form

z. I provided feedback to the Urology Oversight Meeting that Dr Hughes was concerned that patients were still being added to be part of the SAI Review. It was then agreed that nine patients would be part of the Review and that another process, possibly a Structure Judgment Case Note Review, would be conducted for any other patients affected. I advised the Urology Oversight Group that the SAI Review would consist of nine individual reports, one for each of the patients / families, and one overarching report with all of the systematic recommendations that would also be shared with all the families.

aa. It was agreed with Dr Hughes and Mr Gilbert that I would provide any feedback and any early learning from the Review to the Oversight Group, so that changes could be made immediately, without having to wait on the final SAI Review Report(s).

bb. On 26th October 2020 I was asked to attend an urgent meeting at 8am to discuss a leak to the Irish News about issues arising in the Southern Trust following the retirement of a Urology Consultant. I was asked to telephone all nine patients who were part of the SAI Review and advise them that they would be part of the SAI Review. Some of the patients had not, by that point, been advised that they were going to be part of an SAI Review and I therefore offered



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apologies for phoning them about it and advising about the media coverage which we recognised may cause them some distress. I also telephoned six other patients who had previously been involved in relevant SAI reviews and let them know that their reports may be shared with the current SAI panel for information purposes. Please see:

9. 20201026 contact information urology SAI 26.10.2020

cc. Following those telephone calls, I became the link person between the patients (and / or their families) and the panel members of the SAI Review.

dd. Thereafter, I was involved in meeting with the patients / their family members with Dr Hughes. We agreed to meet them in locations closer to their homes to avoid extensive travel for them. In the circumstances, we met some families in Dungannon, some at Daisy Hill Hospital, and others at Craigavon Area Hospital. All of the meetings were very frank. We advised the patients / families that we were reviewing the care provided which appeared not to be in accordance with local and regional guidance. Some of the patients / families were unaware of what the issues were surrounding their care and, in order to be open and honest with the families, Dr Hughes advised them of some of the issues around the aspects of care given to them which appeared not to have been in accordance with guidance or with recommendations from the MDM. He also indicated to them that Mr O'Brien would be afforded the opportunity to advise why he gave the treatment that he did. The draft SAI Review Terms of Reference were discussed at these meetings and the scope of the Review was also discussed. Each patient / family was aware that this Review involved a total of 9 patients. They were very emotional meetings and many of the patients and their families were



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understandably distressed. Dr Hughes and I agreed to keep the families informed of the progress of the SAI Review and to meet them midway through the Review and again at the end to share the findings with them.

ee. I was also involved in a lot of correspondence with Mr O'Brien's solicitors, who wanted copies of the notes for the 9 SAI patients, which were redacted to ensure confidentiality, along with the 9 Datix submissions, and the terms of reference for the SAI reviews including details of the Review Panel members. Dr Hughes also invited Mr O'Brien to be interviewed as part of the Review, but he declined. Dr Hughes agreed to (and did) provide a list of written questions for Mr O'Brien. No answer to the questions was provided, however, and in view of the need to avoid undue delay the report progressed without Mr O'Brien's input, with (I understood) the approval of the Trust SMT. Please see:

10.-13. 20210112 email re your client TS Live FID[Personal Information r], A1-A3

14.-47. 20210306 Timeline to Tughans, 1-32

47a.-47b. 20201211email inviting AOB Pricipate SAI, A1

ff. As part of the SAI Review, Dr Hughes and I met with staff involved in the management of Urology and the Multidisciplinary Team including Mr Mark Haynes (Associate Medical Director for Surgery and Elective Care), Dr Shahid Tariq (Associate Medical Director for Clinical and Cancer Services), Dr Darren Mitchell and Professor Joe O'Sullivan (both Oncologists in Belfast), Mr David McCaul (Clinical Director for Cancer Services), Mr Anthony Glackin (Consultant Urologist), Mr Ronan Carroll (Assistant Director of SEC), Mrs Heather Trouton (Director of Nursing and AHP and former AD for SEC), and Mrs Martina Corrigan (Head of Services for Urology). We also met the Specialist Nurses as a group, to ensure that they didn't feel intimidated, and we also met the Multidisciplinary Team as a



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group. It was my practice to have the notes of these meetings checked for factual accuracy by the participants after the meetings in case I may have misheard or misunderstood what was said. However, the notes were certainly not a verbatim account of what was said nor were the meetings the subject of any audio recording. They were more akin to the minutes of a meeting. The notes are available as follows:

i. A Glackin – 30.11.20 – TRU-162250
ii. S Tariq – 29.12.20 – WIT-84338 and WIT-84418
iii. R Carroll – 18.1.21 – WIT-84342 and WIT-84374
iv. H Trouton – 23.2.21 – WIT-84344 – WIT-84415;
v. Urology MDM – 18.2.21 – WIT-84347 and WIT-84376
vi. M Haynes – 18.1.21 – WIT-84353
vii. M Corrigan – 18.1.21 – WIT-84355
viii. Cancer Nurse Specialists – 22.2.21 – WIT-84357 and WIT-85140 and TRU-162269
ix. J O'Sullivan – 4.1.21 – WIT-84362 and WIT-84423 and TRU-162262
x. D Mitchell – 23.2.21 – WIT-84363 and 84424
xi. B Conway – 29.12.20 – WIT-84413 and TRU-162258
xii. D McCaul – 4.1.21 – WIT-84420

I do recall one meeting via zoom with Mrs Trouton and Dr Hughes. The internet coverage was very poor from Dr Hughes' location and this made the interview very difficult to hear and understand what was being said. In hindsight, it would have been better to do a face to face interview. However, Covid restrictions prevented this.

gg. Mr Gilbert reviewed all 9 patients' clinical notes (including CT images and reports) to provide a summary of each patient's care. If he needed any additional notes or imaging, I would have provided the necessary information to him so that he could make an assessment of the care provided against current practice and relevant guidance.



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hh. Once all of the information had been gathered, Dr Hughes and I corresponded, either through telephone or email, and met to write up the report. Each draft was shared with the Review Team for comments. The electronic platform 'Egress' was the system used to upload the documents and reports for access for Mr Gilbert and Dr Hughes and to ensure appropriate records management.

ii. The HSCB wanted the reports to be completed by January but this was not possible as we had experienced some delays including in respect of the issue of responses from Mr O'Brien. When all of the information was collated, Dr Hughes and I met the families again to discuss the findings and advise that the reports would be sent out to them. Therefore, the nine individual reports and the single overarching report were completed in draft form pending family engagement on 1st March 2021. The reports were shared in draft form with the families / patients on 16th March 2021. Some of the families / patients had some comments which resulted in minor amendments which were shared with the Review team for approval. All the families / patients were given the opportunity to meet with Dr Hughes and I on 8th April 2021 to discuss any issues or questions they had about the report. Only three of the nine patients / families wanted to meet with us. The final reports were sent back to the HSCB on 22 April for 8 of the patients/ families. One patient Patient 9 had sadly passed away as the report was being completed and the family needed more time to consider their responses. I believe that this report was finally submitted to HSCB on 27th September 2021 (after my retirement from post).

jj. As a result of my retirement, I wasn't involved in the implementation of the SAI recommendations. I believe that these were taken forward by the relevant operational teams.



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1.6 I retired from the Trust on 30th June 2021 and subsequently returned on a 16-hour block bank booking as a Risk Midwife (Band 7). I remain in this role today.

**(ii) a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns or governance issues arising.**

1.7 When I came into my Acting Clinical and Social Care Governance Coordinator post in January 2019, my only other support was (a) a Band 6 Nurse who didn't have a background in Governance but who had been redeployed into the role and (b) a Band 5 assisting with the administration of SAIs as well as helping with the Complaints Team. This meant that there were only two of us conducting and facilitating SAI reviews and internal reviews. As previously discussed I inherited 35 SAI (not including the Dr Johnston Urology SAI for 5 patients). I also had new SAIs being notified to the Trust following screening meetings. Two Band 7 Governance Managers were appointed before I came into post but didn't take up their Roles until March 2019 and May 2019 respectively but they had no previous experience in Governance and required a period of induction and training. I was also provided with two days training in SAI reviews which was very helpful in my new role.

1.8 I did escalate to my Director (Mrs Gishkori) and my line manager (Dr Boyce) my concerns regarding adequate resources, especially in relation to the resources my counterparts had in their Directorates which I believed were proportionately greater than what I, with a larger service, had. I was advised that an external review of the current governance structures commissioned by the Trust would address many of my concerns. I accepted that this review of governance services would address some of my resource concerns and understood that there were plans in place to improve the service and that it would take some time.



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1.9 As addressed in my answer to part (i) of this question, I was responsible for the governance in all aspects of Acute Services, which is a vast Directorate. It simply wasn't possible to have complete oversight of every Division and therefore I relied on the Assistant Directors of each Division and their Heads of Service to make me aware of any concerns.

1.10 As previously stated, I was aware that an SAI was being carried out by Dr Johnston into triage issues, but I wasn't fully aware of what those issues were. I had asked my line manager Dr Tracey Boyce, and Martina Corrigan, HOS for Urology, (I cannot recall the date but would guess it was in the summer of 2019) if there were any clinical issues with Mr O'Brien and was advised that the issues were purely administrative but that, once a patient was seen by Mr O'Brien, the care he provided was "gold standard". I was assured there was monitoring in place in relation to the triage of letters and storage of notes to prevent recurrence and that administrative support was in place. I was therefore reassured that there were no clinical patient safety issues and I believe that I was not informed about any other process involving Mr O'Brien (in particular, the MHPS process) during my tenure until September 2020.

1.12 As mentioned above, I believe that I wasn't aware until September 2020 (when I was asked to attend a Urology Oversight Meeting) that an MHPS process had been undertaken by the Trust in respect of Mr O'Brien during 2017 and 2018. This information was not shared with me at an earlier stage.

1.13 As also mentioned in my answer to part (i) of this question, during my involvement with the 9 SAIs and the overarching SAI review chaired by Dr Hughes, I provided weekly feedback to the Director of Acute, the Medical Director, and the Acute Senior Management Team involved in the Urology Oversight Meetings, which (I believe) duly informed a weekly / fortnightly meeting the Trust had with HSCB and DOH. The feedback I submitted related to any initial learning and themes coming out of the SAI Reviews. This was at the request of Dr Hughes, the Chair of the SAI Review. One of the issues discussed at a Review Meeting on 12 October 2020 was the inappropriate use of Bicalutamide instead of the recommended LHRH analogue. Mr Gilbert advised that this inappropriate treatment may have contributed to one patient's



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Patient 1 adverse outcome. I was very shocked by that finding and I escalated this information at the next available Urology Oversight Meeting, which was attended by the Director of Acute Services, the Medical Director, the Assistant Director of Corporate Governance, both the AMD and AD for SEC, and the HOS for Urology. I believe this was the first time that I fully understood the extent of the clinical concerns regarding Mr O'Brien's practice. A review of patients on Bicalutamide was to take place following that meeting.

47c.-47i. 20201110 incident oversight group agenda, A1-A6

2. **Please also provide any and all documents within your custody or under your control relating to the terms of reference of the Urology Services Inquiry ("USI"). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.**

2.1 I was asked, when the Trust was first advised of the Public Inquiry, to provide to the Trust Public Inquiry Team all emails and documents I had that were relevant to urology as well as any documents regarding the SAI reviews, which I duly did. The only additional documents of potential relevance that I wish to submit now are the RCOG 'Trigger Lists' which, although they do not relate to Urology nor to my role from 2019, may nonetheless be of interest to the Inquiry given what I have said above about my previous role as a Risk Midwife.

**Please also address the following questions. If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person. There may be some repetition in your**



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**answers to these questions and your narrative. The key is to ensure that you address the questions asked below, whether in this section or in your general narrative in reply to Q1.**

3. **During your tenure, who did you understand to be in charge of governance and risk within (1) acute services, and (2) urology services?**

**Acute Services**

3.1 Governance is everybody's responsibility to a certain extent**.** I understood the Director of Acute Services ultimately had overall responsibility for clinical governance within Acute Services and she was the person I, as Head of Governance, reported directly to on governance issues (for example, SAI Reports, Complaints, and Datix). Governance responsibility also rested with the Assistant Director for Corporate Governance, the Medical Director, the Assistant Director for the relevant Division (Surgery and Elective Care), the Associate Medical Director and the Clinical Director for the Division. The operational Assistant Directors and Clinical Directors were responsible for the management of the competencies and performance of registrants (NMC/ GMC) which were kept confidential and not shared with the Acute Governance Team.

3.2 As discussed in my response to Question 1 (i) above, in my role as Acting Clinical and Social Care Governance Coordinator I was responsible for monitoring any incidents or issues that were reported, either through the complaints process or Datix, and then I fed back to the Director of Acute Services and the Assistant Directors of each Division. I provided each Assistant Director with a report of every SAI and Action Plan for their information to disseminate the learning through each Division. I required a response back when each of the Action Plans was fully implemented and kept a spreadsheet which was updated when each action was completed. Learning from each SAI was shared at the relevant M&M forums for learning. Learning was also shared at the Sisters' meetings and at a Senior Nurse and Midwifery Forum.

3.3 I was responsible for updating the internal audit responses and RQIA responses for the Trust on behalf of the Acute Directorate. I was involved in the



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management of Standards and Guidelines (S&G) and there were two meetings a fortnight to ensure that the Acute Assistant Directors and Acute Director were aware of the Trust's responsibilities and responses required regarding S&G. I also oversaw the equipment management of medical devices within the Trust.

3.4 There was a separate team within the Trust responsible for Clinical Audit, M&M and Quality Improvement that were not under my remit.

3.5 I kept the Director of Acute appraised of any outstanding issues regarding screening, for example, when screening didn't occur and the reasons for this. This was an issue with surgical screening and the lack of attendance of the Associate Medical Director and Clinical Director as they had competing clinical priorities which made it difficult for them to attend most screening meetings. This was addressed and there was good improvement from April 2020. This may have been related to the Covid pandemic response in that all meetings became accessible remotely, which made attendance for medical managers (who were also busy clinicians) easier.

3.6 There was a separate process followed through Human Resources when issues were identified regarding a staff member's competences. As stated above at Question 1(i), the operational teams are responsible for the competency of, or professional issue with, any registrant and any issues of such a nature would be addressed through this route. Usually, the Medical Director's Office or Executive Director of Nursing would be made aware of any such issues. They would not be shared at my level in view of the confidential nature of them. Of course, the problem with that is that it prevents one from having all the information when an SAI Review is conducted. Practices have now changed somewhat so that any staff member mentioned in an SAI has to discuss this at revalidation.

3.7 As both a Lead Midwife and Risk Midwife, I was aware of midwives being referred for Supervisor of Midwives Investigations or to the NMC. These were robust investigations and could often result in sanctions. Therefore, it was not unusual for these processes to be kept confidential amongst a select number of people. However, as a Band 7 Risk Midwife I would have been made aware that a process had commenced in respect of a named individual, even though



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I would not have been provided with any details, nor did I require any details in my role. I feel this should have happened regarding the MHPS investigation. I did not need to know all of the details; just that there was a separate investigation taking place for a particular staff member. I would then have been more informed and better able to identify any recurrent issues with a particular staff member, thereby enhancing governance.

**Urology**

3.8 I believe the overall responsibility for governance in Urology rested with the Assistant Director of Surgery, Associate Medical Director, and Clinical Directors who would then escalate appropriate issues to the Director of Acute Services, Medical Director, and Chief Executive. I understand there is also a governance responsibility sitting with the Chair of the MDM for Urology to ensure that recommendations made at MDM are actioned.

3.9 There appeared to me to be a “disconnect” between what was happening regarding operational decisions within Divisions and what was shared with the Acute Clinical Governance Coordinator. I was only made aware of any issues through the SAI processes or through Datix, complaints, or the Hospital at Night Report (this is a report that the Bed Manager provides every morning, detailing any incidents or issues that occurred overnight on each hospital site and which includes the number of patients waiting on beds in the Emergency Department). An example of an issue or incident could be an unexpected death on the ward or if a high-risk patient absconded. Each of these information routes might prompt me to seek further information on and / or clarification of the issue raised. Sometimes, the Assistant Director for the Division would let me know of any concerns in their Departments but generally this usually only occurred when a response was required for HSCB and my assistance was called upon. The limitation inherent in these communication channels is that you are relying on someone telling you of any issues or submitting a Datix. On reflection it was not sufficiently robust and I think there was a missed opportunity to discuss clinical concerns, perhaps as a standing agenda item, at the Acute Governance Meeting (when all the operational Assistant Directors, the Director of Acute, and the Clinical Governance Coordinator are present).



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3.10 Whilst I do not believe there was ever any intention to cover up issues, I believe that some serious issues were escalated to my senior colleagues rather than to me given the confidential nature of them. The MHPS case regarding Mr O'Brien is an example of this.

3.11 The Acute Directorate is so vast that I believe it would be impossible to have complete governance oversight of it at my level within the organisation. Whilst I could deal with issues that were made known to me, I believe those with the overall responsibility for governance in Urology (as identified above) may have had greater oversight or a greater ability to have oversight.

**4. What was your understanding of the way in which governance issues might be brought to your attention? What is your view of the efficacy of those methods of identifying governance concerns?**

4.1 I believe that 'governance' is an umbrella term to describe the framework by which healthcare organisations are accountable for continuously improving the quality of their service and safeguarding high quality care. This is achieved through, risk management (including complaints, clinical incidents, equipment management and Standards and Guidelines), training and education, audit, clinical effectiveness, research and development, and patient and public involvement.

4.2 Governance issues were usually highlighted from a Datix (incident report) which would be generated at an operational level. It was my responsibility to ensure all the Datix submitted were reviewed on a daily basis (working hours) and any major or catastrophic incidents were reviewed and screened weekly by the Acute Senior Management Team, which included the Associate Medical Director for the Division, Clinical Director for the Division, Assistant Director for SEC, and a governance officer in the event that I was unavailable. There are limitations with the Datix system in that, once a Datix review is completed, the Datix is closed and, unless a report is generated to look specifically at themes, then it does not remain visible to the governance team. In the circumstances, when I came into post in early 2019 I was not aware that there had previously



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been several Datix submitted years earlier on the issue of Mr O'Brien keeping medical notes at home.

4.3 Any serious concerns would have been escalated to the Director immediately and an Early Alert generated and sent to the HSCB and Department of Health. I would have prepared the documents and appraised my Director who, in turn, would have appraised the Chief Executive and other members of the Trust's Senior Management Team.

4.4 Screening sessions were weekly for each Division. For example:

a. Monday was Medical and Unscheduled Care Screening;

b. Tuesday was Surgical Screening (changed to Wednesday from Feb 2021);

c. Wednesday was Emergency Department Screening (Surgery since Feb 2021);

d. Thursday was IMWH and Radiology / Cancer Services Screening;

4.5 During Screening Meetings any major or catastrophic incidents and major complaints are discussed for a multidisciplinary opinion. Also discussed is an update of the progress of current SAI Reviews, including whether assistance is needed with any outstanding issues to complete the SAIs. For example, if an external opinion was required for an ongoing SAI review, this would be discussed at screening for medical assistance and sign-posting to the appropriate person. This meant that the Divisional management team understood what was outstanding by way of SAI reviews. Any early learning from SAIs would also be discussed at this meeting.

4.6 The outcome from the Screening Meeting would be to process the incident as one of the following:



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a. To investigate the incident as part of the Datix process.

b. To undertake an internal review of the patient's care or, where there is lack of clarity, a debrief may be required with the staff involved. Such a review may be similar to a Serious Event Audit and will ask, 'what happened and why did it happen', directly with the staff involved in the incident. It will consider what measures can be put in place to prevent recurrence. There is usually a quick turnaround and this process can provide early learning promptly and will inform whether an SAI needs to be completed.

c. To undertake a Serious Adverse Incident Review, the level of which (level 1, 2 or 3) will be determined by the Screening Team - HSCB / SPPG would be notified and the Review Panel membership would also be discussed at screening as part of an MDT approach.

4.7 I was also made aware of issues through the Complaints Process. When a complaint was submitted it was screened according to its severity, that is: minor, moderate or major. All major complaints were brought to screening for that Division and also to the "Hot Debrief" (see further Question 5 below) to escalate the concerns to the Director of Acute Services, Assistant Directors of the Division, and the Medical Director. Some complaints were verbal (from telephone conversations) and, if they were assessed as major, they would follow the same process of escalation.

4.8 I would have been emailed about some incidents, but more often I would have been told face to face, sometimes opportunistically, if something had happened before the relevant Datix would have been submitted.

4.9 I was on the out of hours 'On Call Rota' for the Heads of Service of the Acute Directorate and would, during periods on call, have been phoned and advised about any issues within the Acute Directorate. I would in turn have reported anything serious to the Assistant Director 'On Call', if required.



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4.10 When I first came into post my office was on the Administration Floor in the main Craigavon Hospital building, which did help me hear if any incident had occurred because staff would drop by the office and tell me given its central and accessible location. However, my team and I were moved off the main hospital site in June 2019 as there was lack of suitable accommodation. This meant that it was more difficult to ascertain if something had happened. I had asked the Facilities Manager to scope an office back on the Administration Floor but this couldn't be facilitated.

4.11 Another drawback was that, sometimes, Surgical Screening was unable to take place due to the absence of either a Clinical Director or Associate Medical Director (or both). This was often due to competing clinical commitments. This meant that no decisions could be made regarding the screening of adverse incidents and to determine what the most appropriate method of addressing them was. Also, this impacted on the progress of existing SAIs if there were review panel members to be selected (usually the consultants were nominated by the AMD or CD). I didn't have similar concerns with screening within the other Divisions of Acute Services, so this was unique to Surgical. I raised this issue on numerous occasions with both Ronan Carroll, Assistant Director, and Mrs Melanie McClements, the Acute Director. This didn't improve until April 2020, when screening meetings began taking place over 'Zoom' and surgeons were stood down from elective work during the first Covid lockdown. Eventually, the screening day was changed to facilitate all the relevant medical personnel to attend. Screening meetings were not minuted. Rather, an outcome of screening was added to an Excel document.

4.12 Audits carried out within Acute were compliance driven ensuring a high standard of patient care. For example, the Malnutrition Universal Screening Tool (MUST) Audit, to provide assurances that patients in hospital were getting adequate nutrition, or audits on Fluid Balance Charts or Early Warning Score Charts which were directly reflective of good standards of patient care. I understand the Audit Department were not adequately resourced to assist with quality assurance audits to assess the effectiveness of our governance systems and processes. On reflection there was a missed opportunity to be



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more proactive to carry out audits to monitor the systems and processes in place and action any weaknesses.

5. **Please explain your understanding as to whom you were expected to report? To whom did you actually report and how often did these reports/meetings occur? If meetings, did they have an agenda and were they minuted? If so, please provide all minutes and agendas.**

5.1 I had a weekly one to one meeting with my line manager, Dr Tracey Boyce. This usually took place every Tuesday. At this meeting I could discuss any concerns I had, either in relation to my governance team or in relation to any governance issues on which I wanted some advice. I would have raised staffing and resource issues or any problems I was having with my team. I also discussed with Tracey any concerns I had regarding an SAI review or the backlog of complaints or SAI turnover. It was at one of these meetings that I asked Dr Boyce if there were any concerns regarding Mr O'Brien's clinical practice. I do not recall the date, just the conversation, but it was in the context of a draft that I had received from Mrs Trudy Reid in relation to the Dr Johnston SAI Review. I was advised that there were no clinical issues and that any care provided by Mr O'Brien was "gold standard" once the patient got into the system. There were no records kept of these weekly meetings. I was concerned to ensure that I was doing a good enough job in my role and would have asked for constructive advice about my performance as Clinical Governance Coordinator and if I needed to improve in any area. I was assured by Dr Boyce that I was doing a good job.

5.2 I also reported directly to the Director of Acute Services on a weekly basis. Dr Boyce and I met with Mrs Gishkori on a Monday morning (until her leave in May 2019). Meetings with Mrs Gishkori were often cancelled in view of conflicting diaries. They were not structured meetings and I didn't have an agenda for them. From June 2019, I met with Mrs Melanie McClements every Monday morning. These meetings were more structured and I followed an agenda every week. I was held to account to ensure I had all my information prepared before this meeting. In the event of an urgent governance issue



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arising (for example, if anything major had to be escalated), I was able to phone / email the Director directly or leave a message with her secretary to contact me urgently to appraise her. An agenda was prepared for each weekly meeting but no minutes were taken. It was my role to keep the Director informed of any governance issues which were identified. I prepared the agenda, detailing an overview of the status of complaints (how many were outstanding, late or completed within the time frames of 20 working days), an update of the SAI position, and details of any incidents that had occurred of which she needed to be aware prior to her meeting at Trust Board. I would have discussed staffing concerns and additional funding for staff. The format was usually the same with updated information. During the nine SAI Reviews under Dr Hughes, I kept Mrs McClements appraised about how they were progressing in terms of time as we were being held account by the HSCB to have the reviews completed within a 3-month period but this had to be extended for a number of reasons. Please see:

48.-58. 202020227 Meeting with Acute Director, A1-A10

59.-61. 20210106 Meeting with Acute Director, A1-A2

62.-73. 20201006 Meeting with Acute Director, A1-A11

74.-75. 20200127 Meeting with Acute Director, A1

5.3 In addition, as part of ensuring appropriate escalation to the Corporate Governance Office, I reported to the Medical Director / Deputy Medical Director and AD for Corporate Governance at a “hot debrief” meeting every Thursday morning. At this meeting any issues could be discussed including the screening of Datix or Serious Adverse Incident notification. Datix of a major or catastrophic nature were discussed at this meeting and recommendations made. There was a Medicines Governance person at the meeting, which helped with the good communication regarding any medicines incidents within the Acute Directorate, and the details were shared both for learning and for information. There was an opportunity to discuss any ongoing issues or concerns regarding governance. A weekly update was provided on the progress of all SAI Reviews and detail of



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the complaints for each Directorate was available for information. This provided the Trust Senior Management Team with an overview of what was happening within each Directorate. Please see:

76.-97. 20201207-20201213 weekly Governance paper to SMT A1 – A21

5.4 As discussed in detail in Question 1(i) above, in July / August 2020, when a number of Datix were generated regarding deficits in patient care by a consultant in urology, it became apparent that this was only the 'tip of the iceberg' and that there would be other incidents identified as time went on. This was because, when Mr O'Brien retired in June 2020 and other consultant urologists were reviewing his patients, they identified concerns regarding treatment plans the patients were given which they considered were outside recommended guidance. This prompted further discussion and meetings regarding what was to be done and how to identify which patients would require a Serious Adverse Incident Review. I was made aware that a Subject Matter Expert from England was asked to review the care of a number of patients and to identify if any of these patients came to harm. I can't remember the exact dates of these meetings or the outcome with any clarity. However, 3 of the patients were selected to be part of an SAI Review. I was asked to recruit a Chair from the Leadership Centre and, by the time we had our first review meeting in September 2020, the SAI Review numbers had increased to 6 patients, with more patients still being identified. As previously discussed, Dr Hughes expressed concern that more patients were being added for the SAI review. This was discussed at the Urology Oversight Meeting in September 2020 and an agreement was made that the total number of patients involved in the SAI would be the 9 patients identified and there would be 1 overarching review that would look at the overall systems and processes. Please see:

6. 20200915 meeting

**6. Did you have any meetings or discussion with anyone regarding governance issues or concerns within urology? If yes, and not set out in**



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**your previous answers, please set out all details of such meeting and discussions, including dates, times, locations, those present, and details of what was discussed and any follow up actions or reviews to decisions made. Please include all relevant documentation.**

6.1 As set out in my response to Question 1(i) above, I attended the Surgical Screening meeting on 31 July 2020 when two Datix were submitted by Mr Mark Haynes describing that two patients had received inappropriate care (Datix 121045 and Datix 121851). I was asked to bring them to screening by the Deputy Medical Director, Dr Damian Gormley. These were the first two patients identified for the nine SAI Reviews (and one overarching review) undertaken by Dr Dermot Hughes.

6.2 As is also discussed in my response to Question 1(i), I attended weekly Urology Oversight Meetings every Tuesday evening. The first meeting I attended was on 15 September 2020. These meetings were high level meetings involving the Medical Director, Director of Acute Services, Director of Human Resources, Associate Medical Director for Urology, Assistant Director of Surgery, Head of Services for Urology, Assistant Director of Governance, Head of Communications, and myself. The purpose of the meeting was to discuss the issues surrounding the concerns with Mr O'Brien. As discussed above, this was the first time I was made aware that an MHPS investigation had occurred previously in respect of Mr O'Brien. As also indicated above at 1(i), I attended these meetings to provide an update on the SAI Review progress. I also shared issues that the families of the SAI patients had disclosed regarding access to nursing or counselling. It was agreed at this meeting that the Trust would provide counselling services to any of the patients / family members who required it. I then shared the details back to the families. I also recommended that a family liaison person be appointed to help with keeping the families updated as I was under a lot of pressure to complete the SAI Reviews. The Urology Oversight Team agreed to appoint one of the Family Liaison Officers employed specifically for the Covid outbreak SAI to assist with the families involved in the 9 Urology SAI Reviews. Mrs Fiona Sloan was the



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person then duly appointed as Family Liaison Officer and this freed me up more to work on the SAI Reviews. Fiona's background was District Nursing and this assisted her in being able to help one of the patients gain access to equipment and supplies.

6.3 In respect of the nine Dr Hughes SAI Reviews and the Overarching Report, I attended meetings on the following dates:

a. 10th September 2020 – preliminary meeting -
b. 12th October 2020 -
c. 2nd November 2020 -
d. 30th November 2020 -
e. 7th December 2020
f. 14th December 2020
g. 4th January 2021
h. 18thJanuary 2021
i. 25th January 2021
j. 8th February 2021
k. 15th February 2021
l. 22nd February 2021
m. 26th February 2021
n. 12th April 2021

Please see:
97a. 20200910 Level 3 SAI review Notes, 97b. 20201012 Urology SAI review team meeting 12.10.2020, 97c. 20201102 Urology SAI Meeting 02.11.2020, 97d. 20201130 Notes of Meeting 30.11.2020, 97e. 20201207 urology SAI Review Team Meeting, 97f. 20201214 Notes of Meeting 14.12.2020, 97g. 20210104 Notes of meeting 04.01.2021, 97h. 202110118 Notes of Meeting 18.1.2021, 97i. 20210125 notes of Meeting 25.1.2021, 97j. 20210208 Notes of Meeting 8.2.2021, 97k. 20210215 Notes of Meeting 15.2.2021, 97l. 20210222 Notes of Meeting 22.2.2021, 97m. 20210226 Notes of Meeting 26.02.21, 97n. 20210412 Notes of Meeting 12.04.21



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6.4 There were notes kept of all the meetings and emails sent and received related to the meetings are also available. I understand that these have already been disclosed to the Public Inquiry and that some of these have already been considered by the Inquiry during the days when Dr Hughes and Mr Gilbert gave oral evidence.

6.5 As discussed in detail in Question 1(i) above, Dr Hughes and I met with all potentially relevant staff required to assist with the Review process. Notes were kept of these meetings and the people interviewed were asked to check the notes for factual accuracy. Most people were happy with the content of the notes but some requested minor changes, which were duly made. Please see references at paragraph ff at page 14.

6.6 Any themes that were arising from the SAI Reviews I fed back to the Urology Oversight Meeting, which occurred every Tuesday evening, so that measures could be put in place to address any deficits. For example, the lack of a Keyworker for some patients undergoing urology cancer treatment was shared so that this could be rectified.

6.7 Dr Hughes and I had a number of meetings with the families and patients to advise of the progress of the SAI Review to date. The first meeting was face to face and the remaining meetings were via zoom. The draft reports were shared with the HSCB pending family engagement on 1 March 2021. Dr Hughes and I offered Zoom meetings to all the families to discuss the SAI reports with them but only 3 families wanted a meeting and the remaining 6 declined. Fiona Sloan, Family Liaison Officer, was available to support families if they required it after the SAI Review was completed.

**7. If any actions were taken as a result of these meetings, how, if at all, did you assess the effectiveness of these actions?**



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7.1 As mentioned above, the SAI Review involving the nine patients, along with the Overarching Review, provided the Trust with early thematic learning which was shared with the Urology Oversight Meeting every Tuesday. This allowed the Assistant Directors to review their cancer services to make any improvements before the reports were completed. This early learning was effective and enabled the Trust to begin actioning some of the recommendations that were going to be made before the reports were completed.

7.2 Generally, when an SAI is completed an Action Plan is generated and shared with the operational teams to ensure the recommendations made by the SAI Review Team are actioned and signed off when each action is completed. This means that there is often a considerable time delay in sharing learning and making changes to practice. There is always a risk of recurrence due to this delay. For example, the action plan SAI for the 5 patients chaired by Dr Johnston was sent to the Operational team for urology for completion in May 2020 and I had to follow up with them in October 2020 and assist them with the completion of the Action Plan. There were two recommendations that the Trust could not complete as they involved the HSCB. I contacted the HSCB and spoke with Mrs Denise Boulter to see how they had progressed the 2 recommendations aligned to them which were outstanding. The response from the HSCB was that recommendations should not be made without consulting with the Board prior to making them.

98. 20210722 Approved final action plan urology

7.3 It is important that these Action Plans are reviewed annually but this doesn't always happen. The Action Plans are designed with a 'RAG' rating - Red for not completed, Amber for almost completed, and Green for completed. As there are so many SAIs, it is my opinion that, once the SAI Action Plan is completed, there is a danger that it will not be reviewed again. I feel all Action Plans need to be reviewed at least annually to make them meaningful and to



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provide assurances that the actioned recommendations remain in place. This does happen within some areas of Acute.

7.4 I believe that the current SAI process is not an effective tool to extract early learning but, despite its limitations, it is the chosen tool regionally. Although there are recommended time frames for completion of an SAI Review, they are not realistic and don't take into account the clinical commitment required for staff who have outpatient clinics and surgeries planned. In addition, when a large team is involved in the Review, holidays have to be taken into consideration and this can affect the commencement of review team meeting and subsequent review meetings. In my opinion there needs to be a faster method of reviewing adverse incidents to extract learning and to provide assurances for patients / families that their case has been comprehensively reviewed and learning extracted and implemented promptly. I don't think we have the tool perfected yet. There is a tool called a Structured Judgement Review, in which a team of people will review the patient notes and blood results / investigations and make a judgment as to whether the care was suboptimal or not and what learning there is to be shared immediately. As it doesn't involve a lengthy report, it can often be completed within a few weeks of the incident. Whilst this review has its limitations (including that it doesn't take a Root Cause Analysis approach), there must surely be some form of composite review method (encompassing the best parts of both SAI and SJR processes) that would produce a more timely outcome. This would be different from a Case Note Review which, as I understand matters, usually involves a single clinician expert in the relevant field and is used to inform as to the need for a further, more in-depth review.

7.5 I cannot answer as to the effectiveness of the nine SAI Reviews in terms of the implementation of their recommendations as I retired from my governance role and from the Trust in June 2021, before the recommendations could be substantially implemented.



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**8. Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant.**

8.1 As previously indicated, I was not aware of any clinical practice issues with any consultant or other practitioner in Urology. It was practice for the operational teams to oversee professional issues with staff and share any concerns directly with the Medical Director in respect of Doctors and the Director of Nurses, Midwives, and Allied Health Professionals in respect of other registrants. On reflection, I accept that it was sub-optimal to exclude the Head of Governance from this type of knowledge and I believe that there needs to be more joined up approach. The Director of Acute Services and Divisional Assistant Directors at the very least should have been made aware of any issues regarding Mr O'Brien's practices. But I don't believe, for example, that Melanie McClements was aware until the issues came to light following Mr O'Brien's retirement.

8.2 This sort of information was not shared at my level in Governance. However, I would expect the Assistant Director of Corporate Governance and above to have been made aware of such investigations. Infrequently, the Medical Director's Office would ask the Governance Team to provide documentation or information regarding certain personnel (similar to providing information for revalidation for doctors). This was implemented by Dr Diamond (Deputy Medical Director) toward the end of my tenure. On reflection, I believe that there may not always have been a sufficient flow of information in the other direction – from Medical Director's Office to Governance.

8.3 Whist I appreciate the need to respect confidentiality, I believe the Head of Governance should be made aware of issues in respect of medical and nursing staff so that they can identify if a staff member has been involved in previous incidents or complaints and feed this back to the Operational Assistant Directors / Medical Director's office. In the case of Mr O'Brien, we may have



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been able to identify that there were other previous SAI Reviews which had been closed involving Mr O'Brien but we had no clear oversight of that.

8.4 I believe that the process of identifying staff involved in clinical incidents has now changed and there are checks in place regarding any staff member involved or mentioned in adverse incidents and they are shared with the staff member and Medical Director for both appraisals and revalidation.

**9. What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known? If not your role, whose role was it to do this?**

9.1 I believe that my answer to Question 1(i) is relevant to this question as well and would therefore refer back to it because it sets out the detail of the responses (in which I played a role) to the issues involving Mr O'Brien, including, in particular, the 9 SAI Reviews under Dr Hughes.

9.2 By the time the issues regarding Mr O'Brien's practices were known to me following his retirement, they had already been escalated to the Medical Director' Office and appropriate actions taken. This was the reason the Deputy Medical Director, Dr Gormley, wanted the 2 July 2020 Datix (mentioned above) shared at the screening meeting so as to raise awareness within the Division of SEC that these issues had been discovered. From then on I was aware that there was correspondence with the HSCB and DOH to discuss how the Trust best proceeds with an investigation. I was aware that this would result in an SAI Review of patient care but was not advised of the detail until I was invited to attend a Urology Oversight meeting in September 2020 to update the team of the progress of the SAI Review. By then, it was clear that the Trust had taken steps to identify how many patients were involved and how it should proceed regarding investigations which included SCRRs and the Dr Hughes SAI involving 9 patients and an overarching report. I was asked by Dr Maria O'Kane, on behalf of the Urology Oversight Group, to approach Professor Sethia as a subject Matter Expert to review the care of 6 patients and provide



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an opinion as to whether or not patients came to harm. The findings of this were fed back directly to Dr O'Kane and Melanie McClements. I wasn't involved in any processes regarding the remaining patients subject to SCCR. Please see:

98a.-98c. 20210223 Expert Urology Opinion Prof Sethia, A1, A2

**10. Were you ever involved in briefing, either in person or in writing, the Senior Management Team when issues of governance and risk were being reported or discussed? If yes, please provide all details. If no, who was responsible for providing such briefings?**

10.1 I have already covered some of my interactions with Senior Management Team members about governance and risk issues at Question 5 above.

10.2 I wasn't involved directly at SMT meetings when concerns were being escalated. I was invited to attend the Urology Oversight Meeting on 15 September 2020, and weekly every Tuesday thereafter (unless I was on annual leave), to inform the Trust SMT as to the progress of the SAI Review for the 9 urology patients and the Overarching Review and to keep them appraised of the resources that were needed for my team to work through the Lookback on urology cancer services. When the SAI Review for the 9 urology patients identified any early learning, this were shared back to the Urology Oversight Meetings. These meetings were minuted and I understand the Inquiry has these.

10.3 On the second Friday of each month, the Acute Clinical Governance Meeting was held. All the Associate Medical Directors and Clinical Directors for each Division in Acute along with the Assistant Directors of Divisions, were invited to attend this meeting. Minutes were kept of each meeting and Mrs McClements chaired the meetings. At this meeting SAI reports were shared with the clinical teams for comments and rigour and to ensure that the recommendations were 'SMART' (i.e., specific, measurable, attainable,



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realistic, and timely). If not, these reports were sent back to the Chair of the SAI Review to re-word the recommendations in the SMART format. An example of this process is the Patient 16 SAI recommendations, which were considered at the Acute Clinical Governance Meeting on 17thJanuary 2020. In this case, the clinicians felt the recommendations were not 'SMART' or workable, and they requested I take it back to the Chair and the Medical Director for comments (please see email at WIT 40591). When a report was approved it was forwarded to the HSCB (now SPPG) in draft form, pending comments from the patient or their family. Then, following family engagement, the reports were shared as approved copies to the family and HSCB/SPPG. An exception to this process was the sharing of the 9 urology SAI Reviews and the related Overarching Report which were not discussed at Acute Clinical Governance meeting prior to being shared with the HSCB and DOH.

**11. Were you aware if any issues you raised regarding governance and risk were brought to the Senior Management Team? If yes, please explain in full. If no, what were the issues, and how are you aware they were not brought to the Senior Management Team?**

11.1 I didn't raise any governance and risk issues regarding Mr O'Brien to the SMT.

11.2 I only became aware of issues surrounding the clinical practice of Mr O'Brien at the Surgical Screening Meeting on 31 July 2020, by which point I understood the issues had already been raised by others at a higher level than me.

11.3 I do recall raising one discrete issue at a Urology Oversight Meeting, at which some SMT members would have been present. In approximately October 2020, whilst conducting the SAI Review for the 9 urology cases, I was made aware by the Review Panel's Subject Matter Expert, Mr Gilbert, that the treatment (Bicalutamide) given to one of the patients Patient 1 was potentially causing an accelerated growth of cancer cells, adversely affecting the patient's



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outcome. I shared this with the Urology Oversight Meeting the following Tuesday. Please see:

99. 20201020 Meeting

**12. Did you ever feel that issues of governance and risk you raised were not dealt with properly or at all?**

**1. If yes, please provide all details, including the names of those to whom you spoke about the issues.**

12.1 Not applicable.

**2. If no, how did you assure yourself that issues raised by you were properly addressed?**

12.2 As indicated at 11.3 above, I only raised one issue of governance and risk regarding Mr O'Brien: the Bicalutamide issue mentioned by Mr Gilbert in approximately October 2020. I raised it promptly through the Urology Oversight Meeting. I received assurances that the Trust was addressing this issue by taking steps to identify how many people had been prescribed the drug and by conducting a review of each relevant patient. I understand they also alerted the HSCB and DOH. The update on the progress of this issues was discussed as an agenda item in the weekly urology oversight meetings.

**13. Are you aware of any issues of governance, either raised by you or others, being brought to the attention of the Board and/or any of the Board Committees?**

13.1 As previously indicated in my answer to Question 1(i) above, I was aware that the Trust had escalated concerns regarding the practices of Mr O'Brien following his retirement in July 2020. I wasn't present at any Trust Board meetings or Governance Committee meetings but I was aware, through my attendance at the Urology Oversight Meetings, that the matter was being



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considered at a higher level than me including at Trust Board, HSCB/SPPG, and DOH level.

**14. Please detail all systems of oversight and monitoring used and/or developed by you in response to concerns or risks. How did these differ from what previously existed?**

14.1 The main systems in place for oversight and monitoring clinical incidents, of which I am aware, were as set out in my answer to Question 1 and below:

a. **Datix** - This system is the Trust's system to notify relevant staff via email about a clinical incident. It is very dependent on the reporter submitting a Datix and, if this isn't done, then oversight is compromised. However, once submitted there is assurance that someone in the organisation will view the Datix every working day. The Acute Governance Team look at all Datix submitted and screen out the major and catastrophic incidents. I understand that Risk Midwives in IMWH division review the Datix relevant to them every working day and action them according to the severity. The Heads of Service in each Division, Lead Nurses, and Ward Sisters also review the Datix pertinent to them and action them accordingly. Every incident is graded by the reporter as either insignificant, minor, moderate, major or catastrophic. All major and catastrophic incidents are first discussed with the Head of Service for that area to understand what happened and, if they are confirmed to be either major or catastrophic, then the incidents are brought to the "hot debrief" every Thursday or, in the event that screening took place before that debrief, then they would be brought to Screening. Any details would then be shared with the Director of Acute Services for information / action if required.

b. **Emails** – Staff are more likely to report to managers and senior managers (Band 7 and Band 8A) through email when an adverse event



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happens. This is the most common form of communication. A Datix would often then have been submitted retrospectively following email communication with the line manager.

c. **Verbal Communication -** Staff sometimes will report incidents directly, either face to face or by telephone, to their line manager before a Datix is submitted. In some instances, I believe that staff reporting verbally have had to be encouraged to submit a Datix, having initially reported it verbally in the hope that it would remove the need for them to complete what can sometimes be a labour-intensive, user-unfriendly form. Whilst someone in the system therefore becomes aware relatively quickly, not everyone does and a delay in submitting the Datix could lead to some delay in staff at a higher level being made aware.

d. **The "hot debrief" meeting** – This meeting, held every Thursday, is capable of addressing some issues in that staff from multiple Directorates attend (including the Director of Nursing and the Medical Director). At this meeting, high level complaints or incidents would be shared and discussed and a Datix submitted retrospectively. For example, if any adverse incident occurred during the week, one of the members of the operational team may share the details at the hot debrief and then ensure a Datix was submitted and brought to the next screening meeting. This also allows oversight on many levels including the Chief Executive and Trust Board as the minutes of these meetings are shared with them.

e. **Complaints / Ombudsman responses** – These can serve as a tool to identify issues, particularly in relation to patient care and the services the Trust provides. There is more emphasis placed on learning from complaints now than when I first came into post. An action plan is now generated to cascade learning through the appropriate teams.



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f. **Monthly compliance reports on Patient Safety** – These are produced monthly and shared with the operational leads (Assistant Director of the Division and cascaded down to the HOS / Lead Nurses and Ward Sisters) to ensure staff on the ground are aware of them.

g. **Patient Safety Reports** – A patient safety report details all the ward audits including hand hygiene, MUST (patient nutrition audits), and VTE risk assessment audits (i.e., any audit directly involved in patient care and safety). These reports are found in the governance papers. Please see**:**

100. 20190604 Acute Directorate Governance Action Notes

h. **Medicines Incidents** – These are shared through a monthly newsletter sent to all ward managers and there is a Medicines Governance Meeting held monthly by Pharmacy governance.

i. **The Haemovigilance Team** – This team oversees any blood transfusion issues or issues with staff competencies with venepuncture

j. **Maternity** - Learning from incidents are shared through a Risk Newsletter and through social media (a closed Facebook page – Good Practice Matters - which is shared with midwifery and medical staff only in IMWH).

k. There are also poster campaigns and themes of the month that are shared with staff to promote safe care.

l. **Targeted Training** – This is aimed directly at staff when they are involved in a clinical incident.

m. **Nursing and Midwifery Training** – The Nursing Governance Team attend the Nursing and Midwifery Forum monthly to update Lead Nurses, Midwives, HOS, and Assistant Directors of any compliance issues with



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mandatory training or revalidation issues. They will also advise on any practice issues for staff and nursing and midwifery resources.

14.2 I believe that the approach to sharing information within the organisation improved and became more cohesive from late 2019 onwards, which was definitely an improvement in terms of oversight and governance.

14.3 In addition to all of the mechanisms and systems mentioned above, SAI Reviews and the processes surrounding them (as described elsewhere in this statement – e.g., at Question 1) were a key aspect of the oversight and monitoring of clinical incidents. Recommendations following all SAI reviews were reported on a spread sheet for Divisions and shared with the Divisional Teams. In addition, I would provide the related Action Plans and seek assurances that these would be completed and shared with the relevant operational clinical teams. I would have met with the Heads of Services for each Division occasionally to see what progress was being made on the Action Plans. There were no records kept of these meetings. I kept completed Action Plans on the shared drive for governance. Please see:

100a.-100zg. 20190628MUSC Governance mtg, A1-A32

**15. If you were involved in developing systems in response to concern or risks, please set out in full the reasons why you felt it necessary to develop such systems, what the aim of those systems were and how effective you considered them to be. How did you assess or assure yourself of their effectiveness? Were these systems subject to review? Please explain your answers in full.**

15.1 During my tenure as Acute Governance Coordinator, from 21st January 2019 until June 2021, I didn't develop any system but instead built upon the systems already in place to ensure learning was shared. I had offered suggestions about how this could be done more effectively by using social media (for example Maternity Matters Facebook page, themes of the month, and poster campaigns, as used in maternity).



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15.2 Whilst I would have wanted to be involved in quality and service improvement this was not possible given the demands of the services and the resources available to me. I was occupied with the daily running of the service and trying to catch up on SAI reviews and complaints as well as the normal routine workload that demanded responses to the HSCB and RQIA.

**16. If these systems were introduced in response to SAIs, please explain why you think the risk and governance issues those systems were designed to address were not flagged before SAI stage? What was wrong with the systems existing at that time that the issues were not identified? If they were identified by existing systems, why were they not addressed?**

16.1 I am not aware of any new systems introduced as a result of the SAI Reviews completed by either Dr Johnston or Dr Hughes.

**17. During your tenure as Acute Clinical and Social Care Co-ordinator, did you consider, that you were adequately supported by your line managers and other staff? Please explain your answer in full, with names, roles and examples as relevant.**

17.1 When I first took up the post of Acting Acute Clinical and Social Care Governance Coordinator, I was not given a formal induction. My predecessor, Mrs Trudy Reid, was required to take up post as Assistant Director for Corporate Governance before I came into post and was I only afforded a 45-minute handover. However, I did have weekly meetings with my line manager, Dr Tracy Boyce, who was very supportive and offered me guidance and training for the role. I was able to discuss with her any governance concerns and training needs that I required. She also supported me with the governance processes in place and was happy for me to introduce my own suggestions regarding SAI Reviews and sharing learning with staff. I found the Director of Acute Services, Mrs Esther Gishkori to be supportive also. However, Esther did cancel a number of meetings at short notice. Esther was only in post until May



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2019 when she went on leave. I therefore only worked with her for approximately 4 months. Please see:

101. 20190201 E Gishkori cancellation of meetings due to Annual Leave

102. 20190208 Agenda for Governance Briefing with Esther Gishkori

103. 20190222 Diary Entry PK and Esther Gishkori

104. 20190222 Notes of Governance Briefing with Esther Gishkori

105. 20190225 Cancellation of Governance Briefing with Esther Gishkori

106. 20190308 Cancellation of Governance Briefing with Esther Gishkori

17.2 As discussed in question 1(i) above, when I first took up post there was a Band 6 Governance Nurse and a Band 5 Administration to assist me with the SAI Reviews until two newly recruited Band 7 Governance Managers took up post at the end of March and May 2019, respectively. I also had a Complaints Team who comprised a Band 6 Complaints Manager, a Band 5 Complaints Officer, a Band 3 Complaints Assistant, and a Band 2 Administrative Assistant. I had a Band 7 Standards and Guidelines (S&G) Manager who oversaw all the S&G for Acute Services, a Band 5 Governance Officer for Standards and Guidelines to assist her, and a Band 7 Equipment Manager responsible for all the medical devices within Acute Services.

17.3 Whilst staffing was sub-optimal, I could see there were some measures being put in place to improve the staffing situation (for example, the appointment of two Band 7 Governance Managers). Nonetheless, in comparison to the resources available to my counterparts in other Directorates, I was significantly under-resourced for the workload required for Acute Governance.

17.4 I explained my staffing and resource concerns to the Director of Acute Services at the time, Mrs Esther Gishkori, and requested additional support. I advised her, amongst other things, that I had inherited 35 SAI reports which had been started but not progressed and needed to be reviewed and some of them had to be restarted with the review teams. There was an ongoing urology review chaired by Dr Johnston that I was advised was being facilitated by my



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predecessor, Mrs Trudy Reid, who would be completing the review along with the Chair. In my previous role as a Clinical Risk Midwife, I was experienced in facilitating SAI Reviews and liaising with patients and families. However, I found that I was unable to engage fully with patients and their relatives when I took up the post of Acting Governance Coordinator. This was very frustrating and I felt I was not providing as good a service for the families. I was tasked with completing the outstanding SAI reports as a priority and this took up most of my time in my first year in post.

**18. During your tenure, where you offered any support for quality improvement initiatives? If yes, please explain and provide any supporting documentation.**

18.1 Due to the workload in Governance, there was very little opportunity to undertake quality improvement initiatives. Mrs McClements did support me in my suggestion of appointing Risk Nurses within the Divisions to assist with the implementation of the Action Plans from SAIs and the training for staff regarding recommendations. This was taken forward through Quality Improvement Leads (rather than Risk Nurses) who were subsequently recruited and operationalised.

**19. What, in your experience, was *the culture* within (i) Acute Services and (ii) urology, regarding governance? For example, do you think there was enough time to properly manage and respond to governance issues? Did you feel that governance concerns raised by or through you were adequately addressed?**

**(i) Acute Services**

19.1 When I first took up my governance post in 2019, I believe that there was a culture of patient safety as well as an aspiration to improve the governance processes and oversight and a genuine commitment to attain that improvement.

19.2 However, I believe there were significant resources issues facing the Southern Trust that may not have been faced by other Trusts. For example,



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during the SAI Review of the 9 urology patients and the Overarching Review, the Chair and I met with the Urology MDT members and some of them described noticing a considerable difference in resources in the Southern Trust in comparison with Trusts in England where there was good follow-up and where tracking was more robust, more of a priority, and had administrative support. One doctor advised us that there were weekly trackers who would liaise with consultants, enabling them to meet their cancer timelines whereas in our Trust the trackers were only funded in respect of 31-day and 62-day targets and not to act as a broader failsafe system. Please see:

107. 20210218 Notes of Meeting with MDT 18.2.2021

19.3 I think that communication or triangulation of knowledge was also poorer than it could have been. For example, I wasn't made aware in a timely manner of the MHPS process or of the recommendations that flowed from it. I was made aware verbally by Martina Corrigan, following the Dr Johnston SAI, that there were measures in place involving administration staff monitoring the triage of letters and tracking of case notes involving Mr O'Brien. I was under the impression that this monitoring was working well. However, I was under so much pressure with the day-to-day work in governance that I didn't have time to check on it to assure myself that it was effective. I do not know if a broader information / knowledge base in this regard would have made a difference but it might have done.

19.4 The workload in Acute Services and Governance was heavy and staff were constantly trying to deal with the day to day pressures within busy hospitals. There simply wasn't enough time to do compliance audits regarding the adherence to recommendations arising out of all SAIs and complaints. This was a limitation. Audits were limited to compliance directly related to patient care, for example, audits of surgical site infections and infection rates for patients on ventilators (VAP). Whilst these are important, there also needs to be audits regarding the implementation of and adherence to recommendations and guidelines to protect patients and provide good standards of care



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19.5 As previously discussed there were monthly Acute Governance Meetings and Acute Clinical Governance meeting to which issues could be brought and discussed in a multidisciplinary meeting to get a consensus and / or solution. These meetings were poorly attended by some of the Clinical Directors within Acute Services until June 2020, when they were hosted via Zoom. It was always difficult getting staff freed up to attend an 8am Friday morning meeting but, after the introduction of Zoom, meeting attendance improved significantly. This in turn made discussions at these meetings more productive.

19.6 I felt there was very good communication between the Director of Acute Services, Melanie McClements, who came into post in June 2019, and myself. I was able to stock-take on my service requirements and recruit more staff to assist with complaints responses in a more timely manner. The staffing resources provided to the Governance Team improved during my tenure between February 2019 and June 2021.

**(ii) Urology Services**

19.7 As discussed in my answer at Question 1(ii), I wasn't aware of any governance issues regarding urology until the Dr Johnston SAI Review Report was shared and, even then, I was under the impression that the issues were administrative and not clinical. When I asked Dr Boyce if the triaging of letters affected patient safety directly, I was advised that it did on the number of patients identified in the SAI by Dr Johnston. I didn't fully appreciate at the time, that this would have more far-reaching consequences for patient care. When Dr Hughes chaired his SAI Review for the 9 urology patients, it did highlight that the urology MDM was not as effective as it should have been and did not function in the same way as other MDMs did within the Trust (for example, that in respect of Breast Cancer). I made the Director of Acute Services aware of this so that issues could be addressed promptly.

**20. What is your overall view of *the effectiveness* of governance systems within –**



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1. **Acute services generally, and**
2. **Urology service in particular**

**Do you think the governance arrangements, overall, were and are fit for purpose?**

**Acute Services**

20.1 When I first came into post in January 2019 the governance team was significantly under-resourced and there was a huge backlog of work including complaints responses and unfinished Serious Adverse Incident Reviews waiting to be completed. At this point I would have felt the governance system was not fully effective.

20.2 However, there are now some good processes for governance oversight in place that have been implemented since my appointment at the beginning of 2019, for example, the weekly "hot debrief", where any issues that occur are shared with the governance team from a higher level down and vice versa.

20.3 As mentioned already above, I wasn't made aware of certain issues (particularly in relation to professional issues like MHPS processes) of which I have no doubt people higher up in the Trust were aware. Whilst they may have believed they had addressed some of the issues, there were clearly faults in a system that allowed one consultant to continue to be non-adherent to appropriate practice in some areas and, more broadly, for there to be failure to progress matters such as the recommendations made by the MHPS process.

20.4 If there had been issues with a non-clinical staff member or even a nurse or midwife, I believe they would have been held to account and disciplined and perhaps even had their employment terminated. There did seem to be too much deference made to this consultant in particular.

20.5 I have seen vast improvement in oversight and governance in Acute Services, particularly since July 2020. For example, there was more oversight and rigour in the system and escalation when an adverse event happened. In



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my opinion, the Director of Acute, Mrs McClements, clearly made oversight a priority and demanded the same of me and my colleagues to ensure she was fully aware of anything going on within the Acute Directorate.

**Urology Service**

20.6 As stated in the first limb of this answer, the governance team was significantly under-resourced and this, I believe, was also true of the Urology Service. I believe that staff were so busy dealing with the day-to-day issues and backlogs that they accepted that their specialty was under-resourced and tried to get on with the job. This was clear to me from the meetings Dr Hughes and I had with the MDT and Specialist Nurses in the course of the 9 urology SAI Reviews. I do now believe, having been involved with those 9 SAI Reviews, that the issues with Mr O'Brien did not reflect the service provided by the other staff in the urology service. I also got the impression that some staff members in urology were afraid to challenge a senior consultant like Mr O'Brien, with so many years of experience.

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20.7 I think that the positives I take from the 9 SAI Reviews, following discussion with some of the Consultant Urologists, is that they did escalate concerns when they discovered practice issues and concerns regarding patient care. I think it is unfair to judge the Urology Service now with how it was prior to 2020 when the concerns were raised. I think that the systems and processes in place by the time of my retirement were much more rigorous than when I first took up post at the beginning of 2019, when they weren't fit for purpose.

**21. What, in your opinion, could have improved the effectiveness of the governance structures and systems in place during your tenure?**

21.1 More resources could have improved the efficiency and effectiveness of governance systems and structures of the Acute Directorate. Some particular reflections on this are summarised below.



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a. As the largest operational team, the resources were not equitably distributed compared with other Governance Directorates within the Trust.

b. SAI Reviews in particular are difficult to get started due to clinical commitments of specialist Chairs, especially consultants, who have busy schedules and are not provided with dedicated time to investigate an SAI, interview staff, meet families, and write up the report. It really takes a dedicated team with experience to achieve this. However, although the Trust has invested in professional Chairs, there are simply not enough of them to handle the numbers of SAI Reviews. I believe that there should be governance sessions built into clinicians' job plans, whilst I appreciate the shortage of staff and long waiting lists can make this difficult, there is an opportunity for experienced clinicians interested in SAI Reviews to retire and return to assist the Trust. This would expedite the learning from SAI and ensure SMART recommendations are made and implemented and learning shared through M&M and Action Plans. Currently the length of time it takes for SAI reports to be completed means we are exposed to a risk of recurrence before the learning is shared and / or implemented.

c. The introduction of Family Liaison Personnel has improved the feedback and interaction with families so the earlier introduction of this resource would also have been beneficial

21.2 Greater auditing of our services' responses, and more feedback from patients and families, would have improved our services. The reintroduction of the Patient Support Role would have reduced complaint as my experience is that issues were typically addressed by this team at the point of service whilst patients are in hospital. This improved the patient experience.



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**22. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?**

22.1 The SAI Reviews for the 9 urology patients and the Overarching Review identified significant failures in Trust systems and processes which to contributed to patients coming to harm whilst under the care of the Urology Service. Clearly, our systems should be designed and operated to prevent harm and keep patients safe. It is true that other MDTs worked more efficiently than the Urology one but it is also the case, I believe, that they had considerably more resources. For example, Breast MDT had the benefit of oncologists being present at the MDT.

22.2 Regarding one professional's lack of adherence to cancer pathways and recommendations from the MDT, clearly the system should have been able to pick up such non-compliance. A better system would have had a mechanism for following up the actioning of test results and referrals to other services recommended by the MDT. Lack of resources and the lack of robust processes contributed to that in my opinion.

22.3 Regardless of one person's reluctance to practice appropriately, the system should have had measures in place to prevent that happening or to stop it if it occurred.

22.4 I believe that the resources required to 'failsafe the system' could, largely or perhaps entirely, comprise Band 3 clerical staff. It doesn't require professionals to do it, just a clear process (standard operating procedure) to spell out what steps need to be taken and what actions need to occur if a missed step or breach is recognised.



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22.5 I also believe that there were too many individual processes (MHPS) and/or insufficient joined up thinking. For example, the details of the MHPS process were kept confidential and my understanding is that very few people knew about it. There was also an apparent inability to join the dots between, for example, clinical issues identified in previous adverse incidents and issues arising more recently.

22.6 We should be an organisation with an effective corporate memory so that when any adverse incident happens that learning is not only shared for the Division or area of practice but extended to all areas within the Trust. Lessons must be learned by all teams and action plans from recommendations should be kept live and revisited at least annually to prevent recurrence. Too often learning from adverse incidents is shared and there is some learning for a few years; then staff change roles and/or retire and corporate memory is lost, increasing the risk of problems recurring.

22.7 On reflection, I should have probed further into the administrative issues regarding Mr O'Brien to identify what other issues may have been revealed but I was occupied with my heavy work load.

**23. If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.**

23.1 I would like to add that my role in the SAI Review for the 9 urology patients and the Overarching Report was of one of facilitation. I assisted the team with the provision of notes and setting up meetings and liaising with staff and families. I advised the team regarding governance processes to ensure the quality of the reports were in keeping with national and regional guidance.



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23.2 I found it to be one of the most robust and worthwhile SAI reviews I have ever been involved in. I thought Dr Hughes was an excellent Chair and that he endeavoured to create a fair review for the patients (and/or their families) and staff. Meeting the patients and families and hearing their stories was truly moving and some of them really wanted to be involved in sharing the learning from this Review, which was inspirational. I would like to add in this particular regard that I appreciate how stressful this Inquiry must be for the patients and their families and my thoughts and prayers are with them all during this process.

**NOTE:**

**By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.**

**Statement of Truth**

**Signed: Patricia Kingsnorth (Signature attached)**

**Dated: 3rd May 2023**



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**Section 21 Notice Number 2 of 2023**

**Witness: Patricia Kingsnorth**

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**Table 2.** Identifying risk

| Internal sources | External sources |
|---|---|
| Risk assessment conducted in all clinical areas (wards, clinics, theatre, delivery suite, day assessment unit, etc.) | National Confidential Enquiries |
| Incident reporting | CNST standards |
| Complaints and claims | RCOG guidelines, protocols and visitation |
| Staff consultation – workshops, surveys, interviews | National Patient Safety Agency alerts |
| Clinical audit | Postgraduate dean's specialty site visits |
| | Care Quality Commission |

**Table 3.** Suggested trigger list for incident reporting in maternity

| Maternal incident | Fetal/neonatal incident | Organisational incidents |
|---|---|---|
| Maternal death | Stillbirth > 500 g | Unavailability of health record |
| Undiagnosed breech | Neonatal death | Delay in responding to call for assistance |
| Shoulder dystocia | Apgar score < 7 at 5 minutes | Unplanned home birth |
| Blood loss > 1500 ml | Birth trauma | Faulty equipment |
| Return to theatre | Fetal laceration at caesarean section | Conflict over case management |
| Eclampsia | Cord pH < 7.05 arterial or < 7.1 venous | Potential service user complaint |
| Hysterectomy/laparotomy | Neonatal seizures | Medication error |
| Anaesthetic complications | Term baby admitted to neonatal unit | Retained swab or instrument |
| Intensive care admission | Undiagnosed fetal anomaly | Hospital-acquired infection |
| Venous thromboembolism | European Congenital Anomalies and Twins (Eurocat)[21] | Violation of local protocol |
| Pulmonary embolism | | |
| Third-/fourth-degree tears | | |
| Unsuccessful forceps or ventouse | | |
| Uterine rupture | | |
| Readmission of mother | | |

**Table 4.** Suggested trigger list for incident reporting in gynaecology

| Clinical incident | Organisational incidents |
|---|---|
| Damage to structures (e.g. ureter, bowel, vessel) | Delay following call for assistance |
| Delayed or missed diagnosis (e.g. ectopic pregnancy) | Faulty equipment |
| Anaesthetic complications | Conflict over case management |
| Venous thromboembolism | Potential service user complaint |
| Failed procedures (e.g. termination of pregnancy, sterilisation) | Medication error |
| Unplanned intensive care admission | Retained swab or instrument |
| Omission of planned procedures (failure to insert planned intrauterine contraceptive device after a hysteroscopy) | Violation of local protocol |
| Unexpected operative blood loss > 500 ml | |
| Moderate/severe ovarian hyperstimulation (assisted conception) | |
| Procedure performed without consent (e.g. removal of ovaries at hysterectomy) | |
| Unplanned return to theatre | |
| Unplanned return to hospital within 30 days | |

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Southern Health and Social Care Trust

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# Acute Directorate Clinical & Social Care Governance (CSCG) Co-ordinator

Working together Excellence Openness & Honesty Compassion

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BE PART OF IT.

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# JOB DESCRIPTION

| | |
|---|---|
| **JOB TITLE** | **Acute Directorate Clinical & Social Care Governance (CSCG) Co-ordinator** |
| **BAND** | 8B |
| **DIRECTORATE** | ACUTE |
| **INITIAL LOCATION** | Craigavon Area Hospital |
| **REPORTS TO** | Director of Acute Services |
| **ACCOUNTABLE TO** | Director of Acute Services |

**JOB SUMMARY**

The post holder will have responsibility for driving forward and coordinating all aspects of the Trust CSCG agenda within the Acute Directorate with and on behalf of, the Service Director and the Assistant Director with responsibility for Governance. They will provide an internal and external Directorate focus for the prioritisation, linking, implementation and review and monitoring of both the operational and professional governance agenda for the Directorate.

The post holder will, on behalf of the Director, provide a key challenge function to the service teams within the Directorate to ensure that areas where performance improvement in relation to CSCG is required are identified and addressed. They will contribute to developing corporate and operational strategy, policy and decision making within the Trust with respect to the CSCG agenda within the Directorate and as an integral part of the Trust CSCG Working Body and through close collaboration with the Trust's Corporate Assistant Director for CSCG. They will be responsible for advising on and actively participating in planning, delivering, reviewing and monitoring both Directorate and Corporate CSCG plans and will act as a focal point for the Director of Acute Services and the Trust's Corporate Assistant Director for CSCG in respect of any issues relating to the development, implementation, performance management and assurance of CSCG plans, systems and procedures and their associated improvement plans.



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The post holder will provide enhanced CSCG support and performance improvement expertise and intervention in this area to their Directorate and to corporate CSCG projects where required. He/She will provide their Directorate and the organisation with a suite of intelligent information analyses which demonstrate real time performance in relation to all areas of CSCG, including Incidents, Complaints, Risk, Litigation, Audit, Clinical Indicators and Patient Safety. The post holder will also be required in collaboration with the Trust Senior Management Team and the Trust CSCG Senior Manager, to develop the organisation's capacity for continuous improvement in the area of CSCG and to facilitate a culture of openness and learning from experience using dynamic leadership and facilitation skills.

## KEY DUTIES / RESPONSIBILITIES

### Directorate Responsibilities

1. On behalf of the Director of Acute Services, to take the lead within the Directorate in providing assurance to the organisation that all aspects of CSCG are of a sufficiently high standard of compliance and to ensure that the Trust CSCG systems and processes are embedded within the Directorate and are providing timely assurance and alerts to both the Service Director and the organisation.

2. Lead on ensuring that at each level of the Directorate, staff have access to timely, high quality and appropriate information in relation to incidents, complaints, audit, clinical indicators, litigation and risk and that with in each service team this information is being acted on appropriately in order to mitigate risk, improve quality of care and patient and client safety.

3. In particular to coordinate via the Directorate governance team the timely and appropriate responses to both incidents and complaints on behalf of the Directorate and to ensure standards of response times and patient / client satisfaction is the complaints process is maintained.

4. To ensure that strong links are maintained between Directorates and corporate functions such as complaints, the management of SAI's and litigation.

5. Lead on the investigation of serious adverse incidents in the Acute Directorate, ensuring that a consistently high standard of investigation and report writing is maintained at all times.

6. Lead on patient/family engagement in relation to serious adverse incidents within the Acute Directorate.



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7. Lead on the interpretation and implementation planning of all standards and guidelines in relation to patient and client care and service provision within the Directorate and facilitate service teams to ensure that these are implemented, monitored and reviewed in a timely manner.

8. Provide project management leadership when required in relation to implementation of standards and guidelines and / or the implementation of new Trust wide systems and processes related to CSCG. Identify any constraints, including resources, to implementation in a timely way and immediately report this to the Director and/or Assistant Director with responsibility for CSCG.

9. Use expert analytical skills to interpret the broad range of performance information and other data, including internal and external benchmarking, to identify service and Directorate trends, exceptions, risks and alerts in relation to CSCG issues and to present these in an appropriate format to service teams and the Director.

10. Lead on provision of specialist clinical governance and risk management knowledge and expertise to sensitively and constructively challenge and assist directorate teams in diagnosing and addressing the complex issues and factors which are preventing them maximizing their CSCG performance in relation to patient and client quality care and safety.

11. Lead on provision of specialist expertise to the Director and their senior managerial and clinical staff in relation to the management of incidents and complaints requiring detailed analysis and significant learning.

12. Provide expert advice and knowledge to the Directorate in relation to the concepts of risk management and mitigation and ensure that the Directorate proactively manages risk at all levels of service on a continuous basis.

13. Develop and foster excellent working relationships with service teams at all levels of the Directorate based on confidentiality and trust to enable and foster a Directorate and organizational culture of openness in relation to patient and client care.

14. Hold the other members of the governance team to account in relation to the successful delivery of all aspects of CSCG across the Divisions within the Directorate.



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15. On behalf of the Director take the lead on ensuring good communication and clear lines of accountability relating to operational and professional CSCG. Coordinate the various Directorate Governance fora, assist the Director in prioritising new CSCG plans and projects, and be a focal reporting point for professional support and governance functions within the Directorate.

16. Lead on the provision of appropriate training in all aspects of CSCG for Directorate staff.

17. Develop and maintain strong networks with organisational, regional and national CSCG colleagues, keeping up to date with latest thinking and developments and bring this intelligence back to the organisation to inform and drive improvement.

**Organisational Responsibilities**

1. On behalf of the Service Director lead on the provision of key Directorate information and data in a timely and appropriate format to the organisation which provides corporate assurance that both the operational and professional aspects of CSCG are of a sufficiently high standard within the Directorate.

2. Lead the Directorate representation on the Trust CSCG working body and contribute to, and lead on as appropriate, the development, implementation and audit of organisational wide CSCG policies and procedures.

3. Be the lead within the Directorate in relation to sharing and learning from CSCG trends, exceptions, alerts and risk at an organisational wide level via the Trust CSCG working body. Disseminate this information throughout the Directorate and develop measures to evidence that learning has resulted in changes in practice.

4. Work collaboratively with the Trust's Corporate Assistant Director for CSCG to ensure that there is a clear, two way line of communication from Acute Directorate to SMT Governance and Trust Governance Committees.

5. Act as one of a small number of experts in CSCG who advise the Trust, via the CSCG working body, on organisational, regional and national policies, their organisational implications and potential implementation plans / methodologies.

6. Take the lead in planning and implementation of Trust wide policies and procedures as required via the CSCG working body and actively bring forward to the CSCG working body forum strategic plans for driving forward the CSCG



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agenda within the Southern Trust and influencing and shaping this agenda regionally.

7. Ensure through providing robust monitoring arrangements, that at all times the Directorate is complying with and operating within the CSCG policies, procedures and standards that the Trust has agreed. Where monitoring indicates any exception or deviation this must first be brought to the attention of the Director of Acute Services. Where the issue remains unresolved the post holder must identify the deviation or exception to the SMT Governance via the appropriate Executive Director.

## HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

The Trust supports and promotes a culture of collective leadership where those who have responsibility for managing other staff:

1. Establish and promote a supportive, fair and open culture that encourages and enables all parts of the team to have clearly aligned goals and objectives, to meet the required performance standards and to achieve continuous improvement in the services they deliver.

2. Ensure access to skills and personal development through appropriate training and support.

3. Promote a culture of openness and honesty to enable shared learning.

4. Encourage and empower others in their team to achieve their goals and reach their full potential through regular supportive conversation and shared decision making.

5. Adhere to and promote Trust policy and procedure in all staffing matters, participating as appropriate in a way which underpins Trust values.

## RAISING CONCERNS - RESPONSIBILITIES

1. The post holder will promote and support effective team working, fostering a culture of openness and transparency.

2. The post holder will ensure that they take all concerns raised with them seriously and act in accordance with the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and their professional code of conduct, where applicable.



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3. The post holder will, in the event of a concern being raised with them, ensure that it is managed correctly under the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and ensure feedback/learning is communicated at individual, team and organisational level.

## EMERGENCY PLANNING & BUSINESS CONTINUITY RESPONSIBILITIES

- To work proactively with the Trust's Emergency planner and other internal and external stakeholders to develop appropriate emergency response and business continuity plans to ensure the service can maintain a state of emergency preparedness to respond safely and effectively to a range of threats, hazards and disruption.

## PERSONAL AND PUBLIC INVOLVEMENT RESPONSIBILITIES (PPI)

- To ensure effective communication with service users and families and to embed the role of Family Liaison as a key mechanism to involve and support families
- Lead on and be responsible for the co-ordination of the Trust's PPI Strategy within the Division or other sphere of responsibility. This will include supporting active engagement with user groups and the voluntary and independent sectors in the design and delivery of services.

## GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

3. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.



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5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. Employees are required to be conversant with the [org name] policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

8. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

*<April 2021>*



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# PERSONNEL SPECIFICATION

| | |
|---|---|
| **JOB TITLE AND BAND** | **Acute Clinical & Social Care Governance (CSCG) Co-ordinator Band 8B** |
| **DEPARTMENT / DIRECTORATE** | **Acute Services** |
| **HOURS** | **37.5** |

**Notes to applicants:**

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form. Please note the Trust reserves the right to use any desirable criteria outlined in Section 3 at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

## ESSENTIAL CRITERIA

**SECTION 1:** The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.

| Factor | Criteria | Method of Assessment |
|---|---|---|
| **Experience** | 1. Have delivered against challenging performance management programmes for a minimum of 2 years meeting a full range of key targets and making significant improvements.<br><br>2. Have worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes for a minimum of 2 years.<br><br>3. Have successfully demonstrated high | Shortlisting by Application Form |



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| | | |
|---|---|---|
| | level strategic and people management, and organisational skills for a minimum of 2 years. | |
| **Qualifications/ Registration** | 1. Have a relevant professional qualification at degree level of above, and worked for at least 2 years in a senior management role (band 7 or above) in a major complex organisation with responsibilities for aspects of risk management and governance.*<br><br>Or<br><br>2. Have worked for at least 4 years in a senior management role in a major complex organisation with responsibilities for aspects of risk management and governance.* | Shortlisting by Application Form |
| **Other** | Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. *This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post.* | Shortlisting by Application Form |
| **SECTION 2**: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage: | | |
| **Skills / Abilities** | ***The following are essential criteria which will be measured during the interview stage.***<br><br>1. Have good communication skills (written, oral, presentational and interpersonal) with the ability to communicate effectively with all levels of staff.<br><br>2. Evidence of highly effective planning and organisational skills.<br><br>3. Demonstrate the ability to assess risk and problem-solve based on excellent analytical skills. | Interview |



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| | | |
|---|---|---|
| | 4. A good level of computer literacy<br><br>5. Demonstrate the ability to write clear and concise reports related to complex subject matter. | |

| DESIRABLE CRITERIA | | |
|---|---|---|
| **SECTION 3:** these will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted | | |
| **Factor** | **Criteria** | **Method of Assessment** |
| **Experience** | Have 2 years' experience in Clinical and Social Care Governance setting. | Shortlisting by Application Form |

Candidates who are shortlisted for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. The competencies concerned are set out in the NHS Healthcare Leadership Model, details of which can be found at http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model. Particular attention will be given to the following dimensions:

- Inspiring shared purpose
- Leading with care
- Evaluating information
- Connecting our service
- Sharing the vision
- Engaging the team
- Holding to account
- Developing capability
- Influencing for results.

*As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.*
*Successful applicants may be required to attend for a Health Assessment*

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***Successful applicants:***

- *may be required to attend for a Health Assessment*
- *can expect to be placed at the minimum point of the pay scale, although a higher starting salary, within the range of the pay band may be available if the person appointed has experience relevant & equivalent to the post. If the successful candidate is an existing HSC employee moving to a higher band, AfC Pay on Promotion will apply.*



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| HSC Value | What does this mean? | What does this look like in practice? - Behaviours |
|---|---|---|
| **Working Together** | We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all. | • I work with others and value everyone's contribution<br>• I treat people with respect and dignity<br>• I work as part of a team looking for opportunities to support and help people in both my own and other teams<br>• I actively engage people on issues that affect them<br>• I look for feedback and examples of good practice, aiming to improve where possible |



| | | |
|---|---|---|
| **Compassion** | We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves. | • I am sensitive to the different needs and feelings of others and treat people with kindness<br>• I learn from others by listening carefully to them<br>• I look after my own health and well-being so that I can care for and support others |



| | | |
|---|---|---|
| **Excellence** | We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support. | • I put the people I care for and support at the centre of all I do to make a difference<br>• I take responsibility for my decisions and actions<br>• I commit to best practice and sharing learning, while continually learning and developing<br>• I try to improve by asking 'could we do this better?' |



| | | |
|---|---|---|
| **Openness & Honesty** | We are open and honest with each other and act with integrity and candour. | • I am open and honest in order to develop trusting relationships<br>• I ask someone for help when needed<br>• I speak up if I have concerns<br>• I challenge inappropriate or unacceptable behaviour and practice |

**All staff are expected to display the HSC Values at all times**

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#bettertogether

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Health and Social Care Board

# Procedure for the Reporting and Follow up of Serious Adverse Incidents

November 2016
Version 1.1

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| | |
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# FOREWORD

Commissioners and Providers of health and social care want to ensure that when a serious event or incident occurs, there is a systematic process in place for safeguarding services users, staff, and members of the public, as well as property, resources and reputation.

One of the building blocks for doing this is a clear, regionally agreed approach to the reporting, management, follow-up and learning from serious adverse incidents (SAIs). Working in conjunction with other Health and Social Care (HSC) organisations, this procedure was developed to provide a system-wide perspective on serious incidents occurring within the HSC and Special Agencies and also takes account of the independent sector where it provides services on behalf of the HSC.

The procedure seeks to provide a consistent approach to:

- what constitutes a serious adverse incident;
- clarifying the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning;
- fulfilling statutory and regulatory requirements;
- tools and resources that support good practice.

Our aim is to work toward clearer, consistent governance arrangements for reporting and learning from the most serious incidents; supporting preventative measures and reducing the risk of serious harm to service users.

The implementation of this procedure will support governance at a local level within individual organisations and will also improve existing regional governance and risk management arrangements by continuing to facilitate openness, trust, continuous learning and ultimately service improvement.

This procedure will remain under continuous review.

Valerie Watts
**Chief Executive**



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## SECTION ONE - PROCEDURE

# 1.0 BACKGROUND

Circular HSS (PPM) 06/04 introduced interim guidance on the reporting and follow-up on serious adverse incidents (SAIs). Its purpose was to provide guidance for HPSS organisations and special agencies on the reporting and management of SAIs and near misses.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hss(ppm)06-04.pdf

Circular HSS (PPM) 05/05 provided an update on safety issues; to underline the need for HPSS organisations to report SAIs and near misses to the DHSSPS in line with Circular HSS (PPM) 06/04.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hssppm05-05.pdf

Circular HSS (PPM) 02/2006 drew attention to certain aspects of the reporting of SAIs which needed to be managed more effectively. It notified respective organisations of changes in the way SAIs should be reported in the future and provided a revised report pro forma. It also clarified the processes DHSSPS had put in place to consider SAIs notified to it, outlining the feedback that would then be made to the wider HPSS.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/qpi_adverse_incidents_circular.pdf

In March 2006, DHSSPS introduced Safety First: A Framework for Sustainable Improvement in the HPSS. The aim of this document was to draw together key themes to promote service user safety in the HPSS. Its purpose was to build on existing systems and good practice so as to bring about a clear and consistent DHSSPS policy and action plan.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/safety_first_-_a_framework_for_sustainable_improvement_on_the_hpss-2.pdf

The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 imposed a 'statutory duty of quality' on HPSS Boards and Trusts. To support this legal responsibility, the Quality Standards for Health and Social Care were issued by DHSSPS in March 2006.

www.health-ni.gov.uk/publications/quality-standards-health-and-social-care-documents

Circular HSC (SQS) 19/2007 advised of refinements to DHSSPS SAI system and of changes which would be put in place from April 2007, to promote learning from SAIs and reduce any unnecessary duplication of paperwork for organisations. It also clarified arrangements for the reporting of breaches of patients waiting in excess of 12 hours in emergency care departments.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hss__sqsd__19-07.pdf

Under the Provisions of Articles 86(2) of the Mental Health (NI) Order 1986, the Regulation & Quality Improvement Authority (RQIA) has a duty to make inquiry into any



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case where it appears to the Authority that there may be amongst other things, ill treatment or deficiency in care or treatment. Guidance in relation to reporting requirements under the above Order previously issued in April 2000 was reviewed, updated and re-issued in August 2007. (Note: Functions of the previous Mental Health Commission transferred to RQIA on 1 April 2009).

http://webarchive.proni.gov.uk/20101215075727/http://www.dhsspsni.gov.uk/print/utec_guidance_august_2007.pdf

Circular HSC (SQSD) 22/2009 provided specific guidance on initial changes to the operation of the system of SAI reporting arrangements during 2009/10. The immediate changes were to lead to a reduction in the number of SAIs that were required to be reported to DHSSPS. It also advised organisations that a further circular would be issued giving details about the next stage in the phased implementation which would be put in place to manage the transition from the DHSSPS SAI reporting system, through its cessation and to the establishment of the RAIL system.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2022-09.pdf

Circular HSC (SQSC) 08/2010, issued in April 2010, provided guidance on the transfer of SAI reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency. It also provided guidance on the revised incident reporting roles and responsibilities of HSC Trusts, Family Practitioner Services, the Health & Social Care (HSC) Board and Public Health Agency (PHA), the extended remit of the Regulation & Quality Improvement Authority (RQIA), and the Department.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2008-10.pdf

Circular HSC (SQSD) 10/2010 advises on the operation of an Early Alert System, the arrangements to manage the transfer of Serious Adverse Incident (SAI) reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency and the incident reporting roles and responsibilities of Trusts, family practitioner services, the new regional organisations, the Health & Social Care (HSC) Board and Public Health Agency (PHA), and the extended remit of the Regulation & Quality Improvement Authority (RQIA).

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

In May 2010 the Director of Social Care and Children HSCB issued guidance on 'Untoward Events relating to Children in Need and Looked After Children' to HSC Trusts. This guidance clarified the arrangements for the reporting of events, aligned to delegated statutory functions and Departmental Guidance, which are more appropriately reported to the HSCB Social Care and Children's Directorate.

In 2012 the HSCB issued the 'Protocol for responding to SAIs involving an alleged homicide'. The 2013 revised HSCB 'Protocol for responding to SAIs involving an alleged homicide' is contained in Appendix 14.

Circular HSS (MD) 8/2013 replaces HSS (MD) 06/2006 and advises of a revised Memorandum of Understanding (MOU) when investigating patient or client safety incidents. This revised MOU is designed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required when a serious incident occurs.



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www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2013.pdf

DHSSPS Memo dated 17 July 2013 from Chief Medical Officer introduced the HSCB/PHA protocol on the dissemination of guidance/information to the HSC and the assurance arrangements where these are required. The protocol assists the HSCB/PHA in determining what actions would benefit from a regional approach rather than each provider taking action individually.

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/002%20%20HSCB-PHA%20Protocol%20for%20Safety%20Alerts.pdf

Circular HSC (SQSD) 56/16 (21 October 2016) from the Deputy Chief Medical Officer advises of the intention to introduce a Never Events process and that information relating to these events will be captured as part of the Serious Adverse Incident Process. The circular indicates the Never Events process will be based on the adoption of Never Event List with immediate effect.

https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-56-16.pdf



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## 2.0 INTRODUCTION

The purpose of this procedure is to provide guidance to Health and Social Care (HSC) Organisations, and Special Agencies (SA) in relation to the reporting and follow up of Serious Adverse Incidents (SAIs) arising during the course of their business or commissioned service.

The requirement on HSC organisations to routinely report SAIs to the Department of Health (DoH) {formerly known as the DHSSPS} ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, transferred to the Health and Social Care Board (HSCB) working both jointly with the Public Health Agency (PHA) and collaboratively with the Regulation and Quality Improvement Authority (RQIA).

This process aims to:

- Provide a mechanism to effectively share learning in a meaningful way; with a focus on safety and quality; ultimately leading to service improvement for service users;

- Provide a coherent approach to what constitutes a SAI; to ensure consistency in reporting across the HSC and Special Agencies;

- Clarify the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning arising from SAIs which occur during the course of the business of a HSC organisation / Special Agency or commissioned/funded service;

- Ensure the process works simultaneously with all other statutory and regulatory organisations that may require to be notified of the incident or be involved the review;

- Keep the process for the reporting and review of SAIs under review to ensure it is fit for purpose and minimises unnecessary duplication;

- Recognise the responsibilities of individual organisations and support them in ensuring compliance; by providing a culture of openness and transparency that encourages the reporting of SAIs;

- Ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent recurrence;

- Maintain a high quality of information and documentation within a time bound process.



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# 3.0 APPLICATION OF PROCEDURE

## 3.1 Who does this procedure apply to?

This procedure applies to the reporting and follow up of SAIs arising during the course of the business in Department of Health (DoH) Arm's Length Bodies (ALBs) i.e.

- ***HSC organisations (HSC)***
  - Health and Social Care Board
  - Public Health Agency
  - Business Services Organisation
  - Belfast Health and Social Care Trust
  - Northern Health and Social Care Trust
  - Southern Health and Social Care Trust
  - South Eastern Health and Social Care Trust
  - Western Health and Social Care Trust
  - Northern Ireland Ambulance Service
  - Regulation and Quality Improvement Authority

- ***Special Agencies (SA)***
  - Northern Ireland Blood Transfusion Service
  - Patient Client Council
  - Northern Ireland Medical and Dental Training Agency
  - Northern Ireland Practice and Education Council

The principles for SAI management set out in this procedure are relevant to all the above organisations. Each organisation should therefore ensure that its incident policies are consistent with this guidance while being relevant to its own local arrangements.

## 3.2 Incidents reported by Family Practitioner Services (FPS)

Adverse incidents occurring within services provided by independent practitioners within: General Medical Services, Pharmacy, Dental or Optometry, are routinely forwarded to the HSCB Integrated Care Directorate in line with the HSCB Adverse Incident Process within the Directorate of Integrated Care (September 2016). On receipt of reported adverse incidents the HSCB Integrated Care Directorate will decide if the incident meets the criteria of a SAI and if so will be the organisation responsible to report the SAI.



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## 3.3 Incidents that occur within the Independent /Community and Voluntary Sectors (ICVS)

SAIs that occur within ICVS, where the service has been commissioned/funded by a HSC organisation must be reported. For example: service users placed/funded by HSC Trusts in independent sector accommodation, including private hospital, nursing or residential care homes, supported housing, day care facilities or availing of HSC funded voluntary/community services. These SAIs must be reported and reviewed by the HSC organisation who has:

- referred the service user (this includes Extra Contractual Referrals) to the ICVS;

or, if this cannot be determined;

- the HSC organisation who holds the contract with the IVCS.

HSC organisations that refer service users to ICVS should ensure all contracts, held with ICVS, include adequate arrangements for the reporting of adverse incidents in order to ensure SAIs are routinely identified.

All relevant events occurring within ICVS which fall within the relevant notification arrangements under legislation should continue to be notified to RQIA.

## 3.4 Reporting of HSC Interface Incidents

Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation. In such instances, it is possible the organisation where the incident may have occurred is not aware of the incident; however the reporting and follow up review may be their responsibility. It will not be until such times as the organisation, where the incident has occurred, is made aware of the incident; that it can be determined if the incident is a SAI.

In order to ensure these incidents are notified to the correct organisation in a timely manner, the organisation where the incident was identified will report to the HSCB using the HSC Interface Incident Notification Form (see Appendix 3). The HSCB Governance Team will upon receipt contact the organisation where the incident has occurred and advise them of the notification in order to ascertain if the incident will be reported as a SAI.

Some of these incidents will subsequently be reported as SAIs and may require other organisations to jointly input into the review. In these instances refer to Appendix 13 – Guidance on Joint Reviews.



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## 3.5 Incidents reported and Investigated/ reviewed by Organisations external to HSC and Special Agencies

The reporting of SAIs to the HSCB will work in conjunction with and in some circumstances inform the reporting requirements of other statutory agencies and external bodies. In that regard, all existing local or national reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

### 3.5.1 Memorandum of Understanding (MOU)

In February 2006, the DoH issued circular HSS (MD) 06/2006 − a Memorandum of Understanding − which was developed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required into a serious incident.

Circular HSS (MD) 8/2013 replaces the above circular and advises of a revised MOU Investigating patient or client safety incidents which can be found on the Departmental website:

www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2013.pdf

The MOU has been agreed between the DoH, on behalf of the Health and Social Care Service (HSCS), the Police Service of Northern Ireland (PSNI), the Northern Ireland Courts and Tribunals Service (Coroners Service for NI) and the Health and Safety Executive for Northern Ireland (HSENI). It will apply to people receiving care and treatment from HSC in Northern Ireland. The principles and practices promoted in the document apply to other locations, where health and social care is provided e.g. it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care provided by the HSCS.

It sets out the general principles for the HSCS, PSNI, Coroners Service for NI and HSENI to observe when liaising with one another.

The purpose of the MOU is to promote effective communication between the organisations. The MOU will take effect in circumstances of unexpected death or serious untoward harm requiring investigation by the PSNI, Coroners Service for NI or HSENI separately or jointly. This may be the case when an incident has arisen from or involved criminal intent, recklessness and/or gross negligence, or in the context of health and safety, a work-related death.

The MOU is intended to help:



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- Identify which organisations should be involved and the lead investigating body.

- Prompt early decisions about the actions and investigations/reviews thought to be necessary by all organisations and a dialogue about the implications of these.

- Provide an understanding of the roles and responsibilities of the other organisations involved in the memorandum before high level decisions are taken.

- Ensure strategic decisions are taken early in the process and prevent unnecessary duplication of effort and resources of all the organisations concerned.

HSC Organisations should note that the MOU does not preclude simultaneous investigations/reviews by the HSC and other organisations e.g. Root Cause Analysis by the HSC when the case is being reviewed by the Coroners Service and/or PSNI/HSENI.

In these situations, the Strategic Communication and Decision Group can be used to clarify any difficulties that may arise; particularly where an external organisation's investigation/review has the potential to impede a SAI review and subsequently delay the dissemination of regional learning.

## 3.6 Reporting of SAIs to RQIA

RQIA have a statutory obligation to investigate some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA will work in conjunction with the HSCB/PHA with regard to the review of certain categories of SAI. In this regard the following SAIs should be notified to RQIA at the same time of notification to the HSCB:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAI that occurs within the regulated sector (whether statutory or independent) for a service that has been commissioned/funded by a HSC organisation.

  *It is acknowledged these incidents should already have been reported to RQIA as a **'notifiable event'** by the statutory or independent organisation where the incident has occurred (in line with relevant reporting regulations). This notification will alert RQIA that the incident is also being reviewed as a SAI by the HSC organisation who commissioned the service.*

- The HSCB/PHA Designated Review Officer (DRO) will lead and co-ordinate the SAI management, and follow up, with the reporting organisation; however for these SAIs this will be carried out in



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conjunction with RQIA professionals. A separate administrative protocol between the HSCB and RQIA can be accessed at Appendix 15.

### 3.7 Reporting of SAIs to the Safeguarding Board for Northern Ireland

There is a statutory duty for the HSC to notify the Safeguarding Board for Northern Ireland of child deaths where:

- a child has died or been significantly harmed (Regulation 17(2)(a)

**AND**

- abuse/neglect suspected **or** child or sibling on child protection register **or** child or sibling is/has been looked after Regulation (2)(b) (see Appendix 17)

## 4.0 DEFINITION AND CRITERIA

### 4.1 Definition of an Adverse Incident

**'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'**[1] arising during the course of the business of a HSC organisation / Special Agency or commissioned service.

The following criteria will determine whether or not an adverse incident constitutes a SAI.

### 4.2 SAI criteria

**4.2.1** serious injury to, or the unexpected/unexplained death of:

- a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
- a staff member in the course of their work
- a member of the public whilst visiting a HSC facility;

**4.2.2** unexpected serious risk to a service user and/or staff member and/or member of the public;

**4.2.3** unexpected or significant threat to provide service and/or maintain business continuity;

[1] Source: DoH - How to classify adverse incidents and risk guidance 2006
http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/ph_how_to_classify_adverse__incidents_and_risk_-_guidance.pdf



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**4.2.4** serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

**4.2.5** serious self-harm or serious assault *(including homicide and sexual assaults*)

- on other service users,
- on staff or
- on members of the public

by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

**4.2.6** suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

**4.2.7** serious incidents of public interest or concern relating to:

- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner.

**ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.**

*Note: The HSC Regional Risk Matrix may assist organisations in determining the level of 'seriousness' refer to Appendix 16.*

## 5.0 SAI REVIEWS

SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning from all SAIs reported, it is important the level of review focuses on the complexity of the incident and not solely on the significance of the event.

Whilst most SAIs will be subject to a Level 1 review, for some more complex SAIs, reporting organisations may instigate a Level 2 or 3 review immediately following the incident occurring. The level of review should be noted on the SAI notification form.

The HSC Regional Risk Matrix (refer to Appendix 16) may assist organisations in determining the level of 'seriousness' and subsequently the level of review to be



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undertaken. SAIs which meet the criteria in 4.2 above will be reviewed by the reporting organisation using one or more of the following:

## 5.1 Level 1 Review – Significant Event Audit (SEA)

Most SAI notifications will enter the review process at this level and a SEA will immediately be undertaken to:

- assess what has happened;
- assess why did it happened;
  - what went wrong and what went well;
- assess what has been changed or agree what will change;
- identify local and regional learning.

(refer to Appendix 5 – Guidance Notes for Level 1 – SEA & Learning Summary Report; Appendix 9 – Guidance on Incident Debrief); and Appendix 10 – Level 1 Review - Guidance on review team membership)

The possible outcomes from the review may include:

- closed – no new learning;
- closed – with learning;
- requires Level 2 or 3 review.

A SEA report will be completed **which should be retained by the reporting organisation** (see Appendices 4 and 5).

The reporting organisation will then complete a **SEA Learning Summary Report** (see Appendices 4 and 5 – Sections 1, 3-6), which should be signed off by the relevant professional or operational director and submitted to the HSCB within **8 weeks** of the SAI being notified.

The HSCB will not routinely receive SEA reports unless specifically requested by the DRO. This process assigns reporting organisations the responsibility for Quality Assuring Level 1 SEA Reviews. This will entail engaging directly with relevant staff within their organisation to ensure the robustness of the report and identification of learning prior to submission to the HSCB.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review, the review will move to either a Level 2 or 3 RCA review. In this instance the SEA Learning Report Summary will be forwarded to the HSCB within the timescales outlined above, with additional sections being completed to outline membership and Terms of Reference of the team completing the Level 2 or 3 RCA review and proposed timescales.

## 5.2 Level 2 – Root Cause Analysis (RCA)

As stated above, some SAIs will enter at Level 2 review following a SEA.

When a Level 2 or 3 review is instigated immediately following notification of a SAI, the reporting organisation will inform the HSCB within 4 weeks, of the Terms of Reference (TOR) and Membership of the Review Team for



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consideration by the HSCB/PHA DRO. This will be achieved by submitting sections two and three of the review report to the HSCB. (Refer to Appendix 6 – template for Level 2 and 3 review reports).

The review must be conducted to a high level of detail (see Appendix 7 – template for Level 2 and 3 review reports). The review should include use of appropriate analytical tools and will normally be conducted by a multidisciplinary team (not directly involved in the incident), and chaired by someone independent to the incident but who can be within the same organisation. (Refer to Appendix 9 – Guidance on Incident Debrief); and Appendix 11 – Level 2 Review - Guidance on review team membership).

Level 2 RCA reviews may involve two or more organisations. In these instances, it is important a lead organisation is identified but also that all organisations contribute to, and approve the final review report (Refer to Appendix 13 Guidance on joint reviews/investigations).

On completion of Level 2 reviews, the final report must be submitted to the HSCB within 12 weeks from the date the incident was notified.

## 5.3 Level 3 – Independent Reviews

Level 3 reviews will be considered for SAIs that:

- are particularly complex involving multiple organisations;
- have a degree of technical complexity that requires independent expert advice;
- are very high profile and attracting a high level of both public and media attention.

In some instances the whole team may be independent to the organisation/s where the incident/s has occurred.

The timescales for reporting Chair and Membership of the review team will be agreed by the HSCB/PHA Designated Review Officer (DRO) at the outset (see Appendix 9 – Guidance on Incident Debrief); and Appendix 12 – Level 3 Review - Guidance on Review Team Membership).

The format for Level 3 review reports will be the same as for Level 2 reviews (see Appendix 7 – guidance notes on template for Level 2 and 3 reviews).

For any SAI which involves an alleged homicide by a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident, the Protocol for Responding to SAIs in the Event of a Homicide, issued in 2012 and revised in 2013 should be followed (see Appendix 14).



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### 5.4 Involvement of Service Users/Family/Carers in Reviews

- Following a SAI it is important, in the spirit of honesty and openness to ensure a consistent approach is afforded to the level of service user / family engagement across the region. When engaging with Service Users/Family/Carers, organisations should refer to addendum 1 – *A Guide for Health and Social Care Staff Engagement/Communication with Service User/Family/Cares following a SAI.*

- In addition a 'Checklist for Engagement/Communication with the Service User/Family/Carers following a SAI' must be completed for each SAI regardless of the review level, and where relevant, if the SAI was also a Never Event (refer to section 12.2).

- The checklist also includes a section to indicate if the reporting organisation had a statutory requirement to report the death to the Coroners office and that this is also communicated to the Family/Carer.

## 6.0 TIMESCALES

### 6.1 Notification

Any adverse incident that meets the criteria indicated in section 4.2 should be reported within **72 hours** of the incident being discovered using the SAI Notification Form (see Appendix 1).

### 6.2 Review Reports

LEVEL 1 – SEA

SEA reports must be completed using the SEA template which will be retained by the reporting organisation (see Appendices 4 and 5). A SEA Learning Summary Report (see Appendices 4 and 5 – Sections 1, 3-6) must be completed and submitted to the HSCB within **8 weeks** of the SAI being reported for all Level 1 SAIs whether learning has been identified or not. The Checklist for Engagement/Communication with Service User/Family/Carer following a SAI' must also accompany the Learning Summary Report.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review, timescales for completion of the RCA will be indicated by Trusts via the Learning Summary Report to the HSCB.

LEVEL 2 – RCA

For those SAIs where a full RCA is instigated immediately, sections 2 and 3 of the RCA Report, outlining TOR and membership of the review team, must be submitted **no later** than **within 4 weeks** of the SAI being notified to the HSCB.



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RCA review reports must be fully completed using the RCA report template and submitted together with comprehensive action plans for each recommendation identified to the HSCB **12 weeks** following the date the incident was notified. (see Appendix 6 – Level 2 & 3 RCA Review Reports and Appendix 8 – Guidance on Minimum Standards for Action Plans).

LEVEL 3 – INDEPENDENT REVIEWS

Timescales for completion of Level 3 reviews and comprehensive action plans for each recommendation identified will be agreed between the reporting organisation and the HSCB/PHA DRO as soon as it is determined that the SAI requires a Level 3 review.

**Note: Checklist for Engagement/Communication with Service User/Family/Carer following a SAI must accompany all SAI Review/Learning Summary Reports which are included within the report templates.**

## 6.3 Exceptions to Timescales

In most circumstances, all timescales for submission of reports **must be** adhered to. However, it is acknowledged, by exception, there may be occasions where a review is particularly complex, perhaps involving two or more organisations or where other external organisations such as PSNI, HSENI etc.; are involved in the same review. In these instances the reporting organisation must provide the HSCB with regular updates.

## 6.4 Responding to additional information requests

Once the review / learning summary report has been received, the DRO, with appropriate clinical or other support, will review the report to ensure that the necessary documentation relevant to the level of review is adequate.

If the DRO is not satisfied with the information provided additional information may be requested and must be provided in a timely manner. Requests for additional information should be provided as follows:

- Level 1 review within **2 week**
- Level 2 or 3 review within **6 weeks**

# 7.0 OTHER INVESTIGATIVE/REVIEW PROCESSES

The reporting of SAIs to the HSCB will work in conjunction with all other HSC investigation/review processes, statutory agencies and external bodies. In that regard, all existing reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.



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In that regard, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI.

## 7.1 Complaints in the HSC

Complaints in HSC Standards and Guidelines for Resolution and Learning (The Guidance) outlines how HSC organisations should deal with complaints raised by persons who use/have used, or are waiting to use HSC services. While it is a separate process to the management and follow-up of SAIs, there will be occasions when an SAI has been reported by a HSC organisation, and subsequently a complaint is received relating to the same incident or issues, or alternatively, a complaint may generate the reporting of an SAI.

In these instances, the relevant HSC organisation must be clear as to how the issues of complaint will be investigated. For example, there may be elements of the complaint that will be solely reliant on the outcome of the SAI review and there may be aspects of the complaint which will not be part of the SAI review and can only be investigated under the Complaints Procedure.

It is therefore important that complaints handling staff and staff who deal with SAIs communicate effectively and regularly when a complaint is linked to a SAI review. This will ensure that all aspects of the complaint are responded to effectively, via the most appropriate means and in a timely manner. Fundamental to this, will obviously be the need for the organisation investigating the complaint to communicate effectively with the complainant in respect of how their complaint will be investigated, and when and how they can expect to receive a response from the HSC organisation.

## 7.2 HSCB Social Care Untoward Events Procedure

The above procedure provides guidance on the reporting of incidents relating to statutory functions under the Children (NI) Order 1995.

If, during the review of an incident reported under the HSCB Untoward Events procedure, it becomes apparent the incident meets the criteria of a SAI, the incident should immediately be notified to the HSCB as a SAI. Board officers within the HSCB will close the Untoward Events incident and the incident will continue to be managed via the SAI process.

## 7.3 Child and Adult Safeguarding

Any incident involving the suspicion or allegation that a child or adult is at risk of abuse, exploitation or neglect should be investigated under the procedures set down in relation to a child and adult protection.

If during the review of one of these incidents it becomes apparent that the incident meets the criteria for an SAI, the incident will immediately be notified to the HSCB as an SAI.



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It should be noted that, where possible, safeguarding investigations will run in parallel as separate to the SAI process with the relevant findings from these investigations/reviews informing the SAI review (see appendix 17).

On occasion the incident under review may be considered so serious as to meet the criteria for a Case Management Review (CMR) for children, set by the Safeguarding Board for Northern Ireland; a Serious Case Review (SCR) for adults set by the Northern Ireland Adult Safeguarding Partnership; or a Domestic Homicide Review.

In these circumstances, the incident will be notified to the HSCB as an SAI. This notification will indicate that a CMR, SCR or Domestic Homicide Review is underway. This information will be recorded on the Datix system, and the SAI will be closed.

## 7.4 Reporting of Falls

Reporting organisations will no longer be required to routinely report falls as SAIs which have resulted in harm in all Trust facilities, (as defined in the impact levels 3 – 5 of the regional risk matrix - see appendix 16). Instead a new process has been developed with phased implementation, which requires HSC Trusts to do a timely post fall review debrief to ensure local application of learning. See links below to Shared Learning Form and Minimum Data Set for Post Falls Review:

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/033%20Falls_Shared%20Learning%20Template_%20V2_June%202016.rtf

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/032%20Regional%20Falls%20Minimum%20Dataset%202016_V2_June%202016.pdf

Local learning will be shared with the Regional Falls Group where trends and themes will be identified to ensure regional learning.

Reporting organisations will therefore manage falls resulting in moderate to severe harm as adverse incidents, unless there are particular issues or the subsequent internal review identifies contributory issues/concerns in treatment and/or care or service issues, or any identified learning that needs to be reviewed through the serious adverse incident process.

## 7.5 Transferring SAIs to other Investigatory Processes

Following notification and initial review of a SAI, more information may emerge that determines the need for a specialist investigation.

This type of investigation includes:

- Case Management Reviews
- Serious Case Reviews

Once a DRO has been informed a SAI has transferred to one of the above investigation s/he will close the SAI.



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### 7.6 De-escalating a SAI

It is recognised that organisations report SAIs based on limited information and the situation may change when more information has been gathered; which may result in the incident no longer meeting the SAI criteria.

Where a reporting organisation has determined the incident reported no longer meets the criteria of a SAI, a request to de-escalate the SAI should be submitted immediately to the HSCB by completing section 21 of the SAI notification form (Additional Information following initial Notification).

The DRO will review the request to de-escalate and will inform the reporting organisation and RQIA (where relevant) of the decision as soon as possible and at least within **10 working days** from the request was submitted.

If the DRO agrees, the SAI will be de-escalated and no further SAI review will be required. The reporting organisation may however continue to review as an adverse incident or in line with other HSC investigation/review processes (as highlighted above). If the DRO makes a decision that the SAI should not be de-escalated the review report should be submitted in line with previous timescales.

It is important to protect the integrity of the SAI review process from situations where there is the probability of disciplinary action, or criminal charges. The SAI review team must be aware of the clear distinction between the aims and boundaries of SAI reviews, which are solely for the identification and reporting learning points, compared with disciplinary, regulatory or criminal processes.

HSC organisations have a duty to secure the safety and well-being of patients/service users, the review to determine root causes and learning points should still be progressed **in parallel** with other reviews/investigations, ensuring remedial actions are put in place as necessary and to reduce the likelihood of recurrence.

## 8.0 LEARNING FROM SAIs

The key aim of this procedure is to improve services and reduce the risk of incident recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following a SAI is therefore core to achieving this and to ensure shared lessons are embedded in practice and the safety and quality of care provided.

HSCB in conjunction with the PHA will:

- ensure that themes and learning from SAIs are identified and disseminated for implementation in a timely manner; this may be done via:
  - learning letters / reminder of best practice letters;
  - learning newsletter;
  - thematic reviews.



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- provide an assurance mechanism that learning from SAIs has been disseminated and appropriate action taken by all relevant organisations;

- review and consider learning from external/independent reports relating to quality/safety.

It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from adverse incidents and SAIs internally within their own organisations. The management of dissemination and associated assurance of any regional learning is the responsibility of the HSCB/PHA.

# 9.0 TRAINING AND SUPPORT

## 9.1 Training

Training will be provided to ensure that those involved in SAI reviews have the correct knowledge and skills to carry out their role, i.e:

- Chair and/or member of an SAI review team
- HSCB/PHA DRO.

This will be achieved through an educational process in collaboration with all organisations involved, and will include training on review processes, policy distribution and communication updates.

## 9.2 Support

### 9.2.1 Laypersons

The panel of lay persons, (already involved in the HSC Complaints Procedure), have availed of relevant SAI training including Root Cause Analysis. They are now available to be called upon to be a member of a SAI review team; particularly when a degree of independence to the team is required.

Profiles and relevant contact details for all available laypersons can be obtained by contacting seriousincidents@hscni.net

### 9.2.2 Clinical/Professional Advice

If a DRO requires a particular clinical view on the SAI review, the HSCB Governance Team will secure that input, under the direction of the DRO.

# 10.0 INFORMATION GOVERNANCE

The SAI process deals with a considerable amount of sensitive personal information. Appropriate measures must be put in place to ensure the safe and secure transfer of this information. All reporting organisations should adhere to their own Information Governance Policies and Procedures. However, as a minimum the HSCB would recommend the following measures be adopted when



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transferring patient/client identifiable information via e-mail or by standard hard copy mail:

- E-Mail - At present there is not a requirement to apply encryption to sensitive information transferred across the HSC network to other HSC organisations within Northern Ireland. Information transferred between the HSCB, Trusts and Northern Ireland Department of Health is not sent across the internet. If you are transferring information to any address that does not end in one of those listed below, it is essential that electronic measures to secure the data in transit, are employed, and it is advised that encryption is therefore applied at all times to transfers of sensitive / personal information.

  List of email addresses **within the Northern Ireland secure network:**
  **'.hscni.net'**,
  **'n-i.nhs.uk'**
  **'ni.gov.uk'** or
  **'.ni.gov.net'**

  **No sensitive or patient/service user data** must be emailed to an address other than those listed above unless they have been protected by encryption mechanisms that have been approved by the BSO-ITS.

  Further advice on employing encryption software can be sought from the BSO ICT Security Team.

  **Note:** Although there is a degree of protection afforded to email traffic that contains sensitive information when transmitting within the Northern Ireland HSC network it is important that the information is sent to the correct recipient. With the amalgamation of many email systems, the chances of a name being the same or similar to the intended recipient has increased. It is therefore recommended that the following simple mechanism is employed when transmitting information to a new contact or to an officer you haven't emailed previously.

  **Step 1** Contact the recipient and ask for their email address.
  **Step 2** Send a test email to the address provided to ensure that you have inserted the correct email address.
  **Step 3** Ask the recipient on receiving the test email to reply confirming receipt.
  **Step 4** Attach the information to be sent with a subject line 'Private and Confidential, Addressee Only' to the confirmation receipt email and send.

- Standard Mail – It is recommended that any mail which is deemed valuable, confidential or sensitive in nature (such as patient/service user level information) should be sent using 'Special Delivery' Mail.

Further guidance is available from the HSCB Information Governance Team on: Tel 028 95 362912



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## 11.0 ROLE OF DESIGNATED REVIEW OFFICER (DRO)

A DRO is a senior professional/officer within the HSCB / PHA and has a key role in the implementation of the SAI process namely:

- liaising with reporting organisations:
  - on any immediate action to be taken following notification of a SAI
  - where a DRO believes the SAI review is not being undertaken at the appropriate level

- agreeing the Terms of Reference for Level 2 and 3 RCA reviews;

- reviewing completed SEA Learning Summary Reports for Level 1 SEA Reviews and full RCA reports for level 2 and 3 RCA Reviews; liaising with other professionals (where relevant);

- liaising with reporting organisations where there may be concerns regarding the robustness of the level 2 and 3 RCA reviews and providing assurance that an associated action plan has been developed and implemented;

- identification of regional learning, where relevant;

- surveillance of SAIs to identify patterns/clusters/trends.

Whilst the HSCB will not routinely receive Level 1 SEA reports these can be requested, on occasion, by a DRO.

An internal HSCB/PHA protocol provides further guidance for DROs regarding the nomination and role of a DRO.

## 12.0 PROCESS

### 12.1 Reporting Serious Adverse Incidents

Any adverse incident that meets the criteria of a SAI as indicated in section 4.2 should be reported within 72 hours of the incident being discovered using the SAI Notification Form (Appendix 1) and forwarded to seriousincidents@hscni.net

HSC Trusts to copy RQIA at seriousincidents@rqia.org.uk in line with notifications relevant to the functions, powers and duties of RQIA as detailed in section 3.6 of this procedure.

Any SAI reported by FPS or ICVS must be reported in line with 3.2 and 3.3 of this procedure.

Reporting managers must comply with the principles of confidentiality when reporting SAIs and must not refer to service users or staff by name or by any other identifiable information. A unique Incident Reference/Number should be utilised on all forms/reports and associated



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correspondence submitted to the HSCB and this should NOT be the patients H &C Number or their initials. (See section 10 – Information Governance)

## 12.2 Never Events

Never Events are SAIs that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are already available at a national level and should have been implemented by all health care providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.

It is important, in the spirit of honesty and openness, that when staff are engaging with Service Users, Families, Carers as part of the SAI process, that in addition to advising an individual of the SAI, they should also be told if the SAI is a Never Event. However it will be for HSC organisations to determine when to communicate this information to Service Users, Families, Carers.

All categories included in the current NHS Never Events list (see associated DoH link below) should now be identified to the HSCB when notifying a SAI.

A separate section within the SAI notification form is to be completed to specify if the SAI is listed on the Never Events list. The SAI will continue to be reviewed in line with the current SAI procedure.

https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

## 12.3 Reporting Interface Incidents

In line with section 3.4 of this procedure, any organisation alerted to an incident which it feels has the potential to be a SAI should report the incident to the HSCB using the Interface Incident Notification form (Appendix 3) to seriousincidents@hscni.net.

An organisation who has been contacted by the HSCB Governance Team re: an interface incident being reported; will consider the incident in line with section 4.2 of the procedure, and if deemed it meets the criteria of a SAI, will report to the HSCB in line with 12.1 of this procedure.

## 12.4 Acknowledging SAI Notification

On receipt of the SAI notification the HSCB Governance Team will record the SAI on the DATIX risk management system and electronically acknowledge receipt of SAI notification to reporting organisation; advising



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of the HSCB/PHA DRO, HSCB unique identification number, and requesting the completion of:

- SEA Learning Summary Report for Level 1 SAIs within 8 weeks from the date the incident is reported;
- RCA Report for Level 2 SAIs within 12 weeks from the date the incident is reported;
- RCA Report for Level 3 SAIs within the timescale as agreed at the outset by the DRO;

Where relevant, RQIA will be copied into this receipt.

## 12.5 Designated Review Officer (DRO)

Following receipt of a SAI the Governance Team will circulate the SAI Notification Form to the relevant Lead Officers within the HSCB/PHA to assign a DRO.

Once assigned the DRO will consider the SAI notification and if necessary, will contact the reporting organisation to confirm all immediate actions following the incident have been implemented.

## 12.6 Review/Learning Summary Reports

*Note: Appendices 5 and 7 provide guidance notes to assist in the completion of Level 1, 2 & 3 review reports.*

Timescales for submission of review/learning summary reports and associated engagement checklists will be in line with section 6.0 of this procedure.

On receipt of a review/learning summary report, the Governance Team will forward to the relevant DRO and where relevant RQIA.

The DRO will consider the adequacy of the review/learning summary report and liaise with relevant professionals/officers including RQIA (*where relevant*) to ensure that the reporting organisation has taken reasonable action to reduce the risk of recurrence and determine if the SAI can be closed. The DRO will also consider the referral of any learning identified for regional dissemination. In some instances the DRO may require further clarification and may also request sight of the full SEA review report.

If the DRO is not satisfied that a report reflects a robust and timely review s/he will continue to liaise with the reporting organisation and/or other professionals /officers, including RQIA (*where relevant*) until a satisfactory response is received. When the DRO has received all relevant and necessary information the timescale for closure of the SAI will be within 12 weeks, unless in exceptional circumstances which will have been agreed between the Reporting Organisation and the DRO.



Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

## 12.7 Closure of SAI

Following agreement to close a SAI, the Governance Team will submit an email to the reporting organisation to advise the SAI has been closed, copied to RQIA (where relevant). The email will also indicate, if further information is made available to the reporting organisation (for example, Coroners Reports), which impacts on the outcome of the initial review, that it should be communicated to the HSCB/PHA DRO via the serious incidents mailbox.

This will indicate that based on the review / learning summary report received and any other information provided that the DRO is satisfied to close the SAI. It will acknowledge that any recommendations and further actions required will be monitored through the reporting organisation's internal governance arrangements in order to reassure the public that lessons learned, where appropriate have been embedded in practice.

On occasion and in particular when dealing with level 2 and 3 SAIs, a DRO may close a SAI but request the reporting organisation provides an additional assurance mechanism by advising within a stipulated period of time, that action following a SAI has been implemented. In these instances, monitoring will be followed up via the Governance team.

## 12.8 Regional Learning from SAIs

It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from adverse incidents and SAIs internally within their own organisations. However, the management of regional learning and associated assurance is the responsibility of the HSCB/PHA.

Therefore, where regional learning is identified following the review of an SAI, the DRO will refer this for consideration via HSCB/PHA Quality and Safety Structures and where relevant, will be disseminated as outlined in section 8.0.

## 12.9 Communication

All communication between HSCB/PHA and reporting organisation must be conveyed between the HSCB Governance department and Governance departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the SAI, is recorded on the HSCB DATIX risk management system.



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# 13 EQUALITY

This procedure has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. The procedure will therefore not be subject to equality impact assessment.

Similarly, this procedure has been considered under the terms of the Human Rights Act 1998 and was deemed compatible with the European Convention Rights contained in the Act.



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## SECTION TWO APPENDICES

# APPENDICES

Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

**APPENDIX 1**

**Revised November 2016 (Version 1.1)**

# SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

| | |
|---|---|
| **1.** ORGANISATION: | **2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE |
| **3.** HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)* | **4.** DATE OF INCIDENT: DD / MM / YYYY |
| **5.** DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)* | |
| **6.** CONTACT PERSON: | **7.** PROGRAMME OF CARE: *(refer to Guidance Notes)* |

**8.** DESCRIPTION OF INCIDENT:

DOB: DD / MM / YYYY *(complete where relevant)* GENDER: M / F AGE: years

| **9.** IS THIS INCIDENT A NEVER EVENT? | | | | If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars |
|---|---|---|---|---|
| YES | | NO | | |

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

| STAGE OF CARE: *(refer to Guidance Notes)* | DETAIL: *(refer to Guidance Notes)* | ADVERSE EVENT: *(refer to Guidance Notes)* |
|---|---|---|
| | | |

**10.** IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:

**11.** CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*

| | | | |
|---|---|---|---|
| **12.** HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)* | YES | NO | N/A |
| **13.** HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please specify where relevant)* | YES | NO | N/A |

**14.** WHY IS THIS INCIDENT CONSIDERED SERIOUS?: *(please select relevant criteria below)*

| | |
|---|---|
| serious injury to, or the unexpected/unexplained death of:<br>- a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)<br>- a staff member in the course of their work<br>- a member of the public whilst visiting a HSC facility. | |
| unexpected serious risk to a service user and/or staff member and/or member of the public | |
| unexpected or significant threat to provide service and/or maintain business continuity | |
| serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service | |
| serious self-harm or serious assault *(including homicide and sexual assaults)*<br>- on other service users,<br>- on staff or<br>- on members of the public<br>by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the | |

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# SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

| | |
|---|---|
| incident | |
| suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident | |
| serious incidents of public interest or concern relating to:<br>- any of the criteria above<br>- theft, fraud, information breaches or data losses<br>- a member of HSC staff or independent practitioner | |

| | | |
|---|---|---|
| **15.** IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)* | YES | NO |
| if 'YES' (*full details should be submitted*): | | |

| | | |
|---|---|---|
| **16.** HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI? | YES | DATE INFORMED: DD/MM/YY |
| | NO | *specify reason:* |

| | | |
|---|---|---|
| **17.** HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant* | YES | NO |
| if 'YES' (*full details should be submitted including the date notified*): | | |

| **18.** OTHER ORGANISATION/PERSONS INFORMED: *(please select)* | DATE INFORMED: | OTHERS: *(please specify where relevant, including date notified)* |
|---|---|---|
| DoH EARLY ALERT | | |
| HM CORONER | | |
| INFORMATION COMMISSIONER OFFICE (ICO) | | |
| NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC) | | |
| HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI) | | |
| POLICE SERVICE FOR NORTHERN IRELAND (PSNI) | | |
| REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA) | | |
| SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI) | | |
| NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP) | | |

| | | | |
|---|---|---|---|
| **19.** LEVEL OF REVIEW REQUIRED: *(please select)* | LEVEL 1 | LEVEL 2* | LEVEL 3* |

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

**20.** I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

**21.** ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: *(refer to Guidance Notes)*

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

**Completed proforma should be sent to:** seriousincidents@hscni.net
**and (*where relevant*)** seriousincidents@rqia.org.uk

**APPENDIX 2**

**Revised November 2016 (Version 1.1)**

# Guidance Notes
# SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

**The following guidance designed to help you to complete the Serious Adverse Incident Report Form effectively and to minimise the need for the HSCB to seek additional information about the circumstances surrounding the SAI. This guidance should be considered each time a report is submitted.**

| | |
|---|---|
| **1.** ORGANISATION:<br>*Insert the details of the reporting organisation (HSC Organisation /Trust or Family Practitioner Service)* | **2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE<br>*Insert the unique incident number / reference generated by the reporting organisation.* |
| **3.** HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)* *Insert the details of the hospital/facility/specialty/department/ directorate/place where the incident occurred* | **4.** DATE OF INCIDENT: DD / MM / YYYY<br><br>*Insert the date incident occurred* |
| **5.** DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)* | |
| **6.** CONTACT PERSON:<br>*Insert the name of lead officer to be contacted should the HSCB or PHA need to seek further information about the incident* | **7.** PROGRAMME OF CARE:<br>*Insert the Programme of Care from the following: Acute Services/ Maternity and Child Health / Family and Childcare / Elderly Services / Mental Health / Learning Disability / Physical Disability and Sensory Impairment / Primary Health and Adult Community (includes GP's) / Corporate Business(Other)* |

**8.** DESCRIPTION OF INCIDENT:

*Provide a **brief factual description** of what has happened and a summary of the events leading up to the incident. **PLEASE ENSURE SUFFICIENT INFORMATION IS PROVIDED SO THAT THE HSCB/ PHA ARE ABLE TO COME TO AN OPINION ON THE IMMEDIATE ACTIONS, IF ANY, THAT THEY MUST TAKE.** Where relevant include D.O.B, Gender and Age. **All reports should be anonymised** – the names of any practitioners or staff involved must **not** be included. Staff should only be referred to by job title.*

*In addition include the following:*

***Secondary Care** – recent service history; contributory factors to the incident; last point of contact (ward / specialty); early analysis of outcome.*

***Children** – when reporting a child death indicate if the Regional Safeguarding Board has been advised.*

***Mental Health** - when reporting a serious injury to, or the unexpected/unexplained death (including suspected suicide, attempted suicide in an in-patient setting or serious self-harm of a service user who has been known to Mental Health, Learning Disability or Child and Adolescent Mental Health within the last year) include the following details: the most recent HSC service context; the last point of contact with HSC services or their discharge into the community arrangements;*
*whether there was a history of DNAs, where applicable the details of how the death occurred, if known.*

***Infection Control** - when reporting an outbreak which severely impacts on the ability to provide services, include the following: measures to cohort Service Users; IPC arrangements among all staff and visitors in contact with the infection source; Deep cleaning arrangements and restricted visiting/admissions.*

***Information Governance** –when reporting include the following details whether theft, loss, inappropriate disclosure, procedural failure etc.; the number of data subjects (service users/staff )involved, the number of records involved, the media of records (paper/electronic),whether encrypted or not and the type of record or data involved and sensitivity.*

DOB: DD / MM / YYYY GENDER: M / F AGE: years
*(complete where relevant)*

| | |
|---|---|
| **9.** IS THIS INCIDENT A NEVER EVENT? Yes/No<br>*(please select)* | If 'YES' *provide further detail on which never event - refer to DoH link below*<br>https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars |

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| DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING | | |
|---|---|---|
| STAGE OF CARE:<br>*(refer to Guidance Notes)*<br>*Insert CCS Stage of Care Code description* | DETAIL:<br>*(refer to Guidance Notes)*<br>*Insert CCS Detail Code description* | ADVERSE EVENT:<br>*(refer to Guidance Notes)*<br>*Insert CCS Adverse Event Code description* |

**10.** IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:
*Include a summary of what actions, if any, have been taken to address the immediate repercussions of the incident and the actions taken to prevent a recurrence.*

**11.** CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*
***Where relevant** please provide details on the current condition of the service user the incident relates to.*

| | | | |
|---|---|---|---|
| **12**. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)* | YES | NO | N/A |
| **13**. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED *(please select and specify **where relevant**)* | YES | NO | N/A |

**14.** WHY INCIDENT CONSIDERED SERIOUS: *(please select relevant criteria from below )*

| | |
|---|---|
| serious injury to, or the unexpected/unexplained death of:<br>- a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)<br>- a staff member in the course of their work<br>- a member of the public whilst visiting a HSC facility. | |
| unexpected serious risk to a service user and/or staff member and/or member of the public | |
| unexpected or significant threat to provide service and/or maintain business continuity | |
| serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service | |
| serious self-harm or serious assault *(including homicide and sexual assaults*)<br>- on other service users,<br>- on staff or<br>- on members of the public<br>by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident | |
| suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident | |
| serious incidents of public interest or concern relating to:<br>- any of the criteria above<br>- theft, fraud, information breaches or data losses<br>- a member of HSC staff or independent practitioner | |

| | | |
|---|---|---|
| **15.** IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)* | YES | NO |

if 'YES' *(full details should be submitted):*

| | | |
|---|---|---|
| **16.** HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI? *(please select)* | YES | DATE INFORMED: DD/MM/YY<br>*Insert the date informed* |
| | NO | *Specify reason:* |

| **17.** HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant* | YES | NO |
|---|---|---|

if 'YES' (*full details should be submitted including the date notified*):

GENERAL MEDICAL COUNCIL **(GMC)**
GENERAL DENTAL COUNCIL **(GDC)**
PHARMACEUTICAL SOCIETY NORTHERN IRELAND **(PSNI)**
NORTHERN IRELAND SOCIAL CARE COUNCIL **(NISCC)**
LOCAL MEDICAL COMMITTEE **(LMC)**
NURSING AND MIDWIFERY COUNCIL **(NMC**)
HEALTH CARE PROFESSIONAL COUNCIL **(HCPC)**
REGULATION AND QUALITY IMPROVEMENT AUTHORTIY**(RQIA)**
SAFEGUARDING BOARD FOR NORTHERN IRELAND **(SBNI)**

OTHER – PLEASE SPECIFY BELOW

| **18.** OTHER ORGANISATION/PERSONS INFORMED: *(please select)* | DATE INFORMED: | OTHERS: *(please specify where relevant, including date notified)* |
|---|---|---|
| DoH EARLY ALERT | | |
| HM CORONER | | |
| INFORMATION COMMISSIONER OFFICE (ICO) | | |
| NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC) | | |
| HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI) | | |
| POLICE SERVICE FOR NORTHERN IRELAND (PSNI) | | |
| REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA) | | |
| SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI) | | |
| NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP) | | |

| **19.** LEVEL OF REVIEW REQUIRED: *(please select)* | LEVEL 1 | LEVEL 2* | LEVEL 3* |
|---|---|---|---|

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

**20.** I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

**21.** ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION:

*Use this section to provide updated information when the situation changes e.g. the situation deteriorates; the level of media interest changes*

*The HSCB and PHA recognises that organisations report SAIs based on limited information, which on further review may not meet the criteria of a SAI. Use this section to rrequest that a SAI be de-escalated and send to seriousincidents@hscni.net with the unique incident identification number/reference in the subject line. When a request for de-escalation is made the reporting organisation must include information on why the incident does not warrant further review under the SAI process.*

*The HSCB/PHA DRO will review the de-escalation request and inform the reporting organisation of its decision within 5 working days. The HSCB / PHA may take the decision to close the SAI without a report rather than de-escalate it. The HSCB / PHA may decide that the SAI should not be de-escalated and a full review report is required.*

PLEASE NOTE PROGRESS IN RELATION TO TIMELINESS OF COMPLETED REVIEW REPORTS WILL BE REGULARLY REPORTED TO THE HSCB/PHA REGIONALGROUP. THEY WILL BE MONITORED ACCORDING TO AGREED TIMESCALES. IT IS IMPORTANT TO KEEP THE HSCB INFORMED OF PROGRESS TO ENSURE THAT MONITORING INFORMATION IS ACCURATE AND BREECHES ARE NOT REPORTED WHERE AN EXTENDED TIME SCALE HAS BEEN AGREED.

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

**Completed proforma should be sent to:** seriousincidents@hscni.net
**and (*where relevant*)** seriousincidents@rqia.org.uk

**APPENDIX 3**
**Revised November 2016 (Version 1.1)**

# HSC INTERFACE INCIDENT NOTIFICATION FORM

| | |
|---|---|
| **1. REPORTING ORGANISATION:** | **2. DATE OF INCIDENT: DD / MM / YYYY** |
| **3. CONTACT PERSON AND TEL NO:** | **4. UNIQUE REFERENCE NUMBER:** |

**5. DESCRIPTION OF INCIDENT:**

**DOB: DD / MM / YYYY** **GENDER: M / F** **AGE: years**
*(complete where relevant)*

| | | |
|---|---|---|
| **6. ARE OTHER PROVIDERS INVOLVED?** (e.g. *HSC TRUSTS / FPS / OOH / ISP / VOLUNTARY / COMMUNITY ORG'S*) | **YES** | **NO** |
| | **if 'YES' (*full details should be submitted in section 7 below*)** | |

**7. PROVIDE DETAIL ON ISSUES/AREAS OF CONCERN:**

**8. <u>IMMEDIATE</u> ACTION TAKEN BY REPORTING ORGANISATION:**

**9. WHICH ORGANISATION/PROVIDER (*FROM THOSE LISTED IN SECTIONS 6 AND 7 ABOVE*) SHOULD TAKE THE LEAD RESPONSIBILITY FOR THE REVIEW AND FOLLOW UP OF THIS INCIDENT?**

**10. OTHER COMMENTS:**

**REPORT SUBMITTED BY:** _____ **DESIGNATION:** _____

**Email:** **Telephone:** **Date: DD / MM / YYYY**

**Completed proforma should be sent to:** seriousincidents@hscni.net

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**APPENDIX 4**

**Revised November 2016 (Version 1.1)**

# LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

## SECTION 1

| | |
|---|---|
| 1. ORGANISATION: | 2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: |
| 3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: | 4. DATE OF INCIDENT/EVENT: DD / MM / YYYY |
| 5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO<br>***Please select as appropriate*** | 6. IF 'YES' TO 5. PLEASE PROVDE DETAILS: |
| 7. DATE OF SEA MEETING / INCIDENT DEBRIEF: DD / MM / YYYY | |
| 8. SUMMARY OF EVENT: | |

| **SECTION 2** | |
|---|---|
| 9. SEA FACILITATOR / LEAD OFFICER: | 10. TEAM MEMBERS PRESENT: |
| 11. SERVICE USER DETAILS:<br>***Complete where applicable*** | |
| 12. WHAT HAPPENED? | |
| 13. WHY DID IT HAPPEN? | |

| SECTION 3 - LEARNING SUMMARY |
|---|
| 14. WHAT HAS BEEN LEARNED: |
| 15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE? |
| 16. RECOMMENDATIONS (please state by whom and timescale) |
| 17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA: |
| 18. FURTHER REVIEW REQUIRED? YES / NO<br>Please select as appropriate<br><br>If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6. |

| SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED) | |
|---|---|
| 19. PLEASE INDICATE LEVEL OF REVIEW:<br>LEVEL 2 / LEVEL 3<br>**Please select as appropriate** | 20. PROPOSED TIMESCALE FOR COMPLETION:<br>DD / MM / YYYY |
| 21. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*: | |
| 22. TERMS OF REFERENCE *(If known or submit asap)*: | |

| SECTION 5 | |
|---|---|
| **APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR** | |
| 23. NAME: | 24. DATE APPROVED: |
| 25. DESIGANTION: | |

| SECTION 6 |
|---|
| 26. DISTRIBUTION LIST: |

# Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

| Reporting Organisation SAI Ref Number: | | HSCB Ref Number: | |
|---|---|---|---|

## SECTION 1

## INFORMING THE SERVICE USER[1] / FAMILY / CARER

| | | | | | |
|---|---|---|---|---|---|
| 1) Please indicate if the SAI relates to a single service user, or a number of service users.<br>**Please select as appropriate (✓)** | **Single Service User** | | **Multiple Service Users*** | | |
| | **Comment:**<br>***If multiple service users are involved please indicate the number involved*** | | | | |
| 2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| | If **YES**, insert **date informed**: | | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI | | | | |
| | a) No contact or Next of Kin details or Unable to contact | | | | |
| | b) Not applicable as this SAI is not 'patient/service user' related | | | | |
| | c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | | | |
| | d) Case involved suspected or actual abuse by family | | | | |
| | e) Case identified as a result of review exercise | | | | |
| | f) Case is environmental or infrastructure related with no harm to patient/service user | | | | |
| | g) Other rationale | | | | |
| | **If you selected c), d), e), f) or g) above please provide further details:** | | | | |
| 3) Was this SAI also a Never Event?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| 4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event?<br>**Please select as appropriate (✓)** | **YES** | If **YES**, insert **date informed**: DD/MM.YY | | | |
| | **NO** | If **NO**, provide details: | | | |
| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)** | | | | | |
| **Content with rationale?** | **YES** | | **NO** | | |

## SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)***

| | | | | |
|---|---|---|---|---|
| 5) Has the Final Review report been shared with the Service User[1] / Family / Carer?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert date informed: | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer: | | | |
| | a) Draft review report has been shared and further engagement planned to share final report | | | |
| | b) Plan to share final review report at a later date and further engagement planned | | | |

| SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER<br>*(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)* | | |
|---|---|---|
| | c) Report not shared but contents discussed<br>**(*if you select this option please also complete 'l' below*)** | |
| | d) No contact or Next of Kin or Unable to contact | |
| | e) No response to correspondence | |
| | f) Withdrew fully from the SAI process | |
| | g) Participated in SAI process but declined review report | |
| | ***(if you select any of the options below please also complete 'l' below)*** | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer | |
| | i) case involved suspected or actual abuse by family | |
| | j) identified as a result of review exercise | |
| | k) other rationale | |
| | l) If you have selected **c), h), i), j), or k)** above please provide further details: | |

| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)** | | | | |
|---|---|---|---|---|
| **Content with rationale?** | **YES** | | **NO** | |

| SECTION 2<br>**INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)* | | | | |
|---|---|---|---|---|
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert **date informed**: | | | |
| | If **NO**, please provide details: | | | |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert **date report shared**: | | | |
| | If **NO**, please provide details: | | | |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed?<br>**Please select as appropriate (✓)** | **YES** | **NO** | **N/A** | **Not Known** |
| | If **YES**, insert **date informed**: | | | |
| | If **NO**, please provide details: | | | |

| **DATE CHECKLIST COMPLETED** | |
|---|---|

[1] *Service User or their nominated representative*

**APPENDIX 5**

**Revised November 2016 (Version 1.1)**

# GUIDANCE NOTES
# LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

## SECTION 1 (To be submitted to the HSCB)

| | |
|---|---|
| 1. ORGANISATION: *Insert unique identifier number* | 2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: *Self- explanatory* |
| 3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: *Self- explanatory* | 4. DATE OF INCIDENT/EVENT: DD / MM / YYYY *Self- explanatory* |
| 5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO ***Please select as appropriate*** | 6. IF 'YES' TO 5. PLEASE PROVDE DETAILS: *Self- explanatory* |
| 7. DATE OF SEA MEETING / INCIDENT DEBRIEF: DD / MM / YYYY *Self- explanatory* | |
| 8. SUMMARY OF EVENT:<br><br>***As per notification form. (If the notification form does not fully reflect the incident please provide further detail.)*** | |

Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

| SECTION 2 | |
|---|---|
| 9. SEA FACILITATOR / LEAD OFFICER:<br><br>*Refer to guidance on Level 1 review team membership for significant event analysis – Appendix 10* | 10. TEAM MEMBERS PRESENT:<br><br>*NAMES AND DESIGNATIONS* |
| 11. SERVICE USER DETAILS:<br>***Complete where applicable***<br><br>*DOB / GENDER / AGE* | |
| 12. WHAT HAPPENED?<br><br>*(Describe in detailed chronological order what actually happened. Consider, for instance, how it happened, where it happened, who was involved and what the impact was on the patient/service user[1], the team, organisation and/or others).* | |
| 13. WHY DID IT HAPPEN?<br><br>*(Describe the main and underlying reasons contributing to why the event happened. Consider for instance, the professionalism of the team, the lack of a system or failing in a system, the lack of knowledge or the complexity and uncertainty associated with the event)* | |

[1] *ensure sensitivity to the needs of the patient/ service user/ carer/ family member is in line with Regional Guidance on Engagement with Service Users, Families and Carers issued February 2015 (Revised November 2016)*

**All sections below be submitted to the HSCB**

## SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED: *(Based on the reason established as to why the event happened, outline the learning identified. Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event. Consider, for instance: a lack of education and training; the need to follow systems or procedures; the vital importance of team working or effective communication)*

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE? *Based on the understanding of why the event happened and the identification of learning, outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change e.g. a new procedure or protocol.*

*NOTE: Action plans should also be developed and set out how learning will be implemented, with named leads responsible for each action point (Refer to Appendix 7 Minimum Standards for Action Plans).*

*Action plans for this level of review will be retained by the reporting organisation.*

16. RECOMMENDATIONS (please state by whom and timescale) *It should be noted that it is the responsibility of the HSCB/PHA to consider and review all recommendations, of suggested /proposed learning relevant to other organisations, arising from the review of a SAI. In addition, it is the responsibility if the HSCB/PHA to subsequently identify any related learning to be communicated across the HSC and where relevant with other organisations regionally and/or nationally.*

*It is the responsibility of the reporting organisation to communicate to service users, families and carer's that learning identified relevant to other organisations (arising from the review of a SAI) and submitted to the HSCB/PHA, to consider and review, may not on every occasion result in regional learning.*

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

*Self- explanatory*

18. FURTHER REVIEW REQUIRED? YES / NO

***Please select as appropriate***

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

## SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)

19. PLEASE INDICATE LEVEL OF REVIEW:
LEVEL 2 / LEVEL 3
**Please select as appropriate**

20. PROPOSED TIMESCALE FOR COMPLETION:
DD / MM / YYYY

21. REVIEW TEAM MEMBERSHIP(If known or submit ASAP):

**Refer to section 2 of appendix 7.**

22. TERMS OF REFERENCE(If known or submit ASAP):

**Refer to section 3 of appendix 7.**

## SECTION 5 - (COMPLETE THIS SECTION FOR ALL LEVELS OF REVIEW)

**APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR**

23. NAME: *Self- explanatory*

24. DATE APPROVED: *Self- explanatory*

25. DESIGANTION: *Self- explanatory*

## SECTION 6

26. DISTRIBUTION LIST:

**List of the individuals, groups or organisations the final report has been shared with.**

**APPENDIX 5**

**To be submitted to the HSCB**

## Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

| | | | |
|---|---|---|---|
| **Reporting Organisation SAI Ref Number:** | | **HSCB Ref Number:** | |

| **SECTION 1** | | | | | |
|---|---|---|---|---|---|
| **INFORMING THE SERVICE USER[1] / FAMILY / CARER** | | | | | |
| 1) Please indicate if the SAI relates to a single service user, or a number of service users.<br>**Please select as appropriate (✓)** | **Single Service User** | | **Multiple Service Users*** | | |
| | **Comment:**<br>***If multiple service users are involved please indicate the number involved*** | | | | |
| 2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| | If **YES**, insert **date informed**: | | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI | | | | |
| | a) No contact or Next of Kin details or Unable to contact | | | | |
| | b) Not applicable as this SAI is not 'patient/service user' related | | | | |
| | c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | | | |
| | d) Case involved suspected or actual abuse by family | | | | |
| | e) Case identified as a result of review exercise | | | | |
| | f) Case is environmental or infrastructure related with no harm to patient/service user | | | | |
| | g) Other rationale | | | | |
| | **If you selected c), d), e), f) or g) above please provide further details:** | | | | |
| 3) Was this SAI also a Never Event?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| 4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event?<br>**Please select as appropriate (✓)** | **YES** | If **YES**, insert **date informed**: DD/MM.YY | | | |
| | **NO** | If **NO**, provide details: | | | |
| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)** | | | | | |
| **Content with rationale?** | **YES** | | **NO** | | |

| **SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER**<br>***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*** | | | | |
|---|---|---|---|---|
| 5) Has the Final Review report been shared with the Service User[1] / Family / Carer?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert date informed: | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer: | | | |

Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

| SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER<br>*(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)* | | |
|---|---|---|
| | a) Draft review report has been shared and further engagement planned to share final report | |
| | b) Plan to share final review report at a later date and further engagement planned | |
| | c) Report not shared but contents discussed<br>***(if you select this option please also complete 'l' below)*** | |
| | d) No contact or Next of Kin or Unable to contact | |
| | e) No response to correspondence | |
| | f) Withdrew fully from the SAI process | |
| | g) Participated in SAI process but declined review report | |
| | ***(if you select any of the options below please also complete 'l' below)*** | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer | |
| | i) case involved suspected or actual abuse by family | |
| | j) identified as a result of review exercise | |
| | k) other rationale | |
| | l) If you have selected **c), h), i), j), or k)** above please provide further details: | |

| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)**) | | | | |
|---|---|---|---|---|
| **Content with rationale?** | **YES** | | **NO** | |

| SECTION 2<br>**INFORMING THE CORONERS OFFICE**<br>**(under section 7 of the Coroners Act (Northern Ireland) 1959)**<br>*(complete this section for all death related SAIs)* | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | | | |
| | If **YES**, insert **date informed**: | | | | | | |
| | If **NO**, please provide details: | | | | | | |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | | | |
| | If **YES**, insert **date report shared**: | | | | | | |
| | If **NO**, please provide details: | | | | | | |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | **N/A** | | **Not Known** |
| | If **YES**, insert **date informed**: | | | | | | |
| | If **NO**, please provide details: | | | | | | |

| **DATE CHECKLIST COMPLETED** | |
|---|---|

[1] *Service User or their nominated representative*

**APPENDIX 6**

**Revised November 2016 (Version 1.1)**

**Insert organisation Logo**

# Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

## 1.0 EXECUTIVE SUMMARY

## 2.0 THE REVIEW TEAM

## 3.0 SAI REVIEW TERMS OF REFERENCE

## 4.0 REVIEW METHODOLOGY

## 5.0 DESCRIPTION OF INCIDENT/CASE

## 6.0 FINDINGS

## 7.0 CONCLUSIONS

## 8.0 LESSONS LEARNED

## 9.0 RECOMMENDATIONS AND ACTION PLANNING

## 10.0 DISTRIBUTION LIST

Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

# Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

| | | | |
|---|---|---|---|
| **Reporting Organisation SAI Ref Number:** | | **HSCB Ref Number:** | |

## SECTION 1

## INFORMING THE SERVICE USER[1] / FAMILY / CARER

| | | | | |
|---|---|---|---|---|
| 1) Please indicate if the SAI relates to a single service user, or a number of service users.<br>**Please select as appropriate (✓)** | **Single Service User** | | **Multiple Service Users*** | |
| | **Comment:**<br>***If multiple service users are involved please indicate the number involved*** | | | |
| 2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert **date informed**: | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI | | | |
| | a) No contact or Next of Kin details or Unable to contact | | | |
| | b) Not applicable as this SAI is not 'patient/service user' related | | | |
| | c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | | |
| | d) Case involved suspected or actual abuse by family | | | |
| | e) Case identified as a result of review exercise | | | |
| | f) Case is environmental or infrastructure related with no harm to patient/service user | | | |
| | g) Other rationale | | | |
| | **If you selected c), d), e), f) or g) above please provide further details:** | | | |
| 3) Was this SAI also a Never Event?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| 4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event?<br>**Please select as appropriate (✓)** | **YES** | If **YES**, insert **date informed**: DD/MM.YY | | |
| | **NO** | If **NO**, provide details: | | |
| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)** | | | | |
| **Content with rationale?** | **YES** | | **NO** | |

## SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)***

| | | | | |
|---|---|---|---|---|
| 5) Has the Final Review report been shared with the Service User[1] / Family / Carer?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert date informed: | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer: | | | |
| | a) Draft review report has been shared and further engagement planned to share final report | | | |
| | b) Plan to share final review report at a later date and further engagement planned | | | |
| | c) Report not shared but contents discussed<br>***(if you select this option please also complete 'l' below)*** | | | |

Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

| SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER<br>*(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)* | | |
|---|---|---|
| | d) No contact or Next of Kin or Unable to contact | |
| | e) No response to correspondence | |
| | f) Withdrew fully from the SAI process | |
| | g) Participated in SAI process but declined review report | |
| | ***(if you select any of the options below please also complete 'l' below)*** | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer | |
| | i) case involved suspected or actual abuse by family | |
| | j) identified as a result of review exercise | |
| | k) other rationale | |
| | l) If you have selected **c), h), i), j), or k)** above please provide further details: | |

| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)**) | | | | |
|---|---|---|---|---|
| **Content with rationale?** | **YES** | | **NO** | |

| SECTION 2<br>**INFORMING THE CORONERS OFFICE**<br>**(under section 7 of the Coroners Act (Northern Ireland) 1959)**<br>*(complete this section for all death related SAIs)* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death?<br>**Please select as appropriate (✓)** | **YES** | | | | **NO** | | | |
| | If **YES**, insert **date informed**: | | | | | | | |
| | If **NO**, please provide details: | | | | | | | |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner?<br>**Please select as appropriate (✓)** | **YES** | | | | **NO** | | | |
| | If **YES**, insert **date report shared**: | | | | | | | |
| | If **NO**, please provide details: | | | | | | | |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | **N/A** | | **Not Known** | |
| | If **YES**, insert **date informed**: | | | | | | | |
| | If **NO**, please provide details: | | | | | | | |

| **DATE CHECKLIST COMPLETED** | |
|---|---|

[1] *Service User or their nominated representative*

**APPENDIX 7**
**Revised November 2016 (Version 1.1)**

# Health and Social Care Regional Guidance

# for

# Level 2 and 3 RCA Incident Review Reports

Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

# INTRODUCTION

This document is a revision of the template developed by the DoH Safety in Health and Social Care Steering Group in 2007 as part of the action plan contained within "*Safety First: A Framework for Sustainable Improvement in the HPSS.*"

The purpose of this template and guide is to provide practical help and support to those writing review reports and should be used, in as far as possible, for drafting all **HSC Level 2 and Level 3** incident review reports. It is intended as a guide in order to standardise all such reports across the HSC including both internal and external reports.

The review report presents the work of the review team and provides all the necessary information about the incident, the review process and outcome of the review. The purpose of the report is to provide a formal record of the review process and a means of sharing the learning. The report should be clear and logical, and demonstrate that an open and fair approach has taken place.

This guide should assist in ensuring the completeness and readability of such reports. The headings and report content should follow, as far as possible, the order that they appear within the template. Composition of reports to a standardised format will facilitate the collation and dissemination of any regional learning.

This template was designed primarily for incident reviews however it may also be used to examine complaints and claims.

Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

**Insert organisation Logo**

# Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

## 1.0 EXECUTIVE SUMMARY

Summarise the main report: provide a brief overview of the incident and consequences, background information, level of review, concise analysis and main conclusions, lessons learned, recommendations and arrangements for sharing and learning lessons.

## 2.0 THE REVIEW TEAM

**Refer to Guidance on Review Team Membership**

The level of review undertaken will determine the degree of leadership, overview and strategic review required.

- *List names, designation and review team role of the members of the Review Team. The Review Team should be multidisciplinary and should have an Independent Chair.*
- *The degree of independence of the membership of the team needs careful consideration and depends on the severity / sensitivity of the incident and the level of review to be undertaken. However, best practice would indicate that review teams should incorporate at least one informed professional from another area of practice, best practice would also indicate that the chair of the team should be appointed from outside the area of practice.*
- *In the case of more high impact incidents (i.e. categorised as catastrophic or major) inclusion of lay / patient / service user or carer representation should be considered.*

## 3.0 SAI REVIEW TERMS OF REFERENCE

Describe the plan and scope for conducting the review. State the level of review, aims, objectives, outputs and who commissioned the review.

*The following is a sample list of statements of purpose that may be included in the terms of reference:*

- To undertake a review of the incident to identify specific problems or issues to be addressed;
- To consider any other relevant factors raised by the incident;
- To identify and engage appropriately with all relevant services or other agencies associated with the care of those involved in the incident;
- To determine actual or potential involvement of the Police, Health and Safety Executive, Regulation and Quality Improvement Authority and Coroners Service for Northern Ireland[2] [3]
- To agree the remit of the review - the scope and boundaries beyond which the review should not go (e.g. disciplinary process) – state how far back the review will go (what point does the review start and stop e.g. episode of care) and the level of review;
- To consider the outcome of the review, agreeing recommendations, actions to be taken and lessons learned for the improvement of future services;
- To ensure sensitivity to the needs of the patient/ service user/ carer/ family member, where appropriate. The level of involvement clearly depends on the nature of the incident and the service user's or family's wishes or carer's wishes to be involved and must be in line with Regional Guidance on Engagement with Service Users, Families and Carers issued November 2016;

[2] *Memorandum of understanding: Investigating patient or client safety incidents (Unexpected death or serious untoward harm)- http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf*

[3] *Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults 2009*

## 3.0 SAI REVIEW TERMS OF REFERENCE

- To agree the timescales for completing and submitting the review report, including the SAI engagement checklist, distribution of the report and timescales for reviewing actions on the action plan;

Methodology to be used should be agreed at the outset and kept under regular review throughout the course of the SAI review.

Clear documentation should be made of the time-line for completion of the work.

***This list is not exhaustive***

## 4.0 REVIEW METHODOLOGY

This section should provide an outline of the type of review and the methods used to gather information within the review process. The NPSA's "Seven Steps to Patient Safety[4]" and "Root Cause Analysis Review Guidance[5]" provide useful guides for deciding on methodology.

- Review of patient/ service user records and compile a timeline (if relevant)
- Review of staff/witness statements (if available)
- Interviews with relevant staff concerned e.g.
  - Organisation-wide
  - Directorate Team
  - Ward/Team Managers and front line staff
  - Other staff involved
  - Other professionals (including Primary Care)
- Specific reports requested from and provided by staff
- Outline engagement with patients/service users / carers / family members / voluntary organisations/ private providers
- Review of local, regional and national policies and procedures, including professional codes of conduct in operation at the time of the incident
- Review of documentation e.g. consent form(s), risk assessments, care plan(s), photographs, diagrams or drawings, training records, service/maintenance records, including specific reports requested from and provided by staff etc.

***This list is not exhaustive***

## 5.0 DESCRIPTION OF INCIDENT/CASE

Provide an account of the incident including consequences and detail what makes this incident a SAI. The following can provide a useful focus but please note this section is not solely a chronology of events

- Concise factual description of the serious adverse incident include the incident date and

[4] http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787

[5] http://www.nrls.npsa.nhs.uk/resources/?entryid45=75355

## 5.0 DESCRIPTION OF INCIDENT/CASE

type, the healthcare specialty involved and the actual effect of the incident on the service user and/or service and others;

- People, equipment and circumstances involved;
- Any intervention / immediate action taken to reduce consequences;
- Chronology of events leading up to the incident;
- Relevant past history – a brief description of the care and/or treatment/service provided;
- Outcome / consequences / action taken;
- Relevance of local, regional or national policy / guidance / alerts including professional codes of conduct in place at the time of the incident

***This list is not exhaustive***

## 6.0 FINDINGS

This section should clearly outline how the information has been analysed so that it is clear how conclusions have been arrived at from the raw data, events and treatment/care/service provided. This section needs to clearly identify the care and service delivery problems and analysis to identify the causal factors.

Analysis can include the use of root cause and other analysis techniques such as fault tree analysis, etc. The section below is a useful guide particularly when root cause techniques are used. It is based on the NPSA's "Seven Steps to Patient Safety" and "Root Cause Analysis Toolkit".

**(i) Care Delivery Problems (CDP) and/or Service Delivery Problems (SDP) Identified**

*CDP is a problem related to the direct provision of care, usually actions or omissions by staff (active failures) or absence of guidance to enable action to take place (latent failure) e.g. failure to monitor, observe or act; incorrect (with hindsight) decision, NOT seeking help when necessary.*

*SDP are acts and omissions identified during the analysis of incident not associated with direct care provision. They are generally associated with decisions, procedures and systems that are part of the whole process of service delivery e.g. failure to undertake risk assessment, equipment failure.*

**(ii) Contributory Factors**

*Record the influencing factors that have been identified as root causes or fundamental issues.*

- Individual Factors (include employment status i.e. substantive, agency, locum voluntary etc.)
- Team and Social Factors
- Communication Factors
- Task Factors
- Education and Training Factors
- Equipment and Resource Factors
- Working Condition Factors
- Organisational and Management Factors
- Patient / Client Factors

***This list is not exhaustive***

*As a framework for organising the contributory factors reviewed and recorded the table in the NPSA's "Seven Steps to Patient Safety" document (and associated Root Cause Analysis Toolkit) is useful.* http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/

*Where appropriate and where possible careful consideration should be made to facilitate the involvement of patients/service users / carers / family members within this process.*

## 7.0 CONCLUSIONS

Following analysis identified above, list issues that need to be addressed. Include discussion of good practice identified as well as actions to be taken. Where appropriate include details of any on-going engagement / contact with family members or carers.

This section should summarise the key findings and should answer the questions posed in the terms of reference.

## 8.0 LESSONS LEARNED

Lessons learned from the incident and the review should be identified and addressed by the recommendations and relate to the findings. Indicate to whom learning should be communicated and this should be copied to the Committee with responsibility for governance.

## 9.0 RECOMMENDATIONS AND ACTION PLANNING

List the improvement strategies or recommendations for addressing the issues highlighted above (conclusions and lessons learned). Recommendations should be grouped into the following headings and cross-referenced to the relevant conclusions, and should be graded to take account of the strengths and weaknesses of the proposed improvement strategies/actions:

- Recommendations for the reviewing organisation
- Suggested /proposed learning that is relevant to other organisations

Action plans should be developed and should set out how each recommendation will be implemented, with named leads responsible for each action point (Refer to Appendix 8 Guidance on Minimum Standards for Action Plans). This section should clearly demonstrate the arrangements in place to successfully deliver the action plan.

It should be noted that it is the responsibility of the HSCB/PHA to consider and review all recommendations, of suggested /proposed learning relevant to other organisations, arising from the review of a SAI. In addition, it is the responsibility if the HSCB/PHA to subsequently identify any related learning to be communicated across the HSC and where relevant with other organisations regionally and/or nationally.

It is the responsibility of the reporting organisation to communicate to service users/families/carers that regional learning identified and submitted to the HSCB/PHA for consideration may not on every occasion result in regional learning.

## 10.0 DISTRIBUTION LIST

List the individuals, groups or organisations the final report has been shared with. This should have been agreed within the terms of reference.

# Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

| | | | |
|---|---|---|---|
| **Reporting Organisation SAI Ref Number:** | | **HSCB Ref Number:** | |

## SECTION 1

## INFORMING THE SERVICE USER[1] / FAMILY / CARER

| | | | | | |
|---|---|---|---|---|---|
| 1) Please indicate if the SAI relates to a single service user, or a number of service users.<br>**Please select as appropriate (✓)** | **Single Service User** | | **Multiple Service Users*** | | |
| | **Comment:**<br>***If multiple service users are involved please indicate the number involved*** | | | | |
| 2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| | If **YES**, insert **date informed**: | | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI | | | | |
| | a) No contact or Next of Kin details or Unable to contact | | | | |
| | b) Not applicable as this SAI is not 'patient/service user' related | | | | |
| | c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | | | |
| | d) Case involved suspected or actual abuse by family | | | | |
| | e) Case identified as a result of review exercise | | | | |
| | f) Case is environmental or infrastructure related with no harm to patient/service user | | | | |
| | g) Other rationale | | | | |
| | **If you selected c), d), e), f) or g) above please provide further details:** | | | | |
| 3) Was this SAI also a Never Event?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| 4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event?<br>**Please select as appropriate (✓)** | **YES** | If **YES**, insert **date informed**: DD/MM.YY | | | |
| | **NO** | If **NO**, provide details: | | | |
| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)** | | | | | |
| **Content with rationale?** | **YES** | | **NO** | | |

## SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)***

| | | | | | |
|---|---|---|---|---|---|
| 5) Has the Final Review report been shared with the Service User[1] / Family / Carer?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| | If **YES**, insert date informed: | | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer: | | | | |
| | a) Draft review report has been shared and further engagement planned to share final report | | | | |
| | b) Plan to share final review report at a later date and further engagement planned | | | | |

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| SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER<br>*(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)* | | |
|---|---|---|
| | c) Report not shared but contents discussed<br>**(*if you select this option please also complete 'l' below*)** | |
| | d) No contact or Next of Kin or Unable to contact | |
| | e) No response to correspondence | |
| | f) Withdrew fully from the SAI process | |
| | g) Participated in SAI process but declined review report | |
| | ***(if you select any of the options below please also complete 'l' below)*** | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer | |
| | i) case involved suspected or actual abuse by family | |
| | j) identified as a result of review exercise | |
| | k) other rationale | |
| | l) If you have selected **c), h), i), j), or k)** above please provide further details: | |

| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)** | | | | |
|---|---|---|---|---|
| **Content with rationale?** | **YES** | | **NO** | |

| SECTION 2<br>**INFORMING THE CORONERS OFFICE**<br>**(under section 7 of the Coroners Act (Northern Ireland) 1959)**<br>*(complete this section for all death related SAIs)* | | | | |
|---|---|---|---|---|
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert **date informed**: | | | |
| | If **NO**, please provide details: | | | |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert **date report shared**: | | | |
| | If **NO**, please provide details: | | | |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert **date informed**: | | | |
| | If **NO**, please provide details: | | | |

| **DATE CHECKLIST COMPLETED** | |
|---|---|

[1] *Service User or their nominated representative*

## APPENDIX 8

### GUIDANCE ON MINIMUM STANDARDS FOR ACTION PLANS

The action plan must define:

- Who has agreed the action plan
- Who will monitor the implementation of the action plan
- How often the action plan will be reviewed
- Who will sign off the action plan when all actions have been completed

The action plan **MUST** contain the following

| | |
|---|---|
| **1. Recommendations based on the contributing factors** | The recommendations from the report - these should be the analysis and findings of the review |
| **2. Action agreed** | This should be the actions the organisation needs to take to resolve the contributory factors. |
| **3. By who** | Who in the organisation will ensure the action is completed |
| **4. Action start date** | Date particular action is to commence |
| **5. Action end date** | Target date for completion of action |
| **6. Evidence of completion** | Evidence available to demonstrate that action has been completed. This should include any intended action plan reviews or audits |
| **7. Sign off** | Responsible office and date sign off as completed |

**APPENDIX 9**

**GUIDANCE ON INCIDENT DEBRIEF**

- ## Level 1 - SEA Reviews

For level 1 reviews, the incident debrief can serve the purpose of the SEA review, (these can also be known as 'hot debriefs').

The review should:

- Collect and collate as much factual information on the event as possible, including all relevant records. Also gather the accounts of those directly and indirectly involved, including, where relevant, service user/relatives/carers or other health professionals.

- The incident debrief/significant event meeting should be held with all staff involved to provide an opportunity to:

    - support the staff involved[6]
    - assess what has happened;
    - assess why did it happened;
        - what went wrong and what went well;
    - assess what has been changed or agree what will change;
    - identify local and regional learning.

- The meeting/s should be conducted in an open, fair, honest, non-judgemental and supportive atmosphere and should be undertaken as soon as practical following the incident.

- Write it up – keep a written report of the analysis undertaken using the SEA Report template (see Appendix 4)

- Sharing SEA Report – SEA reports should be shared with all relevant staff, particularly those who have been involved in the incident.

- ## Level 2 and 3 RCA Reviews

An incident debrief can also be undertaken for level 2 and 3 reviews. This would be separate from the RCA review and should occur quickly after the incident to provide support to staff and to identify any immediate service actions.

[6] *Note: link to ongoing work in relation to Quality 2020 - Task 2 - Supporting Staff involved in SAIs and other Incidents*

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**APPENDIX 10**

## LEVEL 1 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review of an incident should be proportionate to its significance; this is a judgement to be made by the Review Team.

Membership of the team should include all relevant professionals but should be appropriate and proportionate to the type of incident and professional groups involved. Ultimately, for a Level 1 review, it is for each team to decide who is invited, there has to be a balance between those who can contribute to an honest discussion, and creating such a large group that discussion of sensitive issues is inhibited.

The review team should appoint an experienced facilitator or lead reviewing officer from within the team to co-ordinate the review. The role of the facilitator is as follows:

- Co-ordinate the information gathering process
- Arrange the review meeting
- Explain the aims and process of the review
- Chair the review meeting
- Co-ordinate the production of the Significant Event Audit report
- Ensure learning is shared in line with the Learning Summary Report

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**APPENDIX 11**

## LEVEL 2 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review undertaken will determine the degree of leadership, overview and strategic review required. The level of review of an incident should therefore be proportionate to its significance. This is a judgement to be made by the Review Team.

The core review team should comprise a minimum of three people of appropriate seniority and objectivity. Review teams should be multidisciplinary, (or involve experts/expert opinion/independent advice or specialist reviewers). The team shall have no conflicts of interest in the incident concerned and should have an Independent Chair. (*In the event of a suspected homicide HSC Trusts should follow the HSCB Protocol for responding to SAIs in the event of a Homicide – revised 2013*)

The Chair of the team shall be independent of the service area where the incident occurred and should have relevant experience of the service area and/or chairing investigations/reviews. He/she shall not have been involved in the direct care or treatment of the individual, or be responsible for the service area under review. The Chair may be sourced from the HSCB Lay People Panel *(a panel of 'lay people' with clinical or social care professional areas of expertise in health and social care, who could act as the chair of an independent review panel, or a member of a Trust RCA review panel*).

Where multiple (*two or more*) HSC providers of care are involved, an increased level of independence shall be required. In such instances, the Chair shall be completely independent of the main organisations involved.

Where the service area is specialised, the Chair may have to be appointed from another HSC Trust or from outside NI.

Membership of the team should include all relevant professionals, but should be appropriate and proportionate to the type of incident and professional groups involved.

Membership shall include an experienced representative who shall support the review team in the application of the root cause analysis methodologies and techniques, human error and effective solutions based development.

Members of the team shall be separate from those who provide information to the review team.

It may be helpful to appoint a review officer from within the review team to co-ordinate the review.

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**APPENDIX 12**

## LEVEL 3 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review shall be proportionate to the significance of the incident. The same principles shall apply, as for Level 2 reviews. The degree of independence of the review team will be dependent on the scale, complexity and type of the incident.

Team membership for Level 3 reviews will be agreed between the reporting organisation and the HSCB/PHA DRO prior to the Level 3 review commencing.

**APPENDIX 13**

## GUIDANCE ON JOINT REVIEWS/INVESTIGATIONS

Where a SAI involves multiple (*two or more*) HSC providers of care (e.g. a patient/service user affected by system failures both in an acute hospital and in primary care), a decision must be taken regarding who will lead the review and reporting. This may not necessarily be the initial reporting organisation.

The general rule is for the provider organisation with greatest contact with the patient/service user to lead the review and action. There may, however, be good reason to vary this arrangement e.g. where a patient/service user has died on another organisation's premises. The decision should be made jointly by the organisations concerned, if necessary referring to the HSCB Designated Review Officer for advice. **The lead organisation must be agreed by all organisations involved.**

It will be the responsibility of the lead organisation to engage all organisations in the review as appropriate. This involves collaboration in terms of identifying the appropriate links with the other organisations concerned and in practice, separate meetings in different organisations may take place, but a single review report and action plan should be produced by the lead organisation and submitted to the HSCB in the agreed format.

Points to consider:

- If more than one service is being provided, then all services are required to provide information / involvement reports to the review team;
- All service areas should be represented in terms of professional makeup / expertise on the review team;
- If more than one Trust/Agency is involved in the care of an individual, that the review is conducted jointly with all Trusts/Agencies involved;
- Relevant service providers, particularly those under contract with HSC to provide some specific services, should also be enjoined;
- There should be a clearly articulated expectation that the service user (where possible) and family carers, perspective should be canvassed, as should the perspective of staff directly providing the service, to be given consideration by the panel;
- The perspective of the GP and other relevant independent practitioners providing service to the individual should be sought;
- Service users and carer representatives should be invited / facilitated to participate in the panel discussions with appropriate safeguards to protect the confidentiality of anyone directly involved in the case.

This guidance should be read in conjunction with:

- Guidance on Incident Debrief (Refer to Appendix 9)
- Guidance on Review Team Membership (Refer to Appendix 11 & 12)
- Guidance on completing HSC Review Report Level 2 and 3 (Refer to Appendix 7)

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**APPENDIX 14**

**PROTOCOL FOR RESPONDING TO SERIOUS ADVERSE INCIDENTS IN THE EVENT OF A HOMICIDE – 2013 (updated November 2016 in line with the HSCB Procedure for the Reporting and Follow up of SAIs)**

## 1. INTRODUCTION AND PURPOSE

### 1.1. INTRODUCTION

The Health and Social Care Board (HSCB) Procedure for the Reporting and Follow up of Serious Adverse Incidents (SAIs) was issued in April 2010 and revised November 2016. This procedure provides guidance to Health and Social Care (HSC) Trusts and HSCB Integrated Care staff in relation to the reporting and follow up of SAIs arising during the course of business of a HSC organisation, Special Agency or commissioned service.

This paper is a revised protocol, developed from the above procedure, for the specific SAIs which involves an alleged homicide perpetrated by a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident.

This paper should be read in conjunction with Promoting Quality Care – Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (Sept 2009 & May 2010).

### 1.2. PURPOSE

The purpose of this protocol is to provide HSC Trusts with a standardised approach in managing and coordinating the response to a SAI involving homicide.

## 2. THE PROCESS

### 2.1. REPORTING SERIOUS ADVERSE INCIDENTS

Refer to the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents revised in 2016.

### 2.2. MULTI-DISCIPLINARY REVIEW

As indicated in Promoting Quality Care (5.0) an internal multi-disciplinary review must be held as soon as practicable following an adverse incident. Where the SAI has resulted in homicide a more independent response is required.

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An independent review team should be set up within twenty working days, of the notification of the incident, to the Trust.

## 2.3. ESTABLISHING AN INDEPENDENT REVIEW TEAM

### 2.3.1 CHAIR

The Chair of the Review Team should be independent from the HSC Trust, not a Trust employee or recently employed by the Trust. They should be at Assistant Director level or above with relevant professional expertise.

It is the role of the Chair to ensure engagement with families, that their views are sought, that support has been offered to them at an early stage and they have the opportunity to comment on the final draft of the report.

### 2.3.2 MEMBERSHIP

A review team should include all relevant professionals. The balance of the Team should include non-Trust staff and enable the review team to achieve impartiality, openness, independence, and thoroughness in the review of the incident. [ref: Case Management Review Chapter 10 Cooperating to Protect Children].

The individuals who become members of the Team must not have had any line management responsibility for the staff working with the service user under consideration. The review team must include members who are independent of HSC Trusts and other agencies concerned.

Members of the review team should be trained in the Procedure for the Reporting and Follow up of Serious Adverse Incidents 2016.

## 3. TERMS OF REFERENCE

The terms of reference for the review team should be drafted at the first meeting of the review team and should be agreed by the HSCB before the second meeting.

The Terms of Reference should include, as a minimum, the following:

- establish the facts of the incident;
- analyse the antecedents to the incident;
- consider any other relevant factors raised by the incident;
- establish whether there are failings in the process and systems;
- establish whether there are failings in the performance of individuals;
- identify lessons to be learned from the incident; and

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- identify clearly what those lessons are, how they will be acted upon, what is expected to change as a result, and specify timescales and responsibility for implementation.

## 4. TIMESCALES

The notification to the Trust of a SAI, resulting in homicide, is the starting point of this process.

The Trust should notify the HSCB within 24hours and the Regulation and Quality Improvement Authority (RQIA) as appropriate.

An independent review team should be set up within twenty working days of the notification of the incident to the Trust.

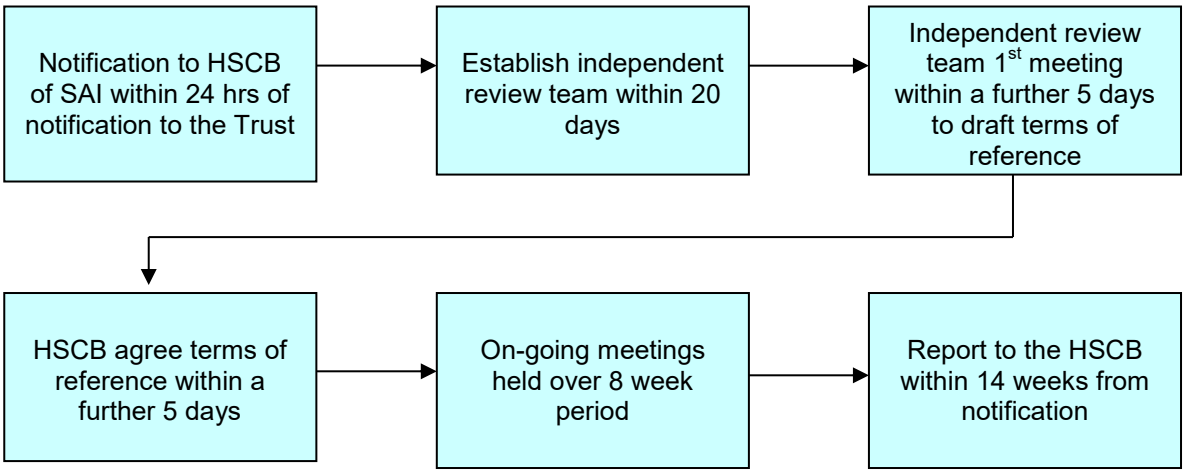
The team should meet to draft the terms of reference within a further five working days (i.e. twenty five days from notification of the incident to the Trust).

The HSCB should agree the terms of reference within a further five working days to enable work to begin at a second meeting.

The review team should complete their work and report to the HSCB within 14 weeks, this may be affected by PSNI investigations.

### FLOWCHART OF PROCESS WITH TIMESCALES

*NB Days refers to working days from the date of notification of the incident to the Trust*




## 5. THE HEALTH AND SOCIAL CARE BOARD RESPONSIBILITY

On receipt of the completed Trust review report the HSCB will consider the findings and recommendations of the report and must form a view as to whether or not an Independent Inquiry is required.

The HSCB must advise the Department of Health, (DoH) as to whether or not an Independent Inquiry is required in this particular SAI.

**APPENDIX 15**

# ADMINISTRATIVE PROTOCOL

## REPORTING AND FOLLOW UP OF SAIs INVOLVING RQIA MENTAL HEALTH/LEARNING DISABILITY AND INDEPENDENT/REGULATED SECTOR

On receipt of a SAI notification and where a HSC Trust has also copied RQIA into the same notification, the following steps will be applied:

1. HSCB acknowledgement email to Trust advising on timescale for review report will also be copied to RQIA.

2. On receipt of the review/learning summary report from Trust, the HSCB Governance Team will forward to the HSCB/PHA Designated Review Officer (DRO).

3. At the same time, the HSCB Governance Team will also forward the review report/learning summary report[1] to RQIA, together with an email advising of a **3 week** timescale from receipt of review report/learning summary report, for RQIA to forward comments for consideration by the DRO.

4. The DRO will continue with his/her review liaising (where s/he feels relevant) with Trust, RQIA and other HSCB/PHA professionals until s/he is satisfied SAI can be closed.

5. If no comments are received from RQIA within the 3 week timescale, the DRO will assume RQIA have no comments.

6. When the SAI is closed by the DRO, an email advising the Trust that the SAI is closed will also be copied to RQIA.

***All communications to be sent or copied via:***

***HSCB Governance Team:*** ***seriousincidents@hscni.net***
***and RQIA:*** **seriousincidents@rqia.org.uk**

[1] **For Level 1 SAIs the HSCB only routinely receive the Learning Summary Report. If RQIA also wish to consider the full SEA Report this should be requested directly by RQIA from the relevant Reporting Organisation.**

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## APPENDIX 16

## HSC Regional Impact Table – with effect from April 2013 (updated June 2016)

| DOMAIN | IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential] | | | | |
|---|---|---|---|---|---|
| | **INSIGNIFICANT (1)** | **MINOR (2)** | **MODERATE (3)** | **MAJOR (4)** | **CATASTROPHIC (5)** |
| **PEOPLE** *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)* | • Near miss, no injury or harm. | • Short-term injury/minor harm requiring first aid/medical treatment.<br>• Any patient safety incident that required extra observation or minor treatment e.g. first aid<br>• Non-permanent harm lasting less than one month<br>• Admission to hospital for observation or extended stay (1-4 days duration)<br>• Emotional distress (recovery expected within days or weeks). | • Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year).<br>• Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days).<br>• Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required | • Long-term permanent harm/disability (physical/emotional injuries/trauma).<br>• Increase in length of hospital stay/care provision by >14 days. | • Permanent harm/disability (physical/ emotional trauma) to more than one person.<br>• Incident leading to death. |
| **QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES** *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)* | • Minor non-compliance with internal standards, professional standards, policy or protocol.<br>• Audit / Inspection – small number of recommendations which focus on minor quality improvements issues. | • Single failure to meet internal professional standard or follow protocol.<br>• Audit/Inspection – recommendations can be addressed by low level management action. | • Repeated failure to meet internal professional standards or follow protocols.<br>• Audit / Inspection – challenging recommendations that can be addressed by action plan. | • Repeated failure to meet regional/ national standards.<br>• Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities.<br>• Audit / Inspection – Critical Report. | • Gross failure to meet external/national standards.<br>• Gross failure to meet professional standards or statutory functions/ responsibilities.<br>• Audit / Inspection – Severely Critical Report. |
| **REPUTATION** *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)* | • Local public/political concern.<br>• Local press < 1day coverage.<br>• Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS). | • Local public/political concern.<br>• Extended local press < 7 day coverage with minor effect on public confidence.<br>• Advisory letter from enforcing authority/increased inspection by regulatory authority. | • Regional public/political concern.<br>• Regional/National press < 3 days coverage. Significant effect on public confidence.<br>• Improvement notice/failure to comply notice. | • MLA concern (Questions in Assembly).<br>• Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined.<br>• Criminal Prosecution.<br>• Prohibition Notice.<br>• Executive Officer dismissed.<br>• External Investigation or Independent Review (eg, Ombudsman).<br>• Major Public Enquiry. | • Full Public Enquiry/Critical PAC Hearing.<br>• Regional and National adverse media publicity > 7 days.<br>• Criminal prosecution – Corporate Manslaughter Act.<br>• Executive Officer fined or imprisoned.<br>• Judicial Review/Public Enquiry. |
| **FINANCE, INFORMATION & ASSETS** *(Protect assets of the organisation and avoid loss)* | • Commissioning costs (£) <1m.<br>• Loss of assets due to damage to premises/property.<br>• Loss – £1K to £10K.<br>• Minor loss of non-personal information. | • Commissioning costs (£) 1m – 2m.<br>• Loss of assets due to minor damage to premises/ property.<br>• Loss – £10K to £100K.<br>• Loss of information.<br>• Impact to service immediately containable, medium financial loss | • Commissioning costs (£) 2m – 5m.<br>• Loss of assets due to moderate damage to premises/ property.<br>• Loss – £100K to £250K.<br>• Loss of or unauthorised access to sensitive / business critical information<br>• Impact on service contained with assistance, high financial loss | • Commissioning costs (£) 5m – 10m.<br>• Loss of assets due to major damage to premises/property.<br>• Loss – £250K to £2m.<br>• Loss of or corruption of sensitive / business critical information.<br>• Loss of ability to provide services, major financial loss | • Commissioning costs (£) > 10m.<br>• Loss of assets due to severe organisation wide damage to property/premises.<br>• Loss – > £2m.<br>• Permanent loss of or corruption of sensitive/business critical information.<br>• Collapse of service, huge financial loss |
| **RESOURCES** *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)* | • Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service.<br>• No impact on public health social care.<br>• Insignificant unmet need.<br>• Minimal disruption to routine activities of staff and organisation. | • Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service.<br>• Short term impact on public health social care.<br>• Minor unmet need.<br>• Minor impact on staff, service delivery and organisation, rapidly absorbed. | • Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service.<br>• Moderate impact on public health and social care.<br>• Moderate unmet need.<br>• Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention.<br>• Access to systems denied and incident expected to last more than 1 day. | • Loss/ interruption 8-31 days resulting in major damage or loss/impact on service.<br>• Major impact on public health and social care.<br>• Major unmet need.<br>• Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations. | • Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service.<br>• Catastrophic impact on public health and social care.<br>• Catastrophic unmet need.<br>• Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations. |
| **ENVIRONMENTAL** *(Air, Land, Water, Waste management)* | • Nuisance release. | • On site release contained by organisation. | • Moderate on site release contained by organisation.<br>• Moderate off site release contained by organisation. | • Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc). | • Toxic release affecting off-site with detrimental effect requiring outside assistance. |

HSC Regional Risk Matrix – April 2013 (updated June 2016)

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# HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

| Risk Likelihood Scoring Table | | | |
|---|---|---|---|
| **Likelihood Scoring Descriptors** | **Score** | **Frequency (How often might it/does it happen?)** | **Time framed Descriptions of Frequency** |
| Almost certain | 5 | Will undoubtedly happen/recur on a frequent basis | Expected to occur at least daily |
| Likely | 4 | Will probably happen/recur, but it is not a persisting issue/circumstances | Expected to occur at least weekly |
| Possible | 3 | Might happen or recur occasionally | Expected to occur at least monthly |
| Unlikely | 2 | Do not expect it to happen/recur but it may do so | Expected to occur at least annually |
| Rare | 1 | This will probably never happen/recur | Not expected to occur for years |

| | **Impact (Consequence) Levels** | | | | |
|---|---|---|---|---|---|
| **Likelihood Scoring Descriptors** | **Insignificant(1)** | **Minor (2)** | **Moderate (3)** | **Major (4)** | **Catastrophic (5)** |
| **Almost Certain (5)** | **Medium** | **Medium** | **High** | **Extreme** | **Extreme** |
| **Likely (4)** | **Low** | **Medium** | **Medium** | **High** | **Extreme** |
| **Possible (3)** | **Low** | **Low** | **Medium** | **High** | **Extreme** |
| **Unlikely (2)** | **Low** | **Low** | **Medium** | **High** | **High** |
| **Rare (1)** | **Low** | **Low** | **Medium** | **High** | **High** |

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**APPENDIX 17**

## CHILD AND ADULT SAFEGUARDING AND SAI PROCESSES

The Procedure for the Reporting and Follow up of Serious Adverse Incidents (Revised November 2016) provides guidance to Health and Social Care organisations in relation to the reporting and follow up of Serious Adverse Incidents arising during the course of their business or commissioned service.

The guidance notes that the SAI review should be conducted at a level appropriate and proportionate to the complexity of the incident under review.

The guidance notes that there are three possible levels of review of an SAI and specifies the expected timescale for reporting on a review report as follows:

**Level 1 Review – Significant Event Audit (SEA).** To be completed and a Learning Summary Report sent to the HSCB within 8 weeks of the SAI being reported.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review timescales for completion of the RCA will be determined following submission of the Learning Summary Report to the HSCB.

**Level 2 Review – Root Cause Analysis (RCA).** The final report to be submitted to the HSCB within 12 weeks from the date the incident was notified.

**Level 3 Review** – Independent Review. Timescales for completion to be agreed by the DRO.

It should be noted that not every referral to child or adult safeguarding processes will proceed to the completion of an SAI report. Within Children's Services, the most complex cases and those that involve death or serious injury to a child, where concerns about how services worked together exist, will be notified to the HSCB as an SAI and may be assessed as meeting the criteria for a Case Management Review (CMR) in which case they will be managed out of the SAI system. The CMR report will highlight the learning from the case.

However, the timescales for the completion of SAI reviews at Level 2 and 3 have proved to be challenging for the cases that do not reach the threshold for a CMR or which result from allegations of abuse of an adult. These are more likely to be some of the more complex cases, and generally involve inter- and multi- agency partnership working.

In responding to allegations of the abuse, neglect or exploitation of a child or vulnerable adult where it is suspected that criminal offence may have been committed, the Health and Social Care Trusts operate under the principles for joint working with the PSNI and other agencies as set out in

- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009);

- Sharing to Safeguard (DoH Revised HSCC 3/96 and currently being revised by DoH);
- Co-operating to Safeguard Children (DoH 2003); and
- Protocol for joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland (2013)

The Memorandum of Understanding: Investigating patient or client safety incidents (2013) states that in cases where more than one organisation may/should have an involvement in investigating any particular incident, then:

*"The HSC Organisation should continue to ensure patient or client safety, but not undertake any activity that might compromise any subsequent statutory investigations."*

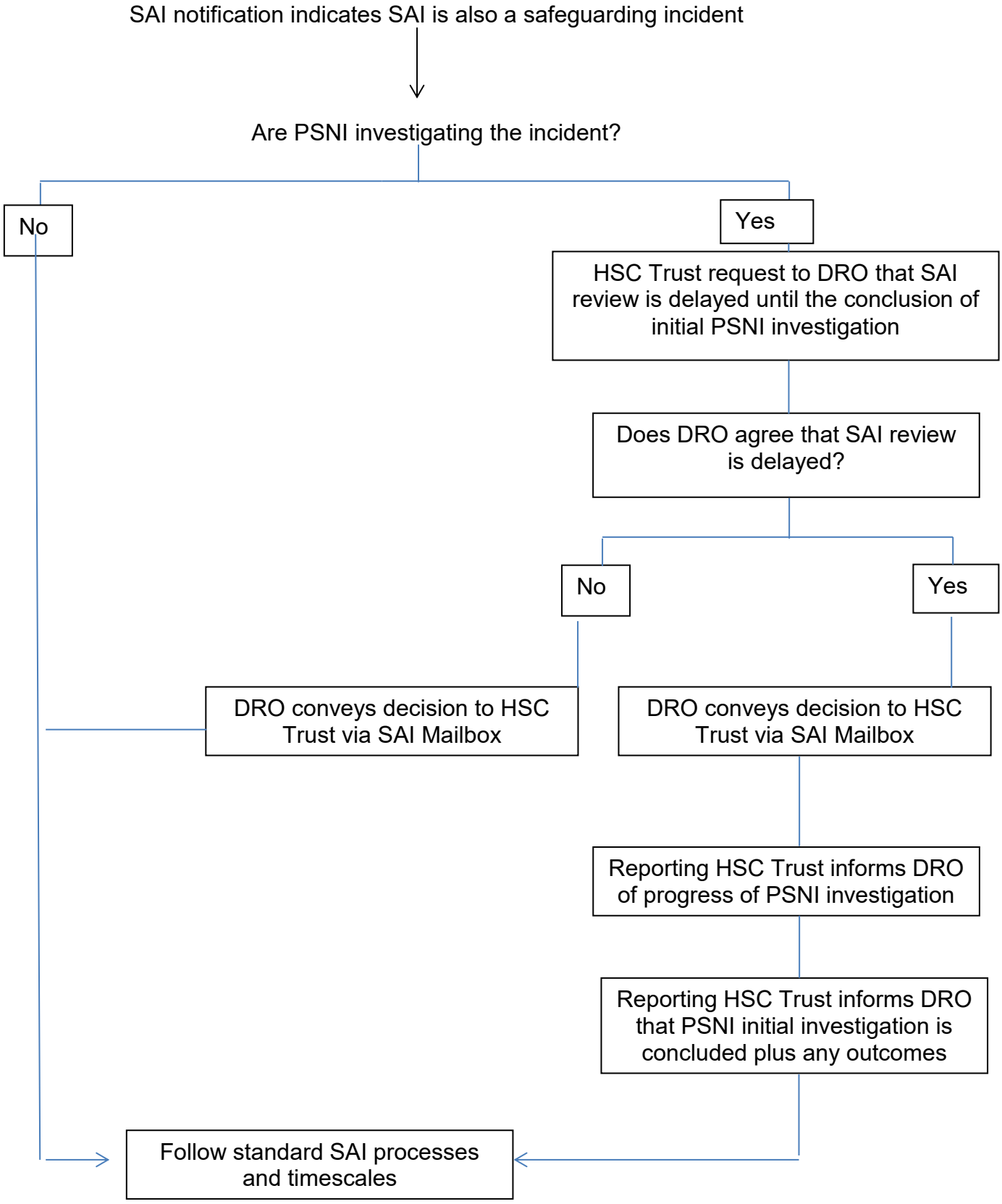
In addition "Achieving Best Evidence: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy" (revised in 2012), sets out clear protocols for interviewing vulnerable witnesses or victims, whether they are children or adults. This guidance ensures that interviews with vulnerable witnesses and victims are led by specially trained staff, conducted at the victims pace and take place in an environment that is conducive to the needs of the victim.

Clearly, there is an inter-dependency between PSNI and HSC investigations/reviews in complex cases involving multi-agency approaches and protocols. The identification and analysis of learning from these events is likely to be incomplete until both the PSNI and HSC have completed their separate and joint investigations/reviews using the protocols outlined above, and it is unlikely that this can be achieved within the timescales set out for both Level 1 and Level 2 reviews under the SAI procedure.

In such circumstances, the following process should be used:

- Trust report SAI to HSCB using the SAI Notification Form;
- The SAI Notification Form or section 22 of the notification form i.e. 'additional information following initial notification, should indicate the following:
  - The SAI is also a Safeguarding incident
  - PSNI are conducting an investigation of the circumstances surrounding the SAI
  - SAI evaluation will commence at the conclusion of the initial PSNI investigation;
  - Set out the arrangements for keeping the DRO informed of the progress of the PSNI initial investigation;
- If satisfied, the DRO will advise the Trust via the SAI Mailbox that he/she is in agreement with the proposal to delay the SAI review until the conclusion of the initial PSNI investigation;
- The reporting HSC Trust will inform the DRO as soon as the initial PSNI investigation has concluded, along with any outcomes and advise the SAI evaluation has commenced;
- The SAI will continue to be monitored by HSCB Governance team in line with timescales within the Procedure for the Reporting and Follow up of SAIs;
- If the DRO is **not** in agreement with the proposal to delay the SAI review, the reasons for this will be clearly conveyed to the Trust via the SAI Mailbox. Possible reasons for this may include, for example, situations where a criminal incident has occurred on HSC Trust premises but does not involve HSC Trust staff, or an incident involving a service user in their own home and a member of the public is reported to the PSNI by HSC Trust staff.

## CHILD AND ADULT SAFEGUARDING AND SAI PROCESSES




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## SECTION THREE ADDENDUM

# ADDENDUM

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**ADDENDUM 1**

# *A Guide for Health and Social Care Staff*

# Engagement/Communication with the Service User/Family/Carers following a Serious Adverse Incident

**November 2016**
**Version 1.1**



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**Notes on the Development of this Guidance**

This guidance has been compiled by the Health and Social Care Board (HSCB) and Public Health Agency (PHA) working in collaboration with the Regulation and Quality Improvement Authority (RQIA), the Patient Client Council (PCC) and Health and Social Care (HSC) Trusts.

This guidance has been informed by:

- National Patient Safety Agency (NPSA) Being Open Framework (2009)
- Health Service Executive (HSE) – Open Disclosure National Guidelines (2013)

*Please note the following points:*

- *The term 'service user' as used throughout this guidance includes patients and clients availing of Health and Social Care Services from HSC organisations and Family Practitioner Services (FPS) and/or services commissioned from the Independent Sector by HSC organisations.*

- *The phrase 'the service user / family' is used throughout this document in order to take account of all types of engagement scenarios, and also includes a carer(s) or the legal guardian of the service user, where appropriate. However, when the service user has capacity, communication should always (in the first instance) be with them (see appendix 1 for further guidance).*

**A review / re-evaluation of this guidance will be undertaken one year following implementation.**



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## 1.0 Introduction

When an adverse outcome occurs for a service user it is important that the service user / family (as appropriate) receive timely information and are fully aware of the processes followed to review the incident.

The purpose of a Serious Adverse Incident (SAI) review is to understand what occurred and where possible improve care by learning from incidents. Being open about what happened and discussing the SAI promptly, fully and compassionately can help the service user / family cope better with the after-effects and reduce the likelihood of them pursuing other routes such as the complaints process or litigation to get answers to their questions.

It is therefore essential that there is:

- full disclosure of a SAI to the service user / family,
- an acknowledgement of responsibility,
- an understanding of what happened and a discussion of what is being done to prevent recurrence.

Communicating effectively with the service user / family is a vital part of the SAI process. If done well, it promotes person-centred care and a fair and open culture, ultimately leading to continuous improvement in the delivery of HSC services. It is human to make mistakes, but rather than blame individuals, the aim is for all of us to identify and address the factors that contributed to the incident. The service user / family can add valuable information to help identify the contributing factors, and should be integral to the review process, unless they wish otherwise.

## 2.0 Purpose

This is a guide for HSC staff to ensure effective communication with the service user / family, following a SAI, is undertaken in an open, transparent, informed, consistent and timely manner.

It is important this guidance is read in conjunction with the regional Procedure for Reporting and Follow up of SAIs (November 2016) and any subsequent revisions relating to the SAI process that have or may be issued in the future. This will ensure the engagement process is closely aligned to the required timescales, documentation, review levels etc. *To view the SAI Procedure please follow the link below* http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf.



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The HSCB Process works in conjunction with all other review processes, statutory agencies and external bodies. Consequently, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI. It is therefore important that all existing processes continue to operate in tandem with the SAI procedure and should not be an obstacle to the engagement of the service user / family; nor should an interaction through another process replace engagement through the SAI process.

In that regard, whilst this guidance is specific to 'being open' when engaging with the service user / family following a SAI, it is important HSC organisations are also mindful of communicating effectively with the service user / family when investigating adverse incidents. In these circumstances, organisations should refer to the NPSABeingOpenFramework www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726 which will provide assistance for organisations to determine the level of service user / family engagement when investigating those adverse incidents that do not meet SAI criteria.

The Being Open Framework may also assist organisations with other investigative processes e.g. complaints, litigation, lookback exercises, and any other relevant human resource and/or risk management related policies and procedures.

## 3.0 Principles of Being Open with the Service User / Family

Being open and honest with the service user / family involves:

- Acknowledging, apologising and explaining that the organisation wishes to review the care and treatment of the service user;
- Explaining that the incident has been categorised as a SAI, and describing the review process to them, including timescales;
- Advising them how they can contribute to the review process, seeking their views on how they wish to be involved and providing them with a leaflet explaining the SAI process (see appendix 2);
- Conducting the correct level of SAI review into the incident and reassuring the service user / family that lessons learned should help prevent the incident recurring;
- Providing / facilitating support for those involved, including staff, acknowledging that there may be physical and psychological consequences of what happened;



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- Ensuring the service user / family have details for a single point of contact within the organisation.

**It is important to remember that saying sorry is not an admission of liability and is the right thing to do.**

The following principles underpin being open with the service user / family following a SAI.

### 3.1 Acknowledgement

All SAIs should be acknowledged and reported as soon as they are identified. In cases where the service user / family inform HSC staff / family practitioner when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all professionals.

In certain circumstances e.g. cases of criminality, child protection, or SAIs involving theft, fraud, information breaches or data losses that do not directly affect service users; it may not be appropriate to communicate with the service user / family. When a lead professional / review team make a decision, based on a situation as outlined above, or based on a professional's opinion, not to disclose to the service user / family that a SAI has occurred, the rationale for this decision must be clearly documented in the SAI notification form / SAI review checklist that is submitted to the HSCB.

**It is expected, the service user / family will be informed that a SAI has occurred, as soon as possible following the incident, for all levels of SAI reviews. In very exceptional circumstances, where a decision is made not to inform the service user / family, this decision must be reviewed and agreed by the review team, approved by an appropriate Director or relevant committee / group, and the decision kept under review as the review progresses. In these instances the HSCB must also be informed:**

- **Level 1 reviews - on submission of Review Report and Checklist Proforma**
- **Level 2 and 3 reviews - on submission of the Terms of Reference and Membership of the review team.**



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### 3.2 Truthfulness, timeliness and clarity of communication

Information about a SAI must be given to the service user / family in a truthful and open manner by an appropriately nominated person (see 4.2.2). The service user / family should be provided with an explanation of what happened in a way that considers their individual circumstances, and is delivered openly. Communication should also be timely, ensuring the service user / family is provided with information about what happened as soon as practicable without causing added distress. Note, where a number of service users are involved in one incident, they should all be informed at the same time where possible.

It is also essential that any information given is based solely on the facts known at the time. Staff should explain that new information may emerge as an incident review is undertaken, and that the service user / family will be kept informed, as the review progresses. The service user / family should receive clear information with a single point of contact for any questions or requests they may have. They should not receive conflicting information from different members of staff, and the use of jargon, should be avoided.

### 3.3 Apology / Expression of Regret

When it is clear, that the organisation / family practitioner is responsible for the harm / distress to the service user, it is imperative that there is an acknowledgement of the incident and an apology provided as soon as possible. Delays are likely to increase the service user / family sense of anxiety, anger or frustration. Relevant to the context of a SAI, the service user / family should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm / distress that has occurred as a result of the SAI.

### 3.4 Recognising the expectations of the Service User / Family

The service user / family may reasonably expect to be fully informed of the facts, consequences and learning in relation to the SAI and to be treated with empathy and respect.

They should also be provided with support in a manner appropriate to their needs. Specific types of service users / families may require additional support (see appendix 1).

In circumstances where the service user / family request the presence of their legal advisor this request should be facilitated. However, HSC staff



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should ensure that the legal advisor is aware that the purpose of the report / meeting is not to apportion liability or blame but to learn from the SAI. Further clarification in relation to this issue should be sought from Legal Services.

### 3.5 Professional Support

HSC organisations must create an environment in which all staff, whether directly employed or independent contractors, are encouraged to report SAIs. Staff should feel supported throughout the incident review process because they too may have been traumatised by being involved. There should be a culture of support and openness with a focus on learning rather than blame.

HSC organisations should encourage staff to seek support where required form relevant professional bodies such as the General Medical Council (GMC), Royal Colleges, the Medical Defence Union (MDU), the Medical Protection Society (MPS), the Nursing and Midwifery Council, the Northern Ireland Association for Social Work (NIASW) and the Northern Ireland Social Care Council (NISCC).

### 3.6 Confidentiality

Details of a SAI should at all times be considered confidential. It is good practice to inform the service user / family about those involved in the review and who the review report will be shared with.

### 3.7 Continuity of Care

In exceptional circumstances, the service user / family may request transfer of their care to another facility; this should be facilitated if possible to do so. A member of staff should be identified to act as a contact person for the service user / family to keep them informed of their on-going treatment and care.

## 4.0 Process

Being open with the service user / family is a process rather than a one-off event. There are 5 stages in the engagement process:

- Stage 1 – Recognition
- Stage 2 - Communication
- Stage 3 – Initial Meeting
- Stage 4 – Follow up Discussions



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- Stage 5 – Process Completion

The duration of this process depends on the level of SAI review being undertaken and the associated timescales as set out in the Procedure for the Reporting and Follow up of SAIs (2013).

## 4.1 Stage 1 - Recognition

As soon as the SAI is identified, the priority is to prevent further harm / distress. The service user / family should be notified that the incident is being reviewed as a SAI.

### 4.1.1 Preliminary Discussion with the Service User / Family

On many occasions it will be at this stage when the lead professional / family practitioner responsible for the care of the service user will have a discussion with the service user / family, advising of the need to review the care and treatment. This preliminary discussion (which could be a telephone call) will be in addition to the formal initial meeting with the service user / family (see 4.3).

**A Level 1 review may not require the same level of engagement as Levels 2 and 3 therefore the preliminary discussion may be the only engagement with service user / family prior to communicating findings of the review, provided they are content they have been provided with all information.**

There may be occasions when the service user / family indicate they do not wish to engage in the process. In these instances the rationale for not engaging further must be clearly documented.



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## 4.2 Stage 2 – Communication

### 4.2.1 Timing of Initial Communication with the Service User / Family

The initial discussion with the service user / family should occur as soon as possible after recognition of the SAI. Factors to consider when timing this discussion include:

- service user's health and wellbeing;
- service user / family circumstances, preference (in terms of when and where the meeting takes place) and availability of key staff *(appendix 1 provides guidance on how to manage different categories of service user / family circumstances);*

### 4.2.2 Choosing the individual to communicate

The person[7] nominated to lead any communications should:

- Be a senior member of staff with a comprehensive understanding of the facts relevant to the incident;
- Have the necessary experience and expertise in relation to the type of incident;
- Have excellent interpersonal skills, including being able to effectively engage in an honest, open and transparent manner, avoiding excessive use of jargon;
- Be willing and able to offer a meaningful apology / expression of regret, reassurance and feedback.

If required, the lead person communicating information about the SAI should also be able to nominate a colleague who may assist them with the meeting and should be someone with experience or training in communicating with the service user / family.

The person/s nominated to engage could also be a member/s of the review team (if already set up).

[7] *FPS SAIs involving FPS this will involve senior professionals/staff from the HSCB Integrated Care Directorate.*



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### 4.3 Stage 3 - Initial Meeting with the Service User / Family

The initial discussion is the first part of an on-going communication process. Many of the points raised here should be expanded on in subsequent meetings with the service user / family.

#### 4.3.1 Preparation Prior to the Initial Meeting

- The service user / family should be given the leaflet - What I Need to Know About a SAI (see appendix 2);
- Share with the service user / family what is going to be discussed at the meeting and who will be in attendance.

#### 4.3.2 During the Initial Meeting

The content of the initial meeting with the service user / family should cover the following:

- Welcome and introductions to all present;
- An expression of genuine sympathy or a meaningful apology for the event that has occurred;
- The facts that are known to the multidisciplinary team;
- Where a service user has died, advising the family that the coroner has been informed (where there is a requirement to do so) and any other relevant organisation/body;
- The service user / family are informed that a SAI review is being carried out;
- Listening to the service user's / families understanding of what happened;
- Consideration and formal noting of the service user's / family's views and concerns;
- An explanation about what will happen next in terms of the SAI review, findings, recommendations and learning and timescales;
- An offer of practical and emotional support for the service user / family. This may involve getting help from third parties such as charities and voluntary organisations, providing details of support from other organisations, as well as offering more direct assistance;
- Advising who will be involved in the review before it takes place and who the review report will be shared with;
- Advising that all SAI information will be treated as confidential.

If for any reason it becomes clear during the initial discussion that the service user / family would prefer to speak to a different health / social



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care professional, these wishes should be respected, and the appropriate actions taken.

It is important during the initial meeting to try to avoid any of the following:

- Speculation;
- Attribution of blame;
- Denial of responsibility;
- Provision of conflicting information from different health and social care individuals.

It should be recognised that the service user / family may be anxious, angry and frustrated, even when the meeting is conducted appropriately. It may therefore be difficult for organisations to ascertain if the service user / family have understood fully everything that has been discussed at the meeting. It is essential however that, at the very least, organisations are assured that the service user / family leave the meeting fully aware that the incident is being reviewed as a SAI, and knowing the organisation will continue to engage with them as the review progresses, so long as the service user / family wish to engage.

*Appendix 3 provides examples of words / language which can be used during the initial discussion with the service user / family.*



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### 4.4 Stage 4 – Follow-up Discussions

Follow-up discussions are dependent on the needs and wishes of the service user / family.

The following guidelines will assist in making the communication effective:

- The service user / family should be updated if there are any delays and the reasons for the delays explained;
- Advise the service user / family if the incident has been referred to any other relevant organisation / body;
- Consideration is given to the timing of the meetings, based on both the service users / families health, personal circumstances and preference on the location of the meeting, e.g. the service users / families home;
- Feedback on progress to date, including informing the service user / family of the Terms of Reference of the review and membership of the review panel (for level 2 and 3 SAI reviews);
- There should be no speculation or attribution of blame. Similarly, the health or social care professional / senior manager communicating the SAI must not criticise or comment on matters outside their own experience;
- A written record of the discussion is kept and shared with the service user / family;
- All queries are responded to appropriately and in a timely way.

### 4.5 Stage 5 – Process Completion

#### 4.5.1 Communicating findings of review / sharing review report

Feedback should take the form most acceptable to the service user / family. Communication should include:

- a repeated apology / expression of regret for the harm / distress suffered;
- the chronology of clinical and other relevant factors that contributed to the incident;
- details of the service users / families concerns;
- information on learning and outcomes from the review
- Service user / family should be assured that lines of communication will be kept open should further questions arise at a later stage and a single point of contact is identified.

It is expected that in most cases there will be a complete discussion of the findings of the review and that the final review report will be shared with



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the service user / family. In some cases however, information may be withheld or restricted, for example:

- Where communicating information will adversely affect the health of the service user / family;
- Where specific legal/coroner requirements preclude disclosure for specific purposes;
- If the deceased service users health record includes a note at their request that he/she did not wish access to be given to his/her family.

Clarification on the above issues should be sought form Legal Services.

There may also be instances where the service user / family does not agree with the information provided, in these instances Appendix 1 (section 1.8) will provide additional assistance.

In order to respond to the timescales as set out in the Procedure for the Reporting and Follow up of SAIs (November 2016) organisations may not have completed stage 5 of the engagement process prior to submission of the review report to HSCB. In these instances, organisations must indicate on the SAI review checklist, submitted with the final review report to the HSCB, the scheduled date to meet with the service user / family to communicate findings of review / share review report.

### 4.5.2 Communicating Changes to Staff

It is important that outcomes / learning is communicated to all staff involved and to the wider organisation as appropriate.

## 4.6 Documentation

Throughout the above stages it is important that discussions with the service user / family are documented and should be shared with the individuals involved.

Documenting the process is essential to ensure continuity and consistency in relation to the information that has been relayed to the service user / family.

Documentation which has been produced in response to a SAI may have to be disclosed later in legal proceedings or in response to a freedom of information application. It is important that care is taken in all communications and documents stating fact only.



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*Appendix 4 provides a checklist which organisations may find useful as an aide memoire to ensure a professional and standardised approach.*

## 5.0 Supporting Information and Tools

In addition to this guidance, supporting tools have been developed to assist HSC organisations with implementing the actions of the NPSA's Being Open Patient Safety Alert.

Training on being open is freely available through an e-learning tool for all HSC organisations.

Information on all these supporting tools can be found at: www.**npsa**.nhs.uk/**beingopen** and www.nrls.**npsa**.nhs.uk/**beingopen**/.

Guidance on sudden death and the role of bereavement co-ordinators in Trusts can be found at:
http://webarchive.proni.gov.uk/20120830110704/http://www.dhsspsni.gov.uk/sudden-death-guidance.pdf



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## List of Acronyms and Abbreviations

| | | |
|---|---|---|
| FPS | - | Family Practitioner Services |
| GMC | - | General Medical Council |
| HSC | - | Health and Social Care |
| HSCB | - | Health and Social Care Board |
| HSE | - | Health Service Executive |
| MDU | - | Medical Defence Union |
| MPS | - | Medical Protection Society |
| NIASW | - | Northern Ireland Association for Social Work |
| NISCC | - | Northern Ireland Social Care Council |
| NMC | - | Nursing and Midwifery Council |
| NPSA | - | National Patient Safety Agency |
| PCC | - | Patient Client Council |
| PHA | - | Public Health Agency |
| RC | - | Royal colleges |
| RCA | - | Root Cause Analysis |
| RQIA | - | Regulation and Quality Improvement Authority |
| SAI | - | Serious Adverse Incident |
| SEA | - | Significant Event Audit |



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## Particular Service user Circumstances

The approach to how an organisation communicates with a service user / family may need to be modified according to the service user's personal circumstances.

The following gives guidance on how to manage different categories of service user circumstances.

### 1.1 When a service user dies

When a SAI has resulted in a service users death, the communication should be sensitive, empathetic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened.

### 1.2 Children

The legal age of maturity for giving consent to treatment is 16 years old. However, it is still considered good practice to encourage young people of this age to involve their families in decision making.

The courts have stated that younger children who understand fully what is involved in the proposed procedure can also give consent. Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the communication process after a SAI.

The opportunity for parents / guardians to be involved should still be provided unless the child expresses a wish for them not to be present. Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents / guardians alone or in the presence of the child. In these instances the parents' / guardians' views on the issue should be sought.



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## 1.3 Service users with mental health issues

Communication with service users with mental health issues should follow normal procedures unless the service user also has cognitive impairment (see1.4 Service users with cognitive impairments).

The only circumstances in which it is appropriate to withhold SAI information from a service user with mental health issues is when advised to do so by a senior clinician who feels it would cause adverse psychological harm to the service user. However, such circumstances are rare and a second opinion may be required to justify withholding information from the service user.

In most circumstances, it is not appropriate to discuss SAI information with a carer or relative without the permission of the service user, unless in the public interest and / or for the protection of third parties.

## 1.4 Service users with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them.

In these cases communication would be conducted with the carer / family as appropriate. Where there is no such person, the clinicians may act in the service users best interest in deciding who the appropriate person is to discuss the SAI with.

## 1.5 Service users with learning disabilities

Where a service user / family has difficulties in expressing their opinion verbally, every effort should be made to ensure they can use or be facilitated to use a communication method of their choice. An advocate / supporter, agreed on in consultation with the service user, should also be identified. Appropriate advocates / supporters may include carer/s, family or friends of the service user or a representative from the Patient Client Council (PCC).



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### 1.6 Service users with different language or cultural considerations

The need for translation and advocacy services and consideration of special cultural needs must be taken into account when planning to discuss SAI information. Avoid using 'unofficial translators' and / or the service users family or friends as they may distort information by editing what is communicated.

### 1.7 Service users with different communication needs

Service users who have communication needs such as hearing impaired, reduced vision may need additional support.

### 1.8 Service users who do not agree with the information provided

Sometimes, despite the best efforts the service user/family/carer may remain dissatisfied with the information provided. In these circumstances, the following strategies may assist:

- Facilitate discussion as soon as possible;
- Write a comprehensive list of the points that the service user / family disagree with and where appropriate reassure them you will follow up these issues.
- Ensure the service user / family has access to support services;
- Offer the service user / family another contact person with whom they may feel more comfortable.
- Use an acceptable service user advocate e.g. PCC or HSC layperson to help identify the issues between the HSC organisation and the service user / family and to achieve a mutually agreeable solution;

There may be occasions despite the above efforts the service user/family/carer remain dissatisfied with the HSC organisation's attempts to resolve their concerns. In these exceptional circumstances, the service user/family/carer through the agreed contact person, should be advised of their right to approach the Northern Ireland Public Services Ombudsman (NIPSO). In doing so, the service user/family requires to be advised by the HSC organisation that the internal procedure has concluded (within two weeks of this process having been concluded), and that the service user/family should approach the NIPSO within six months of this notification.

The contact details for the NIPSO are: Freephone 0800 34 34 34 or Progressive House, 33 Wellington Place, Belfast, BT1 6HN.



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### 1.9 Service Users who do not wish to participate in the engagement process

It should be documented if the service user does not wish to participate in the engagement process.



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Health and Social Care Board

Public Health Agency

# *What I need to know about a Serious Adverse Incident*

## Information for Service Users, Family Members and Carers

## Insert Name of Organisation

Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

This leaflet is written for people who use Health and Social Care (HSC) services and their families.

**The phrase service user / family member and carer is used throughout this document in order to take account of all types of engagement scenarios. However, when a service user has capacity, communication should always (in the first instance) be with them.*

## Introduction

Events which are reported as Serious Adverse Incidents (SAIs) help identify learning even when it is not clear something went wrong with treatment or care provided.

When things do go wrong in health and social care it is important that we identify this, explain what has happened to those affected and learn lessons to ensure the same thing does not happen again. SAIs are an important means to do this. Areas of good practice may also be highlighted and shared, where appropriate.

## What is a Serious Adverse Incident?

A SAI is an incident or event that must be reported to the Health and Social Care Board (HSCB) by the organisation where the SAI has occurred. It may be:

- an incident resulting in serious harm;
- an unexpected or unexplained death;
- a suspected suicide of a service user who has a mental illness or disorder;
- an unexpected serious risk to wellbeing or safety, for example an outbreak of infection in hospital;

A SAI may affect services users, members of the public or staff.

Never events are serious patient safety incidents that should not occur if the appropriate preventative measures have been implemented by healthcare providers. A small number of SAIs may be categorised as never events based on the Department of Health Never Events list.



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SAIs, including never events, occurring within the HSC system are reported to the HSCB. You, as a service user / family member / carer, will be informed where a SAI and/or never event has occurred relating to treatment and care provided to you by the HSC.

## Can a complaint become a SAI?

Yes, if during the follow up of a complaint the **(insert name of organisation)** identifies that a SAI has occurred it will be reported to the HSCB. You, as a service user / family member and carer will be informed of this and updated on progress regularly.

## How is a SAI reviewed?

Depending on the circumstance of the SAI a review will be undertaken. This will take between 8 to 12 weeks depending on the complexity of the case. If more time is required you will be kept informed of the reasons.

The (**insert name of organisation**) will discuss with you how the SAI will be reviewed and who will be involved. The (**insert name of organisation**) will welcome your involvement if you wish to contribute.

Our goal is to find out what happened, why it happened and what can be done to prevent it from happening again and to explain this to those involved.

## How is the service user or their family/carer involved in the review?

An individual will be identified to act as your link person throughout the review process. This person will ensure as soon as possible that you:

- Are made aware of the incident, the review process through meetings / telephone calls;
- Have the opportunity to express any concerns;
- Know how you can contribute to the review, for example share your experiences;
- Are updated and advised if there are any delays so that you are always aware of the status of the review;
- Are offered the opportunity to meet and discuss the review findings;
- Are offered a copy of the review report;



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- Are offered advice in the event that the media make contact.

## What happens once the review is complete?

The findings of the review will be shared with you. This will be done in a way that meets your needs and can include a meeting facilitated by **(insert name of organisation)** staff that is acceptable to you.

## How will learning be used to improve safety?

By reviewing a SAI we aim to find out what happened, how and why. By doing this we aim to identify appropriate actions which will prevent similar circumstances occurring again.

We believe that this process will help to restore the confidence of those affected by a SAI.

For each completed review:

- Recommendations may be identified and included within an action plan;
- Any action plan will be reviewed to ensure real improvement and learning.

We will always preserve your confidentiality while also ensuring that opportunities to do things better are shared throughout our organisation and the wider health and social care system. Therefore as part of our process to improve quality and share learning, we may share the anonymised content of the SAI report with other HSC organisations'

## Do families get a copy of the report?

Yes, a copy of the review report will be shared with service users and/or families with the service user's consent.

If the service user has died, families/carers will be provided with a copy of the report and invited to meet with senior staff.



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## Who else gets a copy of the report?

The report is shared with the Health and Social Care Board (HSCB) and Public Health Agency (PHA). Where appropriate it is also shared with the Coroner.

The Regulation and Quality Improvement Authority (RQIA) have a statutory obligation to review some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA work in conjunction with the HSCB / PHA with regard to the review of certain categories of SAI including the following:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAI that occurs within the regulated sector for example a nursing, residential or children's home (whether statutory or independent) for a service that has been commissioned / funded by a HSC organisation.

In both instances the names and personal details that might identify the individual are removed from the report. The relevant organisations monitor the (**insert name of organisation)** to ensure that the recommendations have been implemented. The family may wish to have follow up / briefing after implementation and if they do this can be arranged by their link person within the (**insert name of organisation**).

All those who attended the review meeting are given a copy of the anonymised report. Any learning from the review will be shared as appropriate with relevant staff/groups within the wider HSC organisations.

## Further Information

If you require further information or have comments regarding this process you should contact the nominated link person - name and contact details below:

Your link person is ……..…….

Your link person's job title is……..…..

Contact number …….

Hours of work……..……



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## Prior to any meetings or telephone call you may wish to consider the following:

Think about what questions and fears/concerns you have in relation to:

(a) What has happened?
(b) Your condition / family member condition
(c) On-going care

You could also:

- Write down any questions or concerns you have;
- Think about who you would like to have present with you at the meeting as a support person;
- Think about what things may assist you going forward;
- Think about which healthcare staff you feel should be in attendance at the meeting.

## Patient and Client Council

The Patient Client Council offers independent, confidential advice and support to people who have a concern about a HSC Service. This may include help with writing letters, making telephone calls or supporting you at meetings, or if you are unhappy with recommendations / outcomes of the reviews.

**Contact details:**
**Free phone number: 0800 917 0222**



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## Appendix 3

| Examples of communication which enhances the effectiveness of being open | |
|---|---|
| **Stage of Process** | **Sample Phrases** |
| Acknowledgement | "We are here to discuss the harm that you have experienced/the complications with your surgery/treatment"<br><br>"I realise that this has caused you great pain/distress/anxiety/worry"<br><br>"I can only imagine how upset you must be"<br><br>"I appreciate that you are anxious and upset about what happened during your surgery – this must have come as a big shock for you"<br><br>"I understand that you are angry/disappointed about what has happened"<br><br>"I think I would feel the same way too" |
| Sorry | "I am so sorry this has happened to you"<br><br>"I am very sorry that the procedure was not as straightforward as we expected and that you will have to stay in hospital an extra few days for observation"<br><br>"I truly regret that you have suffered xxx which is a recognised complication associated with the x procedure/treatment." "I am so sorry about the anxiety this has caused you"<br><br>"A review of your case has indicated that an error occurred – we are truly sorry about this" |
| Story | **Their Story**<br><br>"Tell me about your understanding of your condition"<br><br>"Can you tell me what has been happening to you"<br><br>"What is your understanding of what has been happening to you"<br><br>**Your understanding of their Story: (Summarising)**<br><br>"I understand from what you said that" xxx "and you are very upset and angry about this" |



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|---|---|
| | Is this correct? (i.e. summarise their story and acknowledge any emotions/concerns demonstrated.)<br><br>"Am I right in saying that you……..."<br><br>**Your Story**<br><br>"Is it ok for me to explain to you the facts known to us at this stage in relation to what has happened and hopefully address some of the concerns you have mentioned?<br><br>"Do you mind if I tell you what we have been able to establish at this stage?"<br><br>"We have been able/unable to determine at this stage that……."<br><br>"We are not sure at this stage about exactly what happened but we have established that ……. We will remain in contact with you as information unfolds"<br><br>"You may at a later stage experience xx if this happens you should ……." |
| Inquire | "Do you have any questions about what we just discussed?"<br><br>"How do you feel about this?"<br><br>"Is there anything we talked about that is not clear to you?" |
| Solutions | "What do you think should happen now?"<br><br>"Do you mind if I tell you what I think we should do?"<br><br>"I have reviewed your case and this is what I think we need to do next"<br><br>"What do you think about that?"<br><br>"These are your options now in relation to managing your condition, do you want to have a think about it and I will come back and see you later?"<br><br>"I have discussed your condition with my colleague Dr x we both think that you would benefit from xx. What do you think about that?" |
| Progress | "Our service takes this very seriously and we have already started a review into the incident to see if we can find out what caused it to happen"<br><br>"We will be taking steps to learn from this event so that we can |



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| | |
|---|---|
| | try to prevent it happening again in the future"<br><br>"I will be with you every step of the way as we get through this and this is what I think we need to do now"<br><br>"We will keep you up to date in relation to our progress with the review and you will receive a report in relation to the findings and recommendations of the review team"<br><br>"Would you like us to contact you to set up another meeting to discuss our progress with the review?"<br><br>"I will be seeing you regularly and will see you next in….days/weeks.<br><br>"You will see me at each appointment"<br><br>"Please do not hesitate to contact me at any time if you have any questions or if there are further concerns – you can contact me by……"<br><br>"If you think of any questions write them down and bring them with you to your next appointment."<br><br>"Here are some information leaflets regarding the support services we discussed – we can assist you if you wish to access any of these services" |



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**Appendix 4**

*Organisations may find this checklist useful an aide memoire to ensure a professional and standardised approach*

## Before, During and After Communication / Engagement Documentation Checklist

| ***BEFORE*** | ***Note taking*** |
|---|---|
| Service users full name | |
| Healthcare record number | |
| Date of birth | |
| Date of admission | |
| Diagnosis | |
| Key HSC professional(s) involved in service user's care | |
| Date of discharge (if applicable) | |
| Date of SAI | |
| Description of SAI | |
| Outcome of SAI | |
| Agreed plan for management of SAI | |
| Agreed professional to act as contact person with the service user / family | |



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| | |
|---|---|
| Service user / family informed incident is being reviewed as a SAI:<br><br>• Date<br>• By Whom<br>• By what means (telephone call / letter / in person) | |
| Date of first meeting with the service user / family | |
| Location of first meeting (other details such as room booking, arrangements to ensure confidentiality if shared ward etc) | |
| Person to be responsible for note taking identified | |
| Person Nominated to lead communications identified | |
| Colleague/s to assist nominated lead | |
| Other staff identified to attend the disclosure meeting | |
| Anticipated service user / family concerns queries | |
| Meeting agenda agreed and circulated | |
| Additional support required by the service user / family, if any? | |
| The service user / family has been advised to bring a support person to the meeting? | |
| The service user consented to the sharing of information with others such as designated family members / support person? | |



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| | |
|---|---|
| | |
| It has been established that the service user / family requires an interpreter? If yes, provide details of language and arrangements that have been or to be made. | |

***Signature:*** _____

***Date*:** _____



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| ***DURING*** | ***Note taking*** |
|---|---|
| There has been an acknowledgment of the SAI in relation to the service user / family experience. | |
| An apology / expression of regret provided | |
| The service user / family was provided with factual information regarding the adverse event | |
| The service user / family understanding of the SAI was established | |
| The service user / family was provided with the opportunity to:<br><br>- Tell their story<br>- Voice their concerns and<br>- Ask questions | |
| The next steps in relation to the service user's on-going care were agreed and the service user was involved in the decisions made. | |
| The service user / family was provided with information in relation to the supports available to them. | |
| Reassurance was provided to the service user / family in relation to the on-going communication of facts when the information has been established and available – continuity provided. | |
| Next meeting date and location agreed | |

***Signature:*** _____

***Date*:** _____



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***AFTER***

| |
|---|
| Circulate minutes of the meeting to all relevant parties for timely verification. |
| Follow through on action points agreed. |
| Continue with the incident review. |
| Keep the service user included and informed on any progress made – organise further meetings. |
| Draft report to be provided to the service user in advance of the final report (if agreed within review Terms of Reference that the draft report is to be shared with the service user prior to submission to HSCB/PHA). |
| Offer a meeting with the service user to discuss the review report and allow for amendments if required. |
| Follow through on any recommendations made by the incident review team. |
| Closure of the process is mutually agreed. |
| When closure / reconciliation was not reached the service user was advised of the alternative courses of action which are open to them i.e the complaints process. |

***Signature:*** _____

***Date*:** _____



Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

## Stinson, Emma M

**From:** Connolly, Connie
**Sent:** 11 December 2019 10:19
**To:** Reid, Trudy; Witczak, Maria
**Cc:** Haynes, Mark; Carroll, Ronan; McNaboe, Ted; Corrigan, Martina; McClements, Melanie
**Subject:** FW: SAI 69120
**Attachments:** Comments concerning the RCA Report on Review of SAI [redacted].docx; ISSUES OF CONCERN FOR DISCUSSION.docx

Good Morning- please find feedback received from Mr O'Brien.
For your consideration with regard to amendment of the Draft report. The disaggregation into 4 separate reports also needs to be completed to allow us to forward them to the families.
Regards
Connie

Kind Regards
*Connie Connolly*
Acting Clinical Care and Governance Co-Ordinator
Office Number [redacted]
Mobile Number [redacted]

**From:** Aidan O'Brien [redacted]
**Sent:** 11 December 2019 04:43
**To:** Connolly, Connie
**Subject:** SAI 69120

Dear Connie,

Please find attached my Comments concerning the RCA Report on Review of SAI [redacted].
I have also attached Issues of Concern referred to in the Comments.

I look forward to being advised of any amendments being made to the Report,

Yours,

Aidan O'Brien.



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## Comments concerning the RCA Report on Review of SAI [redacted]

In submitting this commentary regarding the RCA Report of SAI [redacted], I have reviewed all retained correspondence relating to the issue of triage, all retained documentation relating to other issues impacting upon triage and all retained documentation relating to other issues referred to by others interviewed during the course of the Root Cause Analysis. Having done so, I believe that the Recommendations outlined in the Report are its most important component, though I believe that at least one additional recommendation is required to ensure that the others could be effectively implemented. I have endeavoured to be concise.

Having been interviewed by Dr. Johnston and having read the above Report, I do believe that the singular and significant flaw of the Review has been to investigate the failure to triage urgent and routine referrals in isolation of other pressures and clinical priorities which I believe are evidently more important. As a clinician and a clinical department, I believe that these greater clinical priorities cannot be compromised for the sake of triage, as they have been and continue to be.

### Urologist / Consultant of the Week

While agreeing that triage is indeed a serious issue and very important, I was concerned to being expected to agree that triage of referrals has 'number one ranking in the overall scheme of things'. I believe that it is vitally important to fully appreciate the significance of this claim, especially as triage has been aligned with the duties of the Urologist of the Week (UOW). If, as has been my experience during my last week as UOW, one does a ward round from 09.00 am to 11.30 am, prior to going to theatre to undertake seven emergency / urgent operations, is triage the most important concern that day, or the day after, if it is similar?

I most earnestly urge the Review Team to review the wording of Recommendation 6, urging the Trust to re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW. I believe that it is important to appreciate that the Trust has never examined or assured itself in the first place, never mind do so again. I believe that it is crucially important that the duties and priorities of the CoW and the expectations of the Trust of the CoW in the conduct of those duties and priorities, be clearly agreed and expressed in a written Memorandum of Understanding, or similar. I do so as there has been an ambiguity since its inception as to those duties and priorities.

Following a long period of gestational discussion, the UOW came into existence in late 2014. The major reason for the length of that gestational discussion was the belief, particularly on the part of our Lead Clinician, that the duties of the UOW could not possibly take up a whole day. This belief was borne out of his perception that the UOW would essentially be on call. When subsequently persuaded and convinced that it would be a good for inpatient management that the UOW would conduct an ward round each morning, it was then proposed that we could then undertake a clinic in the afternoon each day, as the duties of UOW could be confined to the morning, as one would rarely be called to theatre in an emergency. When successfully disabused of that proposal which would have necessitated the disorderly cancellation of outpatient attendances, the proposal of

being able to undertake triage of all referrals while UOW was born, as it could be undertaken at any flexible time.

There is no doubt that the clinical and operative demands upon the UOW have evolved and increased during the past five years. Nevertheless, there persists a lack of clarity as to its very purpose, and I have no doubt that there persists a dichotomy of Urologist on Call and Urologist of the Week. It had been my understanding ab initio that its raison d'etre was to provide hands-on, clinical management of all inpatients within our department, whether acutely or electively admitted, to provide advice and management to patients attending and referred from other Departments at Craigavon Area, Daisy Hill and South West Acute Hospitals, and to undertake emergency and urgent surgical intervention so far as is possible. To do so effectively in pursuit of optimal clinical outcomes requires knowing patients, often with complex comorbidities, in detail, and that requires time. However, this has not always been the case.

I have experienced a patient being unnecessarily and inappropriately discharged when it would have been entirely possible for them to have had surgical intervention while inpatients, only to be acutely readmitted, sicker than previously and for another UOW to manage. I have witnessed patients undergoing surgery by Registrars (while the UOW triaged referrals) with outcomes inferior to those I believe would have been achieved had the UOW been operating, or at least attending in supervision. I have been requested by Nursing Staff to assess inpatients who had never been seen by a UOW. Indeed, the most frequently occurring practice which persists is that of the UOW not coming to the hospital at all, particularly over weekends, unless 'called' of course, or not undertaking ward rounds even if present in the hospital.

And while it has been and continues to be easier to undertake triage while being 'on call', I have also no doubt whatsoever that the expectation to undertake triage of all referrals lends itself to being Urologist on Call rather than UOW. Indeed, a senior executive manager of the Trust has written that UOW was introduced to facilitate triage! If that is one understanding, there certainly needs to be a discussion and an agreement in the first instance of the duties of the UOW.

In 2018, following discussion amongst our colleagues, it was agreed that we would set aside a whole day, Monday 24 September 2018, to meet with senior management to discuss this very issue, among others. We were requested to submit those issues which we wanted to have discussed (I have separately attached my submission). No clinical commitments were arranged for that day. The meeting was cancelled, with loss of all clinical activity that could have been scheduled. The meeting was rescheduled for Monday 03 December 2018, again with no clinical commitments scheduled. No senior management personnel could attend. I therefore have no confidence whatsoever that Recommendation 6 will be addressed.

## Triage and Waiting Times

I also do contend that it is not possible to deal adequately with the very important issue of triage without consideration of waiting times, and how this could or should affect the nature of the triage conducted. Dr. Johnston was of the view that the Red Flag referrals were not an issue as they 'go straight into the system'. However, the recent waiting time for a first consultation for a patient suspected of having prostatic carcinoma is 107 days. We have recently been circulated with the details of twelve patients referred as, or upgraded to, Red Flags as they were suspected

of having prostatic carcinoma. They were triaged, without any consideration of any form of preliminary investigation being requested. It would have taken less than one minute to ascertain their Red Flag status, and 'they go straight into the system', and wait almost four months for a first consultation. The further ignominy is that, on attending almost four months later, some have waited all of that time just to have a serum PSA repeated, before deciding whether to proceed with Investigative imaging, such as MRI scanning, prior to prostatic biopsies. Lest there be any doubt, the reason for the conduct of triage in such a manner is the lack of time to do otherwise, coupled with a determination that triage will be completed on completion of the period of UOW. As indicated above, I have witnessed such minimalist triage being conducted instead of undertaking ward rounds.

In March 2015, I endeavoured as Lead Clinician of Urology MDT to have my colleagues agree to advanced / enhanced triage of Red Flag patients alone. The purpose of doing so was to facilitate patients progressing along the diagnostic and therapeutic pathway in the timeliest manner possible. I did not succeed, as they declined to commit to doing so, and the reason given then was the lack of adequate time while being UOW. I have retained a written record which can be provided if requested. As a persistent consequent, a patient recently referred with a renal tumour detected on ultrasound scanning, waited for a first consultation before having staging CT scanning performed, and which could have been requested if time had been taken or available to do so, to request the scan, informing the patient (and referrer) that it had been requested.

The issue of the referrals which are actually triaged as urgent and routine is even more pressing. It is worth asserting that a referral triaged as urgent may be as life threatening, except that it is presumed that it will not be threatened by a malignancy. However, as has been a recent experience, last year's pyelonephritis was actually a renal cell carcinoma, and she was not even referred, never mind triaged. The recent waiting time for a first consultation for an urgent appointment was 85 weeks. For a routine consultation, it is over three years! Scrotal swellings considered benign by the referrer are routinely triaged by most as routine, without any imaging requested. Yet, seven of 77 such referrals (9%) have been found in a recent audit to have testicular tumours.

Apart from the lack of adequate time to conduct optimal triage while UOW, an additional disincentive is that the UOW will be responsible for the receipt of any investigations requested, and without any additional administrative time allocated to do so. During my last period as UOW, I requested 47 scans. I did so, mainly in the days following completion of the period as UOW. Today, I have received the result of a CT Urogram indicating that the patient probably has pancreatic carcinoma with hepatic secondaries. I will arrange an outpatient consultation for this patient in coming days.

Yet, despite repeated claims to the contrary, the Trust does not have a policy regarding urological triage, and particularly in the context of such waiting times, and with respect to an ongoing expectation that triage will be conducted by the UOW while being the UOW. It remains the case that the Trust is happy with and prefers that the referral is triaged as quickly as possible, so that they are in the system, without investigation and irrespective of the periods of time waiting for a first consultation. It is now almost three years since I recommended in my report concerning the index case Patient 10 that the Trust should meet with us to discuss and agree who should undertake triage, when it should be conducted, and the nature of the triage to be conducted. There has been

no response to date. Two attempts to arrange meetings with senior Trust management in late 2018 did not materialise. I have come to the view that the Trust is only interested in the avoidance of any shared responsibility for these issues, preferring instead that they will be the sole responsibility of the clinician, without provision of the time to do so.

To conclude this section, the Report implies that, irrespective of the difficulties and pressures which my colleagues did have in conducting triage while UOW, they did so, and that there were no negative consequences in there doing so. Inpatient care or the quality of triage suffered to varying degrees, and particularly in the context of long waiting times. I have personally experienced a number of cases of delayed diagnoses of cancer following triage by my colleagues since 2017.

## Number One Ranking in the Overall Scheme of Things

Number one ranking in the overall scheme of things for any urological department should be the provision of acute care to those most urgently in need of it; hence, the concept of the UOW. Of course, triage is a method of selecting those patients who may next most urgently need such care. Meanwhile, patients languish on ever increasingly long lists awaiting elective admission, some 600 awaiting urgent elective admission for surgery, some now waiting over five years.

We collectively have over 640 patients awaiting admission for prostatic resection. At least 10% of these patients will be found to have prostatic carcinoma. A recent review has reported an incidence of 13.4% in men aged less than 65 years, and of 28.7% of men older than 65 years. One third of the younger patients required curative or palliative treatment. So, we have a situation where at least 64 patients are waiting for years to have a diagnosis of prostatic carcinoma found. Such a figure contrasts profoundly with the five cases found due to the failure to upgrade to Red Flag status, the subject of the Report. Yet, these patients have been assessed by our Department, placed on waiting lists, with a significant risk of having a cancer diagnosis, some requiring treatment with either curative or palliative intent. Which guidelines, goals, objectives, root cause analyses, SAIs apply to these patients? None, but for our concern for them.

## Factual Inaccuracies

AMD1 reported that referrals were not triaged by me in the early 90s, that referrals were being kept in a ring binder and were not on any waiting list, that I stopped the practice when challenged, and would then slip back etc. This is untrue. I was a single handed urologist from 1992 to 1996. I triaged all referrals, sorting them into urgent, soon and routine. Each category had a ring binder of referrals. I had my secretary allocate appointments for patients from each category, in commensurate numbers, to every clinic. I continued to do so until the appointment of Mr. Michael Young in 1998 when it was more appropriate to have an appointments office make appointments.

I find it difficult to believe that patients were waiting 10 years for a first appointment., as claimed by DAS2. It has been my experience that the current waiting times are the longest we have ever had. Of course there were no serious clinical issues due to the effective triage that had been conducted.

DAS1 claimed that I struggled to adapt to the modernisation and change resulting from the Regional Transformation of Urology Services. This is particularly untrue. I can provide for you on request my written submission to the Regional Review Team in 2009, detailing my concerns regarding the future provision of urological services outside of Belfast, my views concerning the lack of a Urological Department at Antrim Area Hospital, and where radical prostatectomies and radical cystectomies should be undertaken in the future. I was particularly concerned regarding the 'centralisation' of radical cystectomies for bladder cancer to Belfast. Even then, I did not entirely appreciate the negative consequences of that centralisation, in that our Department continues to have patients suffering and dying due to their not having radical cystectomies performed.

I was particularly concerned at interview that HOS1 claimed that she had discovered over 700 untriaged referral letters in my filing cabinet, having gained permission to enter my office. I also found that Dr. Johnston appeared to struggle to accept that I had advised HOS1 of the whereabouts of the letters of referral, in the third drawer of the filing cabinet in my office. They were not discovered, or uncovered. Moreover, they were all copies of the originals, as the originals or copies were retained by the Appointments Office for appointment in chronological order in accordance with the Informal Default System (IDS) introduced in 2014.

The Report does acknowledge that I had advised colleagues and management that I had found it impossible to conduct non-Red Flag referrals while UOW, while continuing to triage Red Flag referrals, as detailed in my annual appraisal. It is inconceivable that a IDS was introduced to deal with the lack of triage of non-Red Flag referrals without management being aware that they were not being done, or claiming not to have been informed or aware. The Report implies that it was my sole responsibility, and that Trust management did not bear any responsibility for either their claimed lack of awareness, or its failure to address the issue in a constructive, agreed manner, and which it has still failed to do.

## Recommendation 10

The Trust is recommended to set in place a robust system for highlighting and dealing with 'difficult colleagues' and 'difficult issues'. I entirely agree. I believe that it should be included in this Recommendation that any such systems should conform with and be implemented in compliance with national guidelines.

The Report is entirely silent on any Recommendation as to how clinicians, individually or collectively, are to deal with 'difficult management', and particularly management which has repeatedly and consisted failed to address issues of concern for clinicians. The absence of such a Recommendation implies an asymmetry unworthy of the Report.

## Recommendations 11 and 12

Recommendation 11 advises that I review my chosen 'advanced' method and degree of triage, to align it more completely with that of my Consultant colleagues. This is itself inconsistent with the claim on Page 18 of the Report that other members of the consultant team were also 'ordering

investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to outcomes achieved from Cons 1's advanced triage'.

Nevertheless, I believe that this recommendation should be amended. I believe that I should triage in the manner agreed with and expected by the Trust in a written policy for urological referral. That way, there will be no room for variance in how or when triage is conducted, and the trust will bear responsibility for any negative consequences, provided clinicians have conducted triage in accordance with the agreed policy. In doing so, Recommendation 12 will have been complied with.

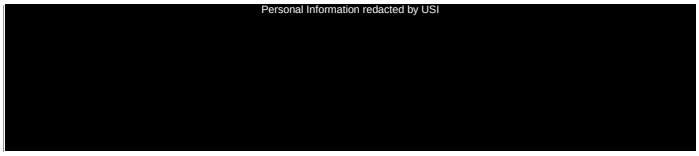
## Conclusions

I do agree with the Recommendations contained in the Report, with a number of caveats. I do believe that it is crucially important that Recommendation be amended to ensure that the Trust develop a clear, agreed, written policy of its expectations, duties and performance of the Urologist of the Week, before it consider whether it is feasible to undertake triage while Urologist of the Week. Qualitatively and quantitatively defining and describing its expectations of the complexity of triage without firstly doing so for UOW will lead to a fudged failure.

I believe that no Consultant Urologist should be expected to concern him or herself with reviewing their conduct of triage to align themselves with his or her colleagues, especially when the colleagues claim to be conducting triage in a similar manner. That proposal wil be replaced by a clear, agreed, written policy of the Trust concerning the conduction of triage. Then each Consultant only has to comply with the policy, and not with conduct of his or her colleagues, real or imagined.

Lastly, the report should include a Recommendation concerning the establishment of systems enabling clinicians, and particularly clinical departments, deal with difficult or dysfunctional management.

I look forward to receiving a revised report in due course. I have little confidence that it will have been significantly amended. I have less confidence that any of its Recommendations will be implemented.




Aidan O'Brien

11 December 2019

Received from SHSCT on 05 May 2023.  Annotated by the Urology Services Inquiry.

**ISSUES OF CONCERN FOR DISCUSSION**
**At**
**DEPARTMENTAL MEETING**
**On**
**24 SEPTEMBER 2018**

The main issues of concern which I would wish to have discussed at the Meeting of 24 September 2018 relate to the practice of 'Urologist of the Week' (UOW), triage of referrals, the waiting times for a first outpatient consultation, the waiting times for elective admission for surgery, and the various relationships and influences between all of these.

I am honest in asserting that I have struggled to know how best to have these issues discussed, as I believe that they will be contentious, with all of us having very differing perspectives of that which is expected of us as individuals. I hope that we can express our views without confrontation and without causing offence. I hope that we can listen to each other respectfully. Above all, I do hope that we will be able to agree standards of practice to be submitted, perhaps in optional form, to senior Trust management, so that we will have a written clarification of expected practices.

**UROLOGIST OF THE WEEK**

From the outset in 2014, I found the discussions regarding the introduction of UOW to be frustrating and incomprehensible. I simply could not understand how it could not be a good thing to have a system where all inpatient care, whether acute or elective, would be undertaken by a consultant urologist with the assistance of junior staff (in training). I could not understand how it was considered that the Trust would not support and fund UOW without offering to undertake other duties when UOW, as it would not take all one's time to look after inpatients. At one time, it was even proposed that the UOW would be able to do an afternoon clinic! Regrettably, in my view, we did agree to include triage in the duties of UOW. In due course, I came to believe that there was a range of perspectives of the concept of UOW, from that which I expected it to be, to being 'Urologist on Call', and variations in between.

It had been my understanding that my week as UOW would begin with a Handover Ward Round at 09.00 am on a Thursday morning. The Handover would be from the consultant urologist whose week was ending, to me whose week was beginning. The Ward Round would continue until all inpatients were reviewed, their care being handed over. It would not be replaced by any other duty or practice by either consultant, with the exception of one or the other having to operate in emergency theatre. It would not be curtailed by attending departmental or other meetings, with the possible exception of the monthly scheduling meeting. The priorities of that first day would be to get to know the inpatients under my care for the next week, to meet them, to know their history, examine them, plan their further management, including definitive operative management when possible. As we all have experienced, I believe that we would also have a duty of care to those patients elsewhere, about whom advice and assessment is sought, and who may become inpatients under our care.

It had been my understanding that each of the seven days of that UOW week would be the same, including Saturdays and Sundays. It has been my experience that the most common conflict has

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been when operating made it impossible to undertake ward rounds. When that has occurred on consecutive days, clinical inpatient care has been undertaken by registrars, often with different registrars on different days, with obvious risk to continuity of care. The other main concern that I have experienced when UOW has been that registrars are dealing with many calls for advice from elsewhere, without input from the UOW, resulting in the default outcome of having the patient referred to the department, to be triaged by another UOW one or two weeks later. The week would end with my handing over to the next UOW with a ward round commencing at 09.00 am the following Thursday morning, and ending when all inpatient care has been handed over.

It has been of increasing concern to me to observe an increasing divergence from the practice which I had understood UOW to require. It has increasingly become a common occurrence for no ward round to be undertaken by the UOW over a weekend, including three day, bank holiday weekends. It has been reported that one whole week went by in recent months without one ward round being conducted by the UOW. As often as not, I have begun my UOW week without handover from the previous UOW, and ended it without the next UOW being present. A recent handover took place with neither UOW being present. It had been my understanding that no activity other than emergency operating was to replace or usurp inpatient management when UOW. I did not consider that operating elsewhere, conducting Stone MDM / Clinic, urodynamic studies (I have been guilty), or getting documentation in file for (successful) appraisal, never mind triage, were to replace the primacy of inpatient management. I believe that there has been an increasing practice of 'letting them get on with it', referring to the registrars, both with inpatient management at ward level, and in some instances, operating, with I believe, suboptimal outcomes as a consequence, on occasion.

But I may have been wrong, and if the consensus is that I have been wrong, and if the Trust will underwrite that consensus, I will abide by it, even though it has been my definite experience that inpatient outcomes have been compromised, and will be again.

**TRIAGE**

I found it impossible to complete triage while being UOW, and I still do. Since returning to work in 2017, I spend the weekend following my UOW completing triage. In doing so, I have requested scans, initiated treatments, dictated letters to GPs, informed patients by telephone or dictated letters to them. I have done so for 45 to 66 patients referred, the equivalent of five to seven, virtual new clinics, without time allocated to doing so, never mind remuneration. Then the reports return! I find it such an anomaly that we have been allocated four hours of total administration time per week, and at least six hours of SPA time in our job plans!

I do believe that we need to consider the complexities of triage. The Red Flag referrals are relatively straight forward, though I was unable to obtain consensus regarding advanced triage of Red Flag referrals in 2015, even though they comprise a minority of the all referrals. I believe the remaining majority are the issue, particularly in the context of the waiting times for first consultation for urgent and routine referrals. If a man is referred with LUTS this month, should he wait until September 2019 before having an ultrasound scan performed, to find that he has a bladder tumour in addition to an enlarged prostate gland? Should he similarly wait until then before having a PSA, or having Tamsulosin prescribed for presumed BPH? Should these be preconditions to referral in the first instance? Should a woman referred with recurrent urinary

infection wait more than one year before she too would have an ultrasound scan performed, or have antibiotic prophylaxis prescribed? Should a man with erectile dysfunction wait even longer before he has treatment initiated? Could one with a scrotal swelling not have an ultrasound scan performed prior to referral, precluding referral in most cases?

In many instances, I find the most egregious referrals are those consequent upon consultation with our registrars. I have triaged referrals for red flag flexible cystoscopy following discharge of patients from our own department! Why was it not organised by those doing the discharging? Why does a registrar advise referral of a patient for a TROC, rather than arranging it at the time? Why does a registrar advise referral of a patient with a small stone at the lower end of the left ureter, instead of arranging the review?

I have requested several times from the Trust its stated Policy and Procedure on Triage, without acknowledgement. I can only conclude that it does not have one. I advised the Director of Acute Services in January 2017 that the issue of triage, its relation to UOW and to waiting times for first consultation, be addressed. There has been no response.

Once again, I would like us to embark upon a discussion of triage in all its complexity, and I expect that the Trust will be engaged in that process, resulting in a clear, written understanding of our obligations, so that we are not to be held liable.

**WAITING TIMES FOR ELECTIVE INPATIENT SURGERY**

This issue hardly needs further comment. We are all aware of the interspecialty disparity in waiting times, as of June 2018. I believe that the disparity is both scandalous and indefensible. I also believe that the lack of any substantive response from the Trust is equally so. I believe that we must collectively bring our concerns to the Trust Executive, and to the Trust Board which I understand to be unaware of the disparity, and unaware of any substantive attempt to remedy the situation.I also do believe that we should look at disparities between our own waiting lists, especially with a view to making every attempt on our part to minimise risk of serious morbidity or mortality.

In January 2015, I placed on my waiting list a pretty fit, 90 year old man for resection of his prostate gland which had regrown since it had previously been resected in 2006, and which had been the source of haematuria in 2015. He was admitted to the Cardiology Ward in August 2017 with coliform urosepsis resulting in a type II, myocardial infarct. He was readmitted again in August 2018, again with urosepsis. Since discharge, he has had visible haematuria, exacerbating a chronic anaemia. A CT Urogram has been normal. There was no evidence of urothelial pathology on flexible cystoscopy which was done during his recent inpatient stay. Yesterday, I arranged his admission on 17 October for TURP, keeping him on antibiotic prophylaxis until then.

I feel a sense of shame when dealing with such a patient. Whether it is disparity within our own specialty, or between specialties, it is unacceptable that such a man should have to wait almost four years, at risk of such morbidity, while an urgent gynaecological case would not have to wait more than three months.

Since I was appointed 26 years ago, the solution to any urological inadequacy has always been regarded as a requirement for additionality, which could either not be afforded, or there was no space for more beds, or staff could not be recruited, or whatever. I do believe that the first solution should be to cause displeasure to those specialties which do not have such a critical situation as we do have. How many gynaecological operating sessions are there per month in the Southern Trust? Why not allocate half of them to Urology?

Lastly, I often think that if I had a tumour of my left kidney, it would have to be removed within 62 days, or thereabouts. If I have a staghorn calculus in the remaining kidney, it does not receive the same clinical priority. I may just develop renal failure, requiring dialysis, a recognised complication!

**SUMMARY**

I hope I may be forgiven for expressing my views, frustrations and concerns, but I believe that it is time to do so. I have equally committed to listening to those of my colleagues. From doing so, I hope that we can collectively arrive at a clear understanding of our individual and collective obligations, and above all, that we have a clear, written memorandum of understanding, or agreement, or covenant, maybe even a Policy and Procedure, from the Trust of our practice obligations.

AIDAN O'BRIEN
24 SEPTEMBER 2018.

Southern Health and Social Care Trust

**APPENDIX 6**

**Revised November 2016 (Version 1.1)**

# Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier: [redacted]

Date of Incident/Event: January 2016 – September 2016

HSCB Unique Case Identifier: S[redacted]

Service User Details: (*complete where relevant*)

Responsible Lead Officer: Dr J R Johnston

Designation: Consultant Medical Advisor

Report Author: The Review Team

Date report signed off: 22 May 2020



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## 1.0 EXECUTIVE SUMMARY

During an internal review in 2016, following an Index Case, the Trust identified a number of GP Urology referrals who were not triaged by one particular Consultant Urologist; 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient Patient 15 discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed.

Patient 15 – a Personal Information-year-old male was referred to Urology Outpatients on 30 August 2015 for assessment and advice for an elevated Prostate specific antigen (PSA) (The blood level of PSA is often elevated in men with prostate cancer). The referral was marked Routine by the GP. The referral was not triaged on receipt. However, a second GP referral was received on 29 January 2016 marked Suspected Cancer Red Flag and had received a red flag appointment. Following this referral, he was seen in clinic on 8 February 2016 (D153). On day 166, Patient 15 was diagnosed with a confirmed cancer; a resultant 6-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Patient 14 – a Personal Information-year-old male was referred to Urology Outpatients on 3 June 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review, the referral was upgraded to Red Flag and was seen in clinic on day 246. On day 304, the patient had a confirmed cancer diagnosis. There has been a resultant 10-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Patient 11 – a Personal Information-year-old male was referred to Urology Outpatients on 28 July 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of an internal review the referral was upgraded to Red Flag and seen in clinic on day 217. On day 258, Patient 11 was diagnosed with a confirmed cancer; a resultant 9-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Patient 13 – a Personal Information-year-old male referred to Urology following an episode of haematuria on 28 July 2016. The referral was marked Routine by the GP. The letter was not triaged and Patient 13 was placed on a routine waiting list on 30 September 2016. As part of an internal review this patient's referral letter was upgraded to a Red Flag referral. Patient 13 was reviewed at OPD on 31January 2017. Subsequent investigations diagnosed with bladder and prostate cancer. Patient 13 has locally advanced bladder cancer. There has been a resultant 6-month significant delay in obtaining a diagnosis and a recommendation of treatment for his bladder cancer.

Patient 12 – a Personal Information-year-old male was referred to Urology Outpatients on 8 Sept 2016 for assessment and advice on lower tract symptoms and elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review the referral was upgraded to Red Flag and was seen in clinic on day 152. On day 215, Patient 12 had a confirmed cancer diagnosis T3a with no nodal metastases. There has been a resultant 8-month delay in



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obtaining diagnosis and a recommendation of treatment for a prostate cancer.

**Causal Factors**

1. Referral letters did not have their clinical priority accurately assigned by the GP. Referral letters were not triaged following receipt by the Hospital.

**HSCB**

**Recommendation 1**

HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

**Recommendation 2**

HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

**Recommendation 3**

HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

**HSCB, Trust and GPs**

**Recommendation 4**

GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

**TRUST**

**Recommendation 5**

Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

**Recommendation 6**

The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

**Recommendation 7**

The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely



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manner.

**Recommendation 8**
The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

**Recommendation 9**
Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

**Recommendation 10**
The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

**CONSULTANT 1**

**Recommendation 11**
Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

**Recommendation 12**
Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.

## 2.0 THE REVIEW TEAM

Dr J R Johnston - Consultant Medical Adviser - Chair

Mr M Haynes - Consultant Urologist

Mrs K Robinson - Booking & Contact Centre Manager

Mrs T Reid - Acute Clinical & Social Care Governance Coordinator

## 3.0 SAI REVIEW TERMS OF REFERENCE

1. To undertake an initial investigation/review of the care and treatment of patients Patient 152, "Patient 13", Patient 12, Patient 14 and Patient 11, in the period after referral to the SHSCT Urology service using



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## 3.0 SAI REVIEW TERMS OF REFERENCE

National Patient Safety Agency root cause analysis methodology.

2. To determine whether there were any factors in the health & social care services interventions delivered or omitted to Patient 15, Patient 13, Patient 12, Patient 14 and Patient 11 that resulted in an unnecessary delay in treatment and care.
3. The investigation / Review Team will provide a draft report for the Director of Acute Services. This report will include the outcome of the Team's investigation/review, identifying any lessons learned and setting out their agreed recommendations and actions to be considered by the Trust and others.
4. The Trust will share or disseminate the outcomes of the investigation/review with all relevant parties internally and externally including the service user and relevant family member(s) (where appropriate).

## 4.0 REVIEW METHODOLOGY

The Review Team will undertake an analysis of the information gathered using RCA tools and may make recommendations in order that sustainable solutions can minimise any recurrence of this type of incident. The Review Team will request, collate, analyse and make recommendations on such information as is relevant under its Terms of Reference in respect of the incident outlined above.

**Gather and review all relevant information**

- Inpatient notes Craigavon Hospital.
- Information from the Northern Ireland Emergency Care Record (NIECR) and Patient Administration System.
- Information from laboratory systems.
- Information obtained from relevant medical, nursing and management staff.
- Review of Relevant Reports, Procedures, Guidelines.

**Information mapping**

- Timeline analysis
- Change analysis for problem identification and prioritisation of care delivery problems and service delivery problems as well as identifying contributory factors.

## 5.0 DESCRIPTION OF INCIDENT/CASE

### 5.1 Triage of GP referrals - background

The general public expect that, when they engage with their GP complaining of symptoms that are potentially due to a cancer, they will be referred to the appropriate secondary care services promptly and that they will respond, also promptly, to confirm or exclude the diagnosis of cancer.



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## 5.0 DESCRIPTION OF INCIDENT/CASE

The DHSSPSNI **Service Framework for cancer prevention, treatment and care** (Standard 13) of 2011 indicates, "*All people with signs and symptoms that might suggest cancer should be appropriately assessed by their GP and referred promptly on to hospital for further tests if needed*".

Cancer specialists, working in networks, have formulated lists of symptom and sign triggers which can signify the development of a cancer. Using these lists, primary care doctors can refer patients into secondary care; triaging a large number of patients by assigning them to different degrees of urgency (Routine, Urgent and Red-flag). If these are used as designed, this can provide an efficient referral system.

NICE have been instrumental in ensuring uniformity and the validity of these cancer recognition and referral lists of symptoms and signs. They have also formulated guidance regarding how safety nets should be setup to ensure patients are not missed. Local programmes, using this type of guidance, have been established, under the auspices of NICaN and the HSCB, to set up these triage pathways and safety nets.

### 5.2 Triage of GP referrals – Northern Ireland

NI Referral Guidance for Suspected Cancer (2012)

The Northern Ireland Referral Guidance for Suspected Cancer 2012 is based on the NICE clinical guideline, CG 27 - *Referral guidelines for suspected cancer,* published in June 2005. This has a section on Urological Cancer. It was introduced to GPs by HSCB correspondence (30/12/2012), revealing the new red-flag process and indicating in appendix A that, "*triaging will take place in a timely manner, within 72 hours of receipt of referral or the referral should continue with the GP Prioritisation".*

This is still the only set of referral guidance for suspected urological cancer available online on the NICaN website (last accessed 18/11/2018).

However, the 2005 CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* published in June 2015. This was endorsed by the Department of Health (NI) with HSC (SQSD) (NICE NG12) 29/15 on the 19th August 2015 which instructed the HSCB / PHA to send out the guidance to the appropriate Family Practitioners. This particular kind of guidance requires the HSCB to circulate regionally endorsed NICE guidelines to Trusts and GPs for implementation. Trusts are expected to review guidance against a base line assessment and provide HSCB with an assurance that the guidance has been implemented. If a Trust is unable to fully implement the guidance within the one-year period without regional co-ordination and/or additional resources, they should provide a formal assurance to HSCB, and this is to be managed as part of the risk management process. This assurance process does not however apply to primary care and GP's.



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## 5.0 DESCRIPTION OF INCIDENT/CASE

NICaN Urology Cancer Clinical Guideline (2016)

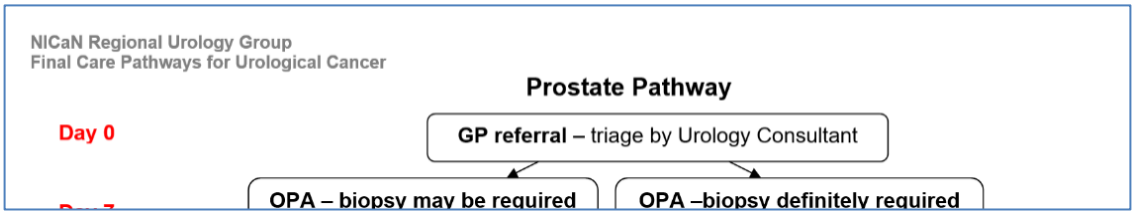
The NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016), was produced regionally to support the diagnosis, treatment and management of urological cancer. This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.

The Review Team's evaluation of the advantages of NICE NG12 (2015) over the CG27 (2005) guidelines reveals fewer cases would be red-flagged for Urology, as a result of,

- a reduction in number of non-visible haematuria patients; and
- increases in age criteria of 45 years and over.

However, rollout of NG12 by the HSCB does not appear to have happened. The Review Team understands that the reason NG12 has not been implemented lies with ongoing discussions between the HSCB and GPs.

Appendix 2 of the NICaN Urology Cancer Clinical Guideline guidelines highlights the Urology Care pathways. Cons1 was present at the workshop discussing those on 02/10/2008. It clearly indicates that, for the Prostate pathway, the GP referral would be triaged by the Urology Consultant.




### 5.3 Triage of GP referrals – SHSCT

The process of Urology triage in CAH is based upon the NI Referral Guidance for Suspected Cancer of 2012 as described above i.e. it is based on the 2005 NICE CG27 guidelines and not the more up to date 2012 NG12. In CAH, triage of referrals is performed by the Consultant Urologist of the week.

The SHSCT Urological Cancer multi-disciplinary team (MDT) was led at the time by Consultant 1 (Cons1), who was also a joint chair.

Over a period of decades, within the SHSCT and Craigavon AH, there were occasions when triage was not performed; and this varied between consultants and specialities. Acute Services had a particular problem with this issue. Preliminary discussions by the Review Team revealed that triaging within Acute Services was a, "*very haphazard process going back for approximately 25 years. There were many Consultants who would not triage but Consultant 1 was the most persistent and there were multiple attempts to tackle this issue*".



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## 5.0 DESCRIPTION OF INCIDENT/CASE

Interview with Associate Medical Director (AMD1)

AMD1 first became aware of waiting list problems with Cons1 in 1996–8 when AMD1 was the lead clinician in outpatients. Cons1's OPD letters were being kept in a ring binder and were not on any waiting list. Once challenged, Cons1 would stop this practice and improve but would then slip back. There were further non-triage meetings with Cons1 when AMD1 was the Clinical Director of Surgery.

Interview with Director of Acute Services (DAS2)

In 2007, DAS2 (while in previous post in CAH) found a waiting list which was 10 years long. They worked on this with the Consultant, Cons1, and cleaned it up; they found no serious patient related issues.

Interview with Director of Acute Services (DAS1)

DAS1 indicated that the Urology Services were under various kinds of pressure during her time as Director. There was a regional transformation project in place for Regional Urology Services under Mr M. Fordham; this generated an element of pressure to modernise and change. Along with this and other issues, including the triage problem, Consultant 1 struggled to adapt to these changes and to comply with the other issues and triaging. DAS1 paints a picture of many issues with Cons1, triaging being only one of many issues but, in her opinion, not the most important issue.

Nevertheless, in April 2010, Consultant 1 (Cons1) was put under pressure to complete his triage list. The surgical Associate Medical Director (AMD1) brought concerns to DAS1. The other Urologists had been 'covering' triaging for Cons1; the Head of Service Surgery had informed AMD1 of this. They met Cons1 the next day. The European Association of Urology meeting was in Spain the following day and Cons1 wished to attend. DAS1 and AMD1 informed Cons1 he would not be attending the meeting unless he triaged all his referrals immediately. Cons1 duly addressed the triage backlog, completing them that evening. From that time on, AMD1 and the Head of Service (HoS1) monitored that Cons 1 was triaging the GP referral letters. However, DAS1 commented that the HoS1 had a difficult job managing Cons1.

Following interview with Head of Service (HoS1)

The Head of Service for Urology (HoS1) indicated that she inherited the problem upon appointment although she was aware that it was a long running issue, going back perhaps 25 years. She highlighted this was an ongoing issue with Cons1. He had the longest backlog and took longest to triage. There were issues with other Consultants who, on occasion, did not triage but Cons1 was the only one, when asked to triage, didn't do it. This came to head in 2010 (referred to above) and again in 2014.

Informal Default Triage (IDT) process

In May 2014, after escalation to HoS1, an Informal Default Triage (IDT) process was put in place by the Trust's booking centre. This process allowed the booking office to allocate



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patients, who had not been triaged in time, to be allocated to a 'waiting list' using the GP triage category. Therefore, this IDT process of putting patients on the waiting list without triage meant that they did not get missed. However, some patients, who should have been triaged as a red flag, waited on the waiting list with their 'incorrect' GP triage category. After much discussion, this detailed process was formally circulated to all specialties on the 6th November 2015 by the Assistant Director of Support Services (ADSS1).

When questioned about this IDT process, the DAS2 was not aware of it even though it started during her time in post i.e. May '14. When asked about its potential problem of leaving incorrectly triaged (by their GP) patients on a waiting list she stated, "*Completely ridiculous, because would allow a cancer patient who should have been red flagged by their GP to go unchallenged by a Consultant triage process i.e. could have to wait for 11 months*".

**5.4 Index case**

In 2016, the SHSC Trust investigated (RCA ID 52720), in what subsequently became an 'Index case' for the cases in this RCA, the treatment and care of Patient 10. Patient 10 was a patient who had had Ca Colon (2010), breast carcinoma (2013) and then developed renal carcinoma. During review for her Breast Ca in June 2014, a CT Scan revealed that, previously noted, renal cysts had increased in size. Further investigation by a MRI scan was reported in a limited and incomplete fashion; resulting in a 'routine' referral GP letter on 29/10/2014.

During the investigation, the Review Team identified that Patient 10's GP referral letter had not been triaged; the Consultant Urologist with responsibility that week for triage duties was Cons1. This referral therefore waited as a 'new routine' referral till January 2016 to be seen by a Consultant Urologist.

The index case Review Panel agreed 3 main contributing factors led directly to Patient 10's delay in diagnosis. Firstly, the content of the MRI report; secondly a letter following a CT scan did not mention important information and thirdly, the opportunity to upgrade the referral to red flag was lost by the omission of triage; this resulted in a 64-week delay to diagnosis of a suspicious renal mass.

The index case Review Panel concluded in March 2017 that, ".... *a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process (*vide infra*) continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team*".

Of the 2 lessons learnt, one indicated that,

> "*Triage of GP referral letters remains a key element in validating appropriate utilisation of specialist services and ensuring patient safety. Triage also serves as an opportunity for early intervention for patients at risk of malignant disease or clinical deterioration*."



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This led to a recommendation that,

> *"This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with the Integrated Elective Access Protocol (IEAP).*
>
> *In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The Urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP."*

The findings of this investigation, chaired by Consultant Urologist 2 (Cons2), were made available in December 2016 and formally signed off on the 15th March 2017. A letter highlighting a number of concerns was sent to the (then) lead for Acute Governance for Acute Services (AGAS1), on the 15th December 2016.

The letter pointed out that the IDT process implied that triage non-compliance was to be expected but that this process did not have a clear escalation plan to include the individual Consultant and, indeed, had not been effective in addressing triage non-compliance. Furthermore, the letter pointed out that, from July 2015 till October 2016, there were 318 non-triaged letters which the Trust could not provide assurance that patients were not being exposed to harm by waiting as a routine or urgent appointment i.e. when they should have been red-flagged.

It is not absolutely clear who wrote this letter as it has no signature, but it appears to have been written by, or on behalf of, Cons2. On the 10th January 2017, Cons2 was requested by the Medical Director (MD3) to share the report with the 2 key Consultants involved in the SAI. One of these was Cons1. Cons2 refused, stating that he was Cons1's colleague and not his manager.

This letter was escalated to the Director of Acute Services (DAS3) and the Assistant Director of Anaesthetics & Surgery. This was further escalated to the Chief Executive of the SHSCT.

Cons1 was written to by AMD1 on the 23rd March 2016, acknowledging his hard work as a Consultant Urologist but pointing out that there were governance and patient safety concerns with regard to untriaged letters dating back over 2 years, and other important issues. Cons1 was asked to respond with a commitment and immediate plan to address these issues.

The Review Panel also determined that there were 7 other patients who were not triaged that week along with Patient 10 [redacted]. They subsequently performed a 'look-back' exercise (number 1) of these referrals. Of the seven referrals, six charts were available and each patient had an appropriate



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management plan. One set of notes were missing and efforts were made to find them.

Cons1 provided his personal review, dated 25/01/2017, of the Index Case to the Chairman of this Review Team. It provides an argued retrospective rationale that a timely triage by himself would not have altered the referral grading. However, it does not provide a sound reason for his actual lack of triage. His report is consistent in arguing his view that he does not have time to perform both Consultant of the Week (CoW) duties and triaging of non-red flag referrals.

### 5.5 Look back exercise #2

Upon realisation that the 'look-back' exercise #1 had resulted from non-triage over the week beginning the 30/10/2014, further efforts were made to investigate the size of this non-triage issue and to find missing referral letters. Cons1 was contacted and the Head of Service for Urology (HoS1) obtained permission to look for missing GP referral letters in his filing cabinet. Cons1 stated that there were referral letters in a filing cabinet in his office. During interview, he stated that he kept the referrals to ensure they would not be missed or overlooked. The Head of Service for Urology retrieved these referral letters, which numbered over 700 along with the triage lists from the booking centre.

These referrals were then reviewed by the Urology Consultant Team revealing 30 patient referrals should have been red-flagged and four of these patients, following review, were diagnosed with cancer, becoming the subject of this review.

This (RCS Personal Information redacted by USI ) Review Team reviewed the clinical notes from these 4 patients and following discussion, under the Urological guidance of AMD1, detailed the clinical course and made the following conclusions.

Patient 14 03/06/2016 - Personal Information -year-old male referred to Urology Outpatients by GP for assessment and advice with a raised PSA.
The referral was marked Urgent by the GP.
The referral was not triaged on receipt.
09/08/2016 - added to W/L Urgent.
27/01/2017, as part of the internal review #2, the referral was upgraded to R/F and was seen in clinic on day 246. Therefore, this was an incorrect GP referral.
05/04/2017 (D304), following U/S guided biopsy, the patient obtained a confirmed cancer diagnosis and there was a recommendation for treatment of a prostate cancer by surveillance protocol.

**Conclusions**

Resultant 10-month delay in obtaining diagnosis.
Following Review Team consideration, deemed not to be a clinically significant delay.

Patient 11 28/07/2016 - Personal Information year-old male referred to Urology Outpatients by GP for assessment and advice, concerning elevated PSA.
The referral was marked Urgent by the GP.



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The referral was not triaged on receipt.
30/09/2016 - added to W/L Urgent.
18/01/2017 - as part of an internal review #2, upgraded to R/F. Therefore, this was an incorrect GP referral.
20/02/2017 (D207) seen at R/F appointment. Sent for MRI and prostate biopsy.
11/04/2017 (D258) - diagnosed with a confirmed low risk prostate cancer and there was a recommendation for treatment of a prostate cancer by surveillance protocol.

**Conclusions**

Resultant 9-month delay in obtaining diagnosis.
Following Review Team consideration, deemed not to be a clinically significant delay.

Patient 13 28/07/2016 - Personal Inform -year-old male referred to Urology by GP following an episode of haematuria.
The referral was marked Routine by the GP.
The letter was not triaged.
30/09/2016 - Patient 13 was placed on a Routine waiting list.
19/01/2017 - As part of an internal review #2, upgraded to a R/F referral. Therefore, this was an incorrect GP referral.
31/01/2017 (188d) - reviewed at OPD and flexible cystoscopy.
22/02/2017 TURBT/TURP - diagnosed with bladder (locally advanced) and prostate cancer and there was a recommendation of treatment for his bladder cancer.

**Conclusions**

Resultant 6-month delay in obtaining diagnosis.
Following Review Team consideration, it is probable that the delay is clinically significant; time will tell*.

* The Review Team referred to an expert for advice.
*Delay in definitive surgical treatment beyond 12 weeks conferred an increased risk of disease-specific and all-cause mortality among subjects with stage II bladder cancer. He remains disease free as of September 2018*.

1. John L. Gore, Julie Lai, Claude M. Setodji, Mark S. Litwin, Christopher S. Saigal, and the Urologic Diseases in America Project. Mortality increases when radical cystectomy is delayed more than 12 weeks. Results from a surveillance, epidemiology, and end results–Medicare analysis. Cancer March 1, 2009.
2. Nader M. Fahmy, Salaheddin Mahmud, Armen G. Aprikian. Delay in the surgical treatment of bladder cancer and survival: Systematic Review of the Literature. *European Urology 50 (2006) 1176–1182.*

Patient 12 08/09/2016 - Personal Inform -year-old male was referred to Urology Outpatients on for assessment and advice on lower tract symptoms and elevated PSA.
The referral was marked Urgent by the GP.
The referral was not triaged on receipt.
27/01/2017 – further GP letter – please upgrade to R/F.
30/01/2017 - as part of the internal review #2, upgraded to R/F.



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06/02/2017 - seen in clinic on day 152.
11/04/2017 (D215) - confirmed cancer diagnosis T3a with no nodal metastases – high risk and there was a recommendation of treatment for a locally advanced non-metastatic prostate cancer.

**Conclusions**

Resultant 8-month delay in obtaining diagnosis.
Following Review Team consideration, it is probable that the delay is not clinically significant.

At a later date, towards the end of 2018, another patient came to the attention of the Review Team – Patient 15. This patient could also have been one of those found in Cons1 filing cabinet but appeared at an outpatient clinic before the outworking of the look back exercise #2. A Consultant Urologist realised in the clinic that this was also a Cons1 non-triaged patient who was incorrectly referred by their GP.

Patient 15 30/08/2015 - Personal Information -year-old male referred to Urology Outpatients by GP for assessment and advice with a raised PSA.
The referral was marked Routine by the GP.
The referral was not triaged on receipt.
29/01/2016 2nd GP referral marked as Suspected Cancer – Red flag; Patient 15 was added to W/L R/F following this referral.
As part of the internal look back #2, the referral was noted.
Patient 15 had already received an appointment and was seen in clinic on day 153. Therefore, 1st GP referral was incorrect; the 2nd was a correct GP referral.
11/02/2016 (D166), following a prostate biopsy, the patient obtained a confirmed cancer diagnosis T3a and there was a recommendation for treatment of a prostate cancer.

**Conclusions**

Resultant 6-month delay in obtaining diagnosis.
Following Review Team consideration, it is felt that the delay is unlikely to be clinically significant.



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## 7.0 CONCLUSIONS

The Review Team interviewed a number of Trust staff including Directors (past and present), an Assistant Director, Head of Service and an Associate Medical Director as part of the review process. These interviews, along with clinical documents and health records systems, have helped inform the conclusions by providing the evidence and also corroboration where there appeared to be differences of opinion.

The Review Team and everybody interviewed, including Cons1, provided affirmation that a timely, efficient triage system which checked the initial GP referral was very important to patients. Comments made when interviewees were asked about the importance of triage and where the process of triaging a potential cancer patient ranked alongside other issues such as probity, patient experience and performance, were consistent,

*"Very significant". Very high up the list in terms of importance".*
*"It is fundamental people are seen in the appropriate time".*
*"Very important" ... "Important for the patient".*
*"Vital" ... "Very significant .. patients are often anxious and depend on the system to work".*

Cons1 replied,

*"It is a serious issue, very important"..... "Number one ranking in overall scheme of things"*

The Review Team established that there were factors in HSC service delivery to the 5 patients under examination that resulted in an unnecessary delay in treatment and care. In 4 patients the delay was thought not to be clinically significant but in 1 Patient 13 there probably was a significant delay.

Consideration of the causative factors to the patients' delays reveal,

- Referral letters did not have the clinical priority accurately assigned by the GP; and
- Referral letters were not triaged following receipt by the Hospital.

### 7.1 Referral letters did not have the clinical priority accurately assigned by the GP.

Contributory factors

*Task Factors (policy and guidelines)*
The Review Team reviewed the GP referrals regarding the five patients listed above. They concluded, as judged from the Northern Ireland Cancer Network (NICaN) Referral Guidance for Suspected Cancer (December 2012), that all five patients should have been referred to Urology by the GP's as red flag referrals (suspected cancer) i.e. incorrect triage.

*Task Factors (decision aids)*
The current decision aid for GPs is the NI Referral Guidance for Suspected Cancer 2012 based on NICE CG 27 *Referral guidelines for suspected cancer* published in June 2005. It is clear that Secondary care, in the form of Consultant Urologists, should triage these GP referrals; by doing so, 11% of GP referrals are changed (from Review Team member). It is also clear that Cons1 would have been in no doubt as to his responsibilities; he was intimately



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involved in setting this standard and signed off the NICaN clinical guidelines.

However, it is clear this very important and critical triage safety net, work can be considered onerous and other electronic methods which GPs can use might be more efficient and help to reduce that load.

According the HoS1, most patient referrals by GPs to Trusts for outpatient appointments are now made through the electronic Clinical Communication Gateway (CCG). However, some paper referrals are still received. CCG is a digital referral system for Primary care which can contain referral criteria that meet NICE and NICaN guidance. This would enable appropriate clinical triaging of referrals to be performed as part of the selection of referral reasons and/or symptom description.

Using the electronic CCG pathway, some clinical specialties, such as gynaecology, have worked closely with the Public Health Authority to develop a better GP referral tool e.g. using 'banner guidance' (a specialty specific banner, listing symptoms and signs) which complies with NICE/NICaN guidance. This 'banner guidance' helps by directing clinicians to use the NICE/NICaN referral criteria which allow for timely and appropriate triage of patients to clinically appropriate appointment types. It is possible when red flag symptoms are chosen that an immediate alert could go to the Red Flag booking team, to allow the appointment booking process to begin immediately. However, currently, the referral criteria fields are optional i.e. not mandatory, so opening up the possibility that fields are not completed, leading to error and delay.

*NICE NG12*
The reference CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* but, despite being endorsed by the DHSSPSNI and accepted by the Regional Urologists, it has yet to be implemented. Its use as a triage standard should result in fewer red-flagged cases which should ease some of the pressure on waiting lists. Its adoption would take place in primary care and should form the basis of the electronic CCG referral tool.

There was a consistent medical staff view from the Review Team, the AMD1, and indeed Cons1, that GP's have a crucial and important responsibility in getting the referral criteria/urgency category correct. If the GP does not provide enough, or the correct information, the NI Electronic Care Record (NIECR) needs to be checked and that slows the whole triage process down. It was clear that the triage system works best when the initial GP referral is usually correct and the Secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

**7.2 Referral letters were not triaged following receipt by the hospital.**

Contributory factor

*Task Factors (policy and guidelines)*



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The Integrated Elective Access Protocol (IEAP) (DHSSPS, April 2008) defines the roles and responsibilities of staff (in both primary and secondary care) when patients enter an elective care pathway. It states,

> '…*an Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to…. Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first*'.

The Principles for booking Cancer Pathway patients states,

> "Clinical *teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients*".

and,

> "*Referrals will be received, registered within one working day and forwarded to Consultants for prioritisation*".

However, the IEAP states,

> *"…if clinical priority is not received from Consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency".*

Following on from the IEAP of 2008, national and regional policies and guidelines, already referred to above, have been introduced which have outlined the detailed role of the Urology Consultant in triaging referrals that have come in from Primary care e.g.,

- Service Framework for cancer prevention, treatment and care (Standard 13) 2011;
- NI Referral Guidance for Suspected Cancer 2012; and
- NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016).

These have provided agreed lists of the critical symptomatology of Urological cancers and the roles and responsibilities of Primary and Secondary care staff in ensuring patients receive prompt recognition and treatment of their cancer.

*Review of Adult Urology Services in Northern Ireland*

In March 2009, a *Review of Adult Urology Services in Northern Ireland - A modernisation and investment plan* was published. Its External Advisor was Mr Mark Fordham. SHSCT Consultant Urologists were represented on the committee.

Recommendation 4 states, "*Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system".* Consultants indicated that they would routinely upgrade a significant number of routine and urgent referrals (GP) to urgent or red flag. It was noted that the development of agreed referral guidelines/criteria for suspected Urological cancers was a priority piece of work for the recently formed NICaN Group. That work was led by Cons1; see page 6.

Section 3.31 of the report indicates that, "*Consultant Urologists unanimously consider that referral triage should be led by Consultants. With over 40% of referrals being cancer related*



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*(and with many not red flagged or marked urgent) they believe that they are best placed and skilled to undertake the triage process. They also believe that despite the volume of referrals, this is not a particularly time consuming process*."

Contributory factor

*Staff factor*

It is obvious from reading the documents referred to above that Cons1 has been aware of developments in this field and, indeed has been party to the discussions and signed some of them off. Cons1 was chair of NICaN (Urology) and was involved in drafting the NICaN regional Urology guidance, and therefore was very familiar with the requirement to triage GP referrals.

Despite all of this, and even though Cons1 agreed that this triaging role was, "*very important*", …. it was, "*a very serious matter not to be minimised, very serious"* he stated he would not triage non-red flag referrals.

When asked, *"Does triage still need done?"* Cons1 answered*, "a procedure is needed to highlight when it needs done and who does it".* When further asked, *"Who was involved in SHSCT Urology service in setting up triage"?* Cons1 answered for urological cancer, "*I was the Lead"*.

He felt triage of referral letters was too time consuming and the amount of time spent on triage, in his opinion, rendered inpatient care unsafe. He highlighted that he had previously escalated his concerns about work load to management teams and medical directors.

In relation to triage, Cons1 stated, '*I would love if we had a Trust Urology agreement on the type of triage to be conducted*'. When it was pointed out that, "*Consultant colleagues did triage for you. How did they do it?"* He stated, "*It depends on how you do it"* ..... "*Not all do advanced / enhanced triage, they compromise. It is a spectrum"... "They have not done it in the detail I felt it needed for routine/urgent non-red flag case".*

When questioned further, regarding his way of organising his own work load, Cons1 stated, '*....yes I did it my way – I wasn't cognisant of being unbending, I am very particular*'.

Cons1 highlighted to the Review Team that he currently takes annual leave each Friday and spends the weekend triaging. He stated that it is impossible to be Urologist of the Week and triage referrals appropriately. He stated he still can't do triage and everything else. He stated, '*I do triage entirely in my own time to allow me to do it properly'*.

When asked about using the NIECR - Electronic Referral using the Clinical Communication Gateway (CCG) method, Cons1 stated found the new CCG triage system*, "Very, very good, I wish all information was available on ECR. It is less time consuming. ECR makes it easier to check information".*

The Review Team concluded that there was a serious inconsistency between the guideline



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standard that a Consultant should triage GP referrals (which Cons1 helped to construct) along with his stated view of the crucial importance of triage and Cons1's actual practice.

Cons1's chosen method of triage was beyond what is required. His triage is the equivalent of a virtual clinic where he reviews NIECR and books investigations for patients. While the Review Team recognised this was a detailed triage process, they concluded that his prioritisation of work and attention to detail meant that some patients got a higher standard of triage/care, while, crucially, others were not triaged, leading to a potentially critical delay in assessment and treatment for those patients. Cons1 is aware of this.

The Review Team concluded that Cons1's prioritisation of work and attention to detail led to some patients receiving a high standard of care, while others ran the real risk of having a cancer diagnosis delayed till it was dangerously late.

Contributory factor

*Work load/scheduling*

In 2008, when the IEAP was published, there was a maximum waiting time of 9 weeks for a first Outpatient appointment. On 30th September 2016, there were 2012 patients on the routine Urology outpatient waiting list, with 597 patients showing as waiting 52 weeks and over. The longest waiting time was 554 days (80 weeks). Therefore, if patient referrals are incorrectly referred, or not triaged and continue to use the GP's classification of urgency, there will be a significant wait. Cons1 is aware of this reality.

The Review Team considered the Consultant of the Week (CoW) work load, including ward rounds, clinics, emergency theatre sessions as a contributory factor. Cons1 has consistently argued that he cannot triage non-red flag referrals and carry out the duties of the CoW. He has not indicated who else should carry out the triage duties. However, the Review Team note that the other Consultant Urologists were able to manage this work load and triage referral letters in a timely fashion, with other members of the consultant team also ordering investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to outcomes achieved from Cons1's 'advanced triage'.

Contributory factor

*Organisational*

The Review Team concluded that the non-triage of Urology referrals by Cons1 has been an ongoing problem in the Trust for many years, possibly decades. While there were pockets of non-compliance by other Consultants, when escalated, compliance improved. However, the Review Team note that Cons1 consistently did not return triage information on referrals thus not allowing the appropriate prioritisation of appointments by clinical need.

Interviews with 2 previous and the current Director of Acute Services, AMD1 and the Head of Surgery Service have highlighted that on many occasions, over a prolonged period, attempts had been made by the Trust's officers to address Cons1's non-compliance with triage. These



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attempts encompassed both direct face to face conversations which were often heated, correspondence and, as in 2010, study leave refusal until there was compliance. These interventions all resulted in a familiar pattern of response; temporary improvement in compliance with triage, followed by a return to non-compliance.

In 2014, due to continuing non-compliance, the Trust implemented an 'Informal' Default Triage Process to manage the referrals which were not being triaged and returned to the Booking Centre. The Review Team considered the intention of this process was to prevent any delay in patients being added to the waiting list. However, this meant the 'non-return of triage' was not individually addressed with the non-compliant clinicians. Furthermore, and most importantly, it allowed patients, who should have been red-flagged, to remain on a waiting list until review.

In 2014, the Director of Acute Service 2 (DAS2) discussed non-compliance with Cons1 and agreed that Cons1 would no longer triage referral letters. Cons1 was heavily involved with formulating the NICaN Urology guidelines at the time and was grateful to the extent that he thanked DAS2.This task was delegated to other Urology Consultants for a time. However, Cons1 does not recollect having to formally stop triage. At interview, DAS2 was not aware that he had resumed those duties; she remembered that their Cancer performance figures improved when Cons1 was not triaging.

*Escalation within Organisation*
At every interview, questions were asked whether Cons1's consistent and prolonged non-compliance with triaging was referred upwards to executive level i.e. the Medical Director and Chief Executive.

Director DAS1 considered that the problem was being managed at Service level, although as it was only one of a series of issues and considered to be a 'minor' one, it did not predominate at higher level meetings with the Medical Director (MD1); to the extent that he may not have been aware of it.

Director DAS2 considered that the problem was dealt with by agreeing with Cons1 to stop triaging. There were other issues that were flagged up to MD2, but she was not able to remember whether MD2 was made aware of the triage problem.

During DAS3's current tenure Executive members certainly knew; at CAH Oversight meeting level and at the time of the look back exercise #2 which ultimately led onto this SAI and RCA process. The Medical Director (MD3) was directly involved in the RCA process and the CEO was aware. At Trust Board level, it is thought that a non-Executive member was asked to examine the situation which would indicate that it had also reached that level.

Overall, the Review Team in considering whether there was a satisfactory escalation of this 'non-triage' issue have concluded that there was no evidence of consistent and proactive escalation of 'non-return of triage' either to the Medical Director or the Chief Executive until the look back exercise #2 basically forced the seriousness of the issue out into the open. Indeed,



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they do not appear to have appreciated the importance of triage, certainly from the patient's perspective. The Trust's officers made efforts to address Cons1's non-triage over time but were consistently thwarted by Cons1's refusal to comply. The Trust failed to put systems, processes and fail safes in place to ensure Cons1's consistently triaged patient referrals until 2017.

Systems and processes have now been put in place so that the Head of Service for Urology reviews Cons1's compliance with triage. HoS1 will check all Urology triage on an adhoc basis but, with Cons1, she will check daily when he is the Consultant of the Week. Any non-compliance with returning referrals without triage is addressed immediately. However, this process is heavily dependent on HoS1 who, when she is on leave, often has to recover non-triaged cases upon her return.

## 8.0 LESSONS LEARNED

1. The clinical urgency category allocated by GPs to 30 patients referred to Urology were incorrect. The referrals using NICaN guidance should have been referred as a Red Flag. Four (plus 1) of these patients were subsequently shown to have cancer.

2. The process of triaging Urology cancer referrals from Primary Care to Secondary Care, under the direction of the HSCB, appears to be less efficient than it could be, bearing in mind that NICE NG12 guidance has not been adopted and electronic referral using CCG is not being used as efficiently as it could.

3. GP's are not mandated to provide HSCB with an assurance that they comply with the most up to date NICE or other guidelines. Therefore, HSCB are unaware of any risks consequent upon the non-compliance with NICE and other guidance within GP practices.

4. GP's are not mandated to refer patients using CCG clinical criteria banners; this can lead to error and delay.

5. There is no Regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters. Triage of patient referrals is obviously viewed as extremely important but does not seem to be at an equivalent level of importance when ranked alongside other clinical governance issues. Despite being an evident problem for decades and requiring considerable time and effort to find a solution, it only really surfaced within the Trust after an Index case forced the situation out into the open.

6. Despite it being absolutely clear to Consultant 1 (based upon his close proximity to the development and signing off of regional guidance) of the consequences of non-triage, he did not routinely triage referral letters. The Review Team consider that Cons1's refusal to triage to a level similar to other clinicians, led to patients not being triaged,



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and this resulted in delays in assessment and treatment. This may have harmed one patient.

7. Cons1 confirmed that despite the Trust reminding him of the requirement to triage, he did not consistently triage referrals. He argued that, due to time pressures, he felt he was unable to perform the duties of the Consultant of the Week and his triaging duties. He has highlighted those views to Trust operational and management teams over a number of years.

8. The Trust made efforts to address Cons1's non-triage over time. However, the Trust failed to put systems, processes and fail safes in place to ensure Cons1 consistently triaged patient referrals until 2017. However, this safeguarding process is heavily dependent on the Head of Service checking triage is completed when Cons1 is Consultant of the Week.

9. The Informal Default Triage process allows patients who should be red flagged to remain on a waiting list of routine or urgent cases.

10. From examining the triaging issue over the length of time it has existed, it is obvious that there is an unwillingness or inability within the medical hierarchy to tackle its 'difficult colleague' problem. The reasons behind this probably include not taking ownership of its own problems and poor support from senior medical management perhaps resulting in issues not being referred upwards.



Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

## 9.0 RECOMMENDATIONS AND ACTION PLANNING

**HSCB**

**Recommendation 1**

HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

**Recommendation 2**

HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

**Recommendation 3**

HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

**HSCB, Trust and GPs**

**Recommendation 4**

GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

**TRUST**

**Recommendation 5**

Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

**Recommendation 6**

The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

**Recommendation 7**

The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.

**Recommendation 8**

The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.



Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

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## 9.0 RECOMMENDATIONS AND ACTION PLANNING

**Recommendation 9**

Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

**Recommendation 10**

The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

**CONSULTANT 1**

**Recommendation 11**

Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

**Recommendation 12**

Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.

## 10.0 DISTRIBUTION LIST

In addition to the Review Team, the following.

Mr S Devlin, Chief Executive SHSCT.

Dr Maria O'Kane, Medical Director, SHSCT.

Mrs Melanie McClements Interim Director of Acute Services.

Health & Social Care Board (HSCB).

Chairs of Morbidity & Mortality Groups SHSCT.



Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

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## Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

| | | | |
|---|---|---|---|
| **Reporting Organisation SAI Ref Number:** | Personal Information | **HSCB Ref Number:** | **S11471** |

| **SECTION 1** | | | | | |
|---|---|---|---|---|---|
| **INFORMING THE SERVICE USER[1] / FAMILY / CARER** | | | | | |
| 1) Please indicate if the SAI relates to a single service user, or a number of service users.<br>**Please select as appropriate (✓)** | **Single Service User** | | **Multiple Service Users*** | ✓ | |
| | **Comment: 5**<br>***If multiple service users are involved please indicate the number involved*** | | | | |
| 2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI?<br>**Please select as appropriate (✓)** | **YES** | ✓ | **NO** | | |
| | If **YES**, insert **date informed**:19.2.18 | | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI | | | | |
| | a) No contact or Next of Kin details or Unable to contact | | | | |
| | b) Not applicable as this SAI is not 'patient/service user' related | | | | |
| | c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | | | |
| | d) Case involved suspected or actual abuse by family | | | | |
| | e) Case identified as a result of review exercise | | | | |
| | f) Case is environmental or infrastructure related with no harm to patient/service user | | | | |
| | g) Other rationale | | | | |
| | **If you selected c), d), e), f) or g) above please provide further details:** | | | | |
| 3) Was this SAI also a Never Event?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| 4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event?<br>**Please select as appropriate (✓)** | **YES** | If **YES**, insert **date informed**: DD/MM.YY | | | |
| | **NO** | If **NO**, provide details: | | | |
| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)** | | | | | |
| **Content with rationale?** | **YES** | | **NO** | | |

| **SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER**<br>***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*** | | | | |
|---|---|---|---|---|
| 5) Has the Final Review report been shared with the Service User[1] / Family / Carer?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | ✓ |
| | If **YES**, insert date informed: | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer: | | | |
| | a) Draft review report has been shared and further engagement planned to share final report | | | |
| | b) Plan to share final review report at a later date and further engagement planned | | | ✓ |



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| SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER<br>*(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)* | | |
|---|---|---|
| | c) Report not shared but contents discussed<br>***(if you select this option please also complete 'l' below)*** | |
| | d) No contact or Next of Kin or Unable to contact | |
| | e) No response to correspondence | |
| | f) Withdrew fully from the SAI process | |
| | g) Participated in SAI process but declined review report | |
| | ***(if you select any of the options below please also complete 'l' below)*** | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer | |
| | i) case involved suspected or actual abuse by family | |
| | j) identified as a result of review exercise | |
| | k) other rationale | |
| | l) If you have selected **c), h), i), j), or k)** above please provide further details: | |

| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)**) | | | | |
|---|---|---|---|---|
| **Content with rationale?** | **YES** | | **NO** | |

| SECTION 2<br>**INFORMING THE CORONERS OFFICE**<br>**(under section 7 of the Coroners Act (Northern Ireland) 1959)**<br>*(complete this section for all death related SAIs)* | | | | |
|---|---|---|---|---|
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert **date informed**: | | | |
| | If **NO**, please provide details: | | | |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert **date report shared**: | | | |
| | If **NO**, please provide details: | | | |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert **date informed**: | | | |
| | If **NO**, please provide details: | | | |

| **DATE CHECKLIST COMPLETED** | **22.5.2020** |
|---|---|

[1] *Service User or their nominated representative*



Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

**DIRECTORATE OF ACUTE SERVICES**

Director: Mrs Melanie McClement

Tel: Personal Information redacted by the USI

# ACUTE CLINICAL GOVERNANCE

Date: Friday 14th February 2020

8am, Board Room (beside the Canteen), CAH Video link to Clanrye House DHH

| | | |
|---|---|---|
| **1.0** | **Apologies**: Dr McCaffery, Dr Bradley, Dr Clarke Dr Currie, Dr McGalie<br><br>Attendees: Melanie McClements, Tracey Boyce, Anne McVey, Ronan Carroll, Barry Conway, Philip Murphy, Seamus Murphy, Ted McNaboe, Damian Scullion, Imran Yousuf, Shahid Tariq Gareth Hampton Patricia Kingsnorth | |
| **2.0** | 10012020 Acute Clinical Governance a<br>**Notes from last meeting** | |
| **3.0** | **Chairs Business**<br>• | |
| **4.0** | **Electronic Sign off**<br><br>SIGNOFF_2020_01_ SHSCT.xlsx<br>**There is a small focus group being set up by Dr OKane.** | |
| **5.0** | **Standards and Guidelines**<br>Papers sent separately | |
| **6.0** | **Update on previous reports**<br>Patient 16 – Recommendations not approved at meeting- there was a meeting between review team and AD to discuss the workability of the recommendations. Agreement was sought and following discussions with the Director/ AMD and AD a decision was made to agree the report and share with the family.<br>Report Personal Information recommendation 1 not robust and recommendations 2<br>Final draft report Personal ACG.docx<br>New recommendations now reads:<br>1. Morbidly obese patients attending the SHSCT radiology departments **must** be accompanied and monitored by a doctor familiar with the patient. The patient should be transferred with appropriate monitoring equipment to maintain patient safety and facilitate rapid turnaround within the department.'<br>2. The report will be presented at ED, Surgical and Medical | AMDs/ CD |

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mortality and morbidity (M&M) meeting for learning.

3. The report will be shared with nursing ED staff to highlight the importance of commencing a NEWS chart and recording of observations prior to discharge.

[redacted]– recommendations – back to chair to review.

**SAIs**:

**Barry**


1. Level 1 Report final for ACG[redacted].docx


SEA report [redacted] 106323 fv for Acute [redacted]- Shahid

Barry presented [redacted] report had been previously shared and radiology was unhappy to sign off. Amendments were made and represented this month. Comments made in the body of the report to be shared with chair of review team.

Barry presented the case today - recommendations need amended, there is a problem in the body of the report to suggest radiology is responsible for following up on reports despite sharing

GP have a good system in terms of system to display all blood results daily and alert to GPs. PK to go back to Stephen Hylands


[redacted] SEA final report for ACG.docx


SEA [redacted] final report for Feb ACG.d

Phil presented [redacted] comments sent back to the chair – there was no identified learning in this case- go back to chair.

Ronan presented [redacted] Approved pending some word changes in the recommendations relating to the Senior consultant and the appropriate place in recommendation 2.


1. Level 1 Report 20.01.2019[redacted].docx


1. Level 1 Report 20.01.2019[redacted].docx

Ted presented 5 urology cases


1. Level 1 Report 20.01.2019[redacted].docx


1. Level 1 Report 20.01.2019[redacted].docx )


1. Level 1 Report 20.01.2019[redacted].docx


RCA [redacted]_Urology Report_5 cases_after

There were a number of concerns with this report, staff members names in the body of the report and some of the action plans have already been joint report.
Individual reports need to be worked through properly. Asked Maria O'Kane Medical Director, if recommendations concerning consultant's recommendations can be omitted for family copies as not relevant also 10 and 11 need to be sorted. Dr O'kane will go back to the chair regarding the HSCB recommendations as Trusts do not usually make

Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

| | | |
|---|---|---|
| | recommendations for the HSCB or other trusts.<br>To take off the table and work through with Melanie and PK. 4 cases with no impact should be a summary report for families as he did not suffer any adverse event as a result of the delay. Only one case was affected. | |
| **7.0** | **Audit**<br>  <br>1) Clinical audit summary for Acute Cl Melanie advised that all attached reports below are available for information.<br><br>**Patient Safety Report**<br>  <br>Acute Governance Report Jan20.doc | ADs and AMDs |
| **8.0** | **Monthly Acute Governance report**<br><br>Reports for information<br>  <br>December 2019 Acute SMT Governan<br>**Complaints Position** –<br>  <br>Current Complaints 10.2.20.xlsx | |
| **9.0** | Reports for information.<br>**Medicine Incidents/ Incident Management Position**<br>  <br>December 2019 Acute.xlsx | |
| **10.0** | Reports for information<br>**Risk Registers** – additions, amendments and closures to the governance team.<br><br>  <br>CCS Div.HOS.TEAM RR by Owner Dec19.:<br>  <br>FSS Div.HOS.Team RR by Owner Dec19.:<br>  <br>IMWH Div.HOS.Team RR by Owner Dec19.:<br>  <br>MUC Dir.Div.HOS.Team RR<br>  <br>Pharmacy Div.HOS.Team RR De<br><br>  <br>SEC.ATICS Div.HOS.Team RR by | ADs & AMDs |
| **11.0** | **Mandatory training** | |


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| | | |
|---|---|---|
| | Will be available in Feb 2020 | |
| **12.0** | **Any Other Business** | |
| **13.0** | **Date of Next Meeting:**<br><br>**Friday 14th March at 8.00 am in the Board Room, CAH** | |

Southern Health and Social Care Trust

**DIRECTORATE OF ACUTE SERVICES**

Director: Mrs Melanie McClement

Tel: Personal Information redacted by the USI

# ACUTE CLINICAL GOVERNANCE

Date: Friday 17th January 2020

8am, Board Room (beside the Canteen), CAH Video link to Clanrye House DHH

| | | |
|---|---|---|
| **1.0** | **Apologies**:<br>Chris Clarke, Shahid Tariq, Damian Scullion, Clare McGalie, Neville Rutherford-Jones, Anne McVey | |
| **2.0** | **Notes from last meeting**<br>No action notes available | |
| **3.0** | **Chairs Business**<br>• The learning from SAI was discussed; the report does show that SHSCT is reporting less incidents t the board than other trusts. Patricia suggested we review the current process of internal investigations, and we will bring the process to the next meeting for discussion. | |
| **4.0** | **Electronic Sign off**<br>The reports shows that southern trust is ahead of other trusts in relation to Electronic sign off.<br>**There is a small focus group being set up by Dr OKane.** | |
| **5.0** | **Standards and Guidelines**<br>Papers sent separately | |
| **6.0** | **SAIs**:<br>**Barry**<br>1. Level 1 Report final for ACG.docx **remove to next month (talk to Barry)**<br>**Anne / Gareth**<br>2nd draft report Personal ACG.docx Personal draft report ACG Jan.docx Personal Informatio SEA final report for ACG.docx<br>Personal Information redacted by Personal Inform to be brought back to Feb meeting<br>approved by acute and cyp – ensure Personal Information added to report. | AMDs/ CD |

Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

| | | |
|---|---|---|
| |  SEA report [redacted]<br>(Approved or [redacted] report passed, no abdominal x ray was done. Consideration should be given to families for psychological support.<br>[redacted] – Recommendations not strong, need to be more specific, using SMART pneumonic. Abdominal hernia is difficult to detect and require CT and lactate. Radiology should have been contacted before recommendations.<br><br>[redacted]- recommendation 1 not achievable go back to chairperson, recommendation 2 approved .<br><br>Ronan (Ronan to offer assurance that measures in place will prevent recurrence)<br><br>[redacted] – Ronan presented – the systems and processes were in place and the processes advised staff there was a problem. The process recommends the process was not followed.<br>This has been the 3rd incidence of this nature,<br>This is a cultural issue- approved<br>Ronan – approve on the basis of strengthening recommendation 1.<br><br>[redacted] – to be deferred to Feb 2020 – Ronan presented -<br>**Reports need to go M+M for learning**<br>  [redacted] draft report  RCA 69133_Urology [redacted]<br>[redacted]- suggestions to go back to medical director to advise that the report was discussed today, they acknowledge the external report and that the process has been debated. The overall summation is that the recommendations are too broad and difficult to deliver. The recommendations do not follow the SMART process. This report needs to be agreed and shared with the ombudsman's office. PK will take to MDO to take back to the chair. | |
| **7.0** | **Audit**<br><br>**Patient Safety Report**<br><br>Reports for information | ADs and AMDs |
| **8.0** | **Monthly Acute Governance report**<br><br>Discussion about the need for action plans for learning from complaints.<br>**Complaints Position** – | |
| **9.0** | **Medicine Incidents/ Incident Management Position**<br><br>Reports shared for information | |

| | | |
|---|---|---|
| **10.0** | **Risk Registers** – additions, amendments and closures to the governance team. | ADs & AMDs |
| **11.0**<br>**SI** | **Mandatory training**<br>Will be available in Feb 2020 | |
| **12.0** | **Any Other Business**<br><br>Patricia discussed the need for medical staff to assist with SAI investigations. There are training places available but some medics are not taking up the training slots as they don't want to be involved in the process. | |
| **13.0** | **Date of Next Meeting:**<br><br>**Friday 14th February at 8.00 am in the Board Room, CAH** | |

**SIGN OFF REPORTS**

**Time period:** **01/01/2020 to 31/01/2020**

Total Sign Off for all trusts for current month and previous two months

| Trust | November | December | January |
|---|---|---|---|
| Southern | 46900 | 48936 | 56354 |
| Western | 29093 | 27867 | 29664 |
| South-Eastern | 6100 | 5833 | 6845 |
| Belfast | 9278 | 8713 | 9099 |
| Northern | 1519 | 1672 | 1430 |
| **Total** | **92890** | **93021** | **103392** |

Total Sign Off for Southern Trust previous three months

| Month | October | November | December |
|---|---|---|---|
| **Total** | 41383 | 46900 | 48936 |

Total Sign Off per Southern Trust

| Description | Radiology | Blood Sciences | Microbiology | Histopathology | Cytology | Blood Bank | Virology | Total |
|---|---|---|---|---|---|---|---|---|
| **Total** | 2842 | 49438 | 3777 | 233 | 49 | 15 | 0 | **56354** |

Total Sign Off per Location

| Location | Radiology | Blood Sciences | Microbiology | Histopathology | Cytology | Blood Bank | Virology | Total |
|---|---|---|---|---|---|---|---|---|
| Craigavon Area Hospital | 2151 | 36302 | 2582 | 191 | 21 | 15 | 0 | **41262** |
| Daisy Hill Hospital | 571 | 9392 | 949 | 42 | 28 | 0 | 0 | **10982** |
| Lurgan Hospital | 56 | 2935 | 175 | 0 | 0 | 0 | 0 | **3166** |
| Undefined* | 62 | 513 | 56 | 0 | 0 | 0 | 0 | **631** |
| Community | 1 | 154 | 2 | 0 | 0 | 0 | 0 | **157** |
| South Tyrone Hospital | 1 | 130 | 13 | 0 | 0 | 0 | 0 | **144** |
| Downe Hospital | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Mullinure Health & Wellbein | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| St Luke's | 0 | 12 | 0 | 0 | 0 | 0 | 0 | **12** |
| | **2842** | **49438** | **3777** | **233** | **49** | **15** | **0** | **56354** |

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

| Location | Radiology | Blood Sciences | Microbiology | Histopathology | Cytology | Blood Bank | Virology | Grand Total |
|---|---|---|---|---|---|---|---|---|
| **Craigavon Area Hospital** | **2151** | **36302** | **2582** | **191** | **21** | **15** | **0** | **41262** |
| Doctor | 1006 | 23900 | 1198 | 66 | 6 | 6 | 0 | **26182** |
| Consultant | 1110 | 7941 | 666 | 115 | 15 | 8 | 0 | **9855** |
| Midwife | 6 | 2062 | 540 | 0 | 0 | 0 | 0 | **2608** |
| Nurse | 29 | 2302 | 178 | 10 | 0 | 1 | 0 | **2520** |
| Pharmacist | 0 | 96 | 0 | 0 | 0 | 0 | 0 | **96** |
| AHP | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Clinical Admin | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| GP | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **1** |
| **Daisy Hill Hospital** | **571** | **9392** | **949** | **42** | **28** | **0** | **0** | **10982** |
| Doctor | 147 | 6884 | 293 | 11 | 20 | 0 | 0 | **7355** |
| Consultant | 359 | 1802 | 233 | 31 | 8 | 0 | 0 | **2433** |
| Midwife | 64 | 556 | 409 | 0 | 0 | 0 | 0 | **1029** |
| Nurse | 1 | 116 | 14 | 0 | 0 | 0 | 0 | **131** |
| Pharmacist | 0 | 32 | 0 | 0 | 0 | 0 | 0 | **32** |
| AHP | 0 | 2 | 0 | 0 | 0 | 0 | 0 | **2** |
| **Grand Total** | **2722** | **45694** | **3531** | **233** | **49** | **15** | **0** | **52244** |

**SIGN OFF REPORTS**

**Time period:** **01/01/2020 to 31/01/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

| UserID | Name | Role | Location | Radiology | Blood Sciences | Microbiology | Histopathology | Cytology | Blood Bank | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by the USI | Personal Information redacted by the USI | Doctor | Craigavon Area Hospital | 226 | 1260 | 153 | 1 | 1 | 1 | **1642** |
| | | Doctor | Craigavon Area Hospital | 126 | 1210 | 193 | 1 | 0 | 0 | **1530** |
| | | Doctor | Craigavon Area Hospital | 86 | 1067 | 100 | 0 | 0 | 0 | **1253** |
| | | Doctor | Craigavon Area Hospital | 91 | 1077 | 82 | 0 | 0 | 1 | **1251** |
| | | Doctor | Craigavon Area Hospital | 0 | 1183 | 1 | 0 | 0 | 0 | **1184** |
| | | Doctor | Craigavon Area Hospital | 91 | 869 | 28 | 2 | 0 | 0 | **990** |
| | | Consultant | Craigavon Area Hospital | 42 | 830 | 43 | 1 | 0 | 0 | **916** |
| | | Consultant | Craigavon Area Hospital | 183 | 646 | 64 | 9 | 2 | 8 | **912** |
| | | Doctor | Craigavon Area Hospital | 10 | 764 | 8 | 0 | 0 | 0 | **782** |
| | | Doctor | Lurgan Hospital | 20 | 694 | 46 | 0 | 0 | 0 | **760** |
| | | Consultant | Craigavon Area Hospital | 50 | 681 | 2 | 1 | 0 | 0 | **734** |
| | | Consultant | Daisy Hill Hospital | 122 | 516 | 63 | 0 | 0 | 0 | **701** |
| | | Doctor | Lurgan Hospital | 3 | 577 | 91 | 0 | 0 | 0 | **671** |
| | | Doctor | Craigavon Area Hospital | 37 | 548 | 58 | 0 | 0 | 0 | **643** |
| | | Consultant | Craigavon Area Hospital | 97 | 450 | 53 | 6 | 5 | 0 | **611** |
| | | Doctor | Craigavon Area Hospital | 1 | 583 | 0 | 0 | 0 | 0 | **584** |
| | | Doctor | Craigavon Area Hospital | 21 | 555 | 3 | 1 | 0 | 0 | **580** |
| | | Doctor | Daisy Hill Hospital | 14 | 537 | 26 | 0 | 0 | 0 | **577** |
| | | Doctor | Craigavon Area Hospital | 0 | 577 | 0 | 0 | 0 | 0 | **577** |
| | | Midwife | Daisy Hill Hospital | 64 | 293 | 197 | 0 | 0 | 0 | **554** |
| | | Doctor | Craigavon Area Hospital | 32 | 481 | 29 | 0 | 0 | 0 | **542** |
| | | Consultant | Craigavon Area Hospital | 108 | 362 | 50 | 14 | 2 | 0 | **536** |
| | | Doctor | Craigavon Area Hospital | 0 | 526 | 3 | 2 | 0 | 0 | **531** |
| | | Midwife | Craigavon Area Hospital | 0 | 345 | 179 | 0 | 0 | 0 | **524** |
| | | Doctor | Daisy Hill Hospital | 1 | 504 | 1 | 0 | 0 | 0 | **506** |
| | | | **Grand Total** | **1425** | **17135** | **1473** | **38** | **10** | **10** | **20091** |

Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

**SIGN OFF REPORTS**

**Time period:** **01/12/2019 to 31/12/2019**

Total Sign Off for all trusts for current month and previous two months

| Trust | October | November | December |
|---|---|---|---|
| Southern | 41383 | 46900 | 48936 |
| Western | 25176 | 29093 | 27867 |
| South-Eastern | 6341 | 6100 | 5833 |
| Belfast | 8253 | 9278 | 8713 |
| Northern | 1611 | 1519 | 1672 |
| **Total** | **82764** | **92890** | **93021** |

Total Sign Off for Southern Trust previous three months

| Month | September | October | November |
|---|---|---|---|
| **Total** | 34155 | 41383 | 46900 |

Total Sign Off per Southern Trust

| Description | Radiology | Blood Sciences | Microbiology | Histopathology | Cytology | Blood Bank | Virology | Total |
|---|---|---|---|---|---|---|---|---|
| **Total** | 2612 | 42324 | 3719 | 192 | 72 | 17 | 0 | **48936** |

Total Sign Off per Location

| Location | Radiology | Blood Sciences | Microbiology | Histopathology | Cytology | Blood Bank | Virology | Total |
|---|---|---|---|---|---|---|---|---|
| Craigavon Area Hospital | 1946 | 31085 | 2650 | 147 | 35 | 17 | 0 | **35880** |
| Daisy Hill Hospital | 436 | 7524 | 726 | 42 | 33 | 0 | 0 | **8761** |
| Lurgan Hospital | 128 | 2725 | 196 | 0 | 0 | 0 | 0 | **3049** |
| Undefined* | 102 | 681 | 136 | 3 | 4 | 0 | 0 | **926** |
| Community | 0 | 177 | 7 | 0 | 0 | 0 | 0 | **184** |
| South Tyrone Hospital | 0 | 122 | 4 | 0 | 0 | 0 | 0 | **126** |
| Downe Hospital | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Mullinure Health & Wellbein | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| St Luke's | 0 | 10 | 0 | 0 | 0 | 0 | 0 | **10** |
| | **2612** | **42324** | **3719** | **192** | **72** | **17** | **0** | 48936 |

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

| Location | Radiology | Blood Sciences | Microbiology | Histopathology | Cytology | Blood Bank | Virology | Grand Total |
|---|---|---|---|---|---|---|---|---|
| **Craigavon Area Hospital** | **1946** | **31085** | **2650** | **147** | **35** | **17** | **0** | **35880** |
| Doctor | 875 | 20406 | 1460 | 32 | 16 | 2 | 0 | **22791** |
| Consultant | 1026 | 6710 | 554 | 115 | 19 | 15 | 0 | **8439** |
| Midwife | 4 | 1834 | 499 | 0 | 0 | 0 | 0 | **2337** |
| Nurse | 41 | 2038 | 137 | 0 | 0 | 0 | 0 | **2216** |
| Pharmacist | 0 | 91 | 0 | 0 | 0 | 0 | 0 | **91** |
| AHP | 0 | 6 | 0 | 0 | 0 | 0 | 0 | **6** |
| Clinical Admin | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| GP | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Daisy Hill Hospital** | **436** | **7524** | **726** | **42** | **33** | **0** | **0** | **8761** |
| Doctor | 113 | 5717 | 209 | 18 | 22 | 0 | 0 | **6079** |
| Consultant | 217 | 966 | 151 | 24 | 11 | 0 | 0 | **1369** |
| Midwife | 106 | 728 | 360 | 0 | 0 | 0 | 0 | **1194** |
| Nurse | 0 | 51 | 3 | 0 | 0 | 0 | 0 | **54** |
| Pharmacist | 0 | 62 | 0 | 0 | 0 | 0 | 0 | **62** |
| GP | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Undefined* | 0 | 0 | 3 | 0 | 0 | 0 | 0 | **3** |
| **Grand Total** | **2382** | **38609** | **3376** | **189** | **68** | **17** | **0** | **44641** |

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**SIGN OFF REPORTS**

**Time period:** **01/12/2019 to 31/12/2019**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

| UserID | Name | Role | Location | Radiology | Blood Sciences | Microbiology | Histopathology | Cytology | Blood Bank | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by the USI | | Doctor | Craigavon Area Hospital | 281 | 2394 | 476 | 0 | 1 | 0 | **3152** |
| | | Doctor | Craigavon Area Hospital | 0 | 1523 | 2 | 0 | 0 | 0 | **1525** |
| | | Doctor | Craigavon Area Hospital | 187 | 976 | 170 | 1 | 0 | 0 | **1334** |
| | | Consultant | Craigavon Area Hospital | 118 | 868 | 128 | 8 | 9 | 0 | **1131** |
| | | Consultant | Craigavon Area Hospital | 45 | 936 | 63 | 0 | 0 | 0 | **1044** |
| | | Consultant | Craigavon Area Hospital | 198 | 700 | 93 | 24 | 3 | 15 | **1033** |
| | | Doctor | Craigavon Area Hospital | 62 | 763 | 74 | 0 | 0 | 0 | **899** |
| | | Midwife | Daisy Hill Hospital | 106 | 419 | 234 | 0 | 0 | 0 | **759** |
| | | Doctor | Craigavon Area Hospital | 1 | 750 | 0 | 0 | 0 | 0 | **751** |
| | | Doctor | Lurgan Hospital | 49 | 593 | 94 | 0 | 0 | 0 | **736** |
| | | Doctor | Craigavon Area Hospital | 52 | 462 | 132 | 1 | 6 | 0 | **653** |
| | | Doctor | Daisy Hill Hospital | 28 | 523 | 42 | 0 | 2 | 0 | **595** |
| | | Consultant | Daisy Hill Hospital | 93 | 429 | 65 | 0 | 0 | 0 | **587** |
| | | Doctor | Craigavon Area Hospital | 12 | 521 | 17 | 0 | 0 | 0 | **550** |
| | | Doctor | Craigavon Area Hospital | 10 | 508 | 31 | 0 | 0 | 0 | **549** |
| | | Doctor | Craigavon Area Hospital | 20 | 508 | 19 | 1 | 1 | 0 | **549** |
| | | Consultant | Daisy Hill Hospital | 88 | 370 | 32 | 10 | 6 | 0 | **506** |
| | | Consultant | Craigavon Area Hospital | 35 | 433 | 33 | 0 | 0 | 0 | **501** |
| | | Consultant | Craigavon Area Hospital | 44 | 421 | 31 | 0 | 0 | 0 | **496** |
| | | Doctor | Daisy Hill Hospital | 3 | 482 | 0 | 0 | 0 | 0 | **485** |
| | | Doctor | Lurgan Hospital | 9 | 423 | 50 | 0 | 0 | 0 | **482** |
| | | Doctor | Daisy Hill Hospital | 15 | 434 | 11 | 0 | 0 | 0 | **460** |
| | | Doctor | Craigavon Area Hospital | 24 | 314 | 106 | 0 | 0 | 0 | **444** |
| | | Midwife | Craigavon Area Hospital | 0 | 283 | 136 | 0 | 0 | 0 | **419** |
| | | Consultant | Craigavon Area Hospital | 110 | 225 | 63 | 13 | 2 | 0 | **413** |
| | | | **Grand Total** | **1590** | **16258** | **2102** | **58** | **30** | **15** | **20053** |

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**SIGN OFF REPORTS**

**Time period:** **01/11/2019 to 30/11/2019**

Total Sign Off for all trusts for current month and previous two months

| Trust | September | October | November |
|---|---|---|---|
| Southern | 34155 | 41383 | 46900 |
| Western | 19280 | 25176 | 29093 |
| South-Eastern | 6974 | 6341 | 6100 |
| Belfast | 6752 | 8253 | 9278 |
| Northern | 1582 | 1611 | 1519 |
| **Total** | **68743** | **82764** | **92890** |

Total Sign Off for Southern Trust previous three months

| Month | August | September | October |
|---|---|---|---|
| **Total** | 32704 | 34155 | 41383 |

Total Sign Off per Southern Trust

| Description | Radiology | Blood Sciences | Microbiology | Histopathology | Cytology | Blood Bank | Virology | Total |
|---|---|---|---|---|---|---|---|---|
| **Total** | 2387 | 40627 | 3597 | 232 | 39 | 18 | 0 | **46900** |

Total Sign Off per Location

| Location | Radiology | Blood Sciences | Microbiology | Histopathology | Cytology | Blood Bank | Virology | Total |
|---|---|---|---|---|---|---|---|---|
| Craigavon Area Hospital | 1786 | 30821 | 2656 | 207 | 32 | 18 | 0 | **35520** |
| Daisy Hill Hospital | 385 | 6701 | 732 | 25 | 7 | 0 | 0 | **7850** |
| Lurgan Hospital | 69 | 2357 | 120 | 0 | 0 | 0 | 0 | **2546** |
| Undefined* | 91 | 364 | 59 | 0 | 0 | 0 | 0 | **514** |
| Community | 1 | 242 | 3 | 0 | 0 | 0 | 0 | **246** |
| South Tyrone Hospital | 55 | 141 | 26 | 0 | 0 | 0 | 0 | **222** |
| Downe Hospital | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Mullinure Health & Wellbein | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| St Luke's | 0 | 1 | 1 | 0 | 0 | 0 | 0 | **2** |
| | **2387** | **40627** | **3597** | **232** | **39** | **18** | **0** | 46900 |

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

| Location | Radiology | Blood Sciences | Microbiology | Histopathology | Cytology | Blood Bank | Virology | Grand Total |
|---|---|---|---|---|---|---|---|---|
| **Craigavon Area Hospital** | **1786** | **30821** | **2656** | **207** | **32** | **18** | **0** | **35520** |
| Doctor | 946 | 18761 | 1443 | 78 | 11 | 0 | 0 | **21239** |
| Consultant | 804 | 7714 | 537 | 125 | 21 | 17 | 0 | **9218** |
| Midwife | 4 | 2173 | 474 | 0 | 0 | 1 | 0 | **2652** |
| Nurse | 32 | 2077 | 202 | 3 | 0 | 0 | 0 | **2314** |
| Pharmacist | 0 | 93 | 0 | 0 | 0 | 0 | 0 | **93** |
| | 0 | 2 | 0 | 0 | 0 | 0 | 0 | **2** |
| Clinical Admin | 0 | 1 | 0 | 0 | 0 | 0 | 0 | **1** |
| GP | 0 | 0 | 0 | 1 | 0 | 0 | 0 | **1** |
| **Daisy Hill Hospital** | **385** | **6701** | **732** | **25** | **7** | **0** | **0** | **7850** |
| Doctor | 112 | 5405 | 124 | 17 | 5 | 0 | 0 | **5663** |
| Consultant | 162 | 454 | 102 | 8 | 2 | 0 | 0 | **728** |
| Midwife | 110 | 672 | 497 | 0 | 0 | 0 | 0 | **1279** |
| Nurse | 0 | 117 | 9 | 0 | 0 | 0 | 0 | **126** |
| Pharmacist | 0 | 51 | 0 | 0 | 0 | 0 | 0 | **51** |
| GP | 1 | 2 | 0 | 0 | 0 | 0 | 0 | **3** |
| **Grand Total** | **2171** | **37522** | **3388** | **232** | **39** | **18** | **0** | **43370** |

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**SIGN OFF REPORTS**

**Time period:** **01/11/2019 to 30/11/2019**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

| UserID | Name | Role | Location | Radiology | Blood Sciences | Microbiology | Histopathology | Cytology | Blood Bank | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by the USI | | Doctor | Craigavon Area Hospital | 82 | 957 | 363 | 0 | 0 | 0 | **1402** |
| | | Doctor | Craigavon Area Hospital | 83 | 1080 | 99 | 0 | 0 | 0 | **1262** |
| | | Doctor | Craigavon Area Hospital | 284 | 564 | 373 | 4 | 0 | 0 | **1225** |
| | | Doctor | Craigavon Area Hospital | 4 | 1064 | 5 | 0 | 0 | 0 | **1073** |
| | | Consultant | Craigavon Area Hospital | 35 | 865 | 100 | 3 | 2 | 0 | **1005** |
| | | Consultant | Craigavon Area Hospital | 173 | 589 | 84 | 23 | 5 | 16 | **890** |
| | | Doctor | Lurgan Hospital | 43 | 656 | 70 | 0 | 0 | 0 | **769** |
| | | Consultant | Craigavon Area Hospital | 43 | 585 | 68 | 0 | 0 | 0 | **696** |
| | | Consultant | Craigavon Area Hospital | 29 | 619 | 23 | 2 | 0 | 0 | **673** |
| | | Midwife | Daisy Hill Hospital | 110 | 340 | 221 | 0 | 0 | 0 | **671** |
| | | Doctor | Craigavon Area Hospital | 20 | 615 | 21 | 1 | 1 | 0 | **658** |
| | | Doctor | Craigavon Area Hospital | 24 | 621 | 4 | 1 | 0 | 0 | **650** |
| | | Doctor | Craigavon Area Hospital | 18 | 544 | 12 | 0 | 0 | 0 | **574** |
| | | Consultant | Craigavon Area Hospital | 30 | 521 | 17 | 0 | 0 | 0 | **568** |
| | | Consultant | Craigavon Area Hospital | 40 | 518 | 7 | 0 | 0 | 0 | **565** |
| | | Consultant | Craigavon Area Hospital | 103 | 371 | 68 | 10 | 3 | 0 | **555** |
| | | Doctor | Craigavon Area Hospital | 189 | 226 | 104 | 2 | 1 | 0 | **522** |
| | | Doctor | Lurgan Hospital | 0 | 441 | 29 | 0 | 0 | 0 | **470** |
| | | Doctor | Craigavon Area Hospital | 0 | 461 | 0 | 0 | 0 | 0 | **461** |
| | | Doctor | Craigavon Area Hospital | 6 | 404 | 14 | 0 | 0 | 0 | **424** |
| | | Doctor | Craigavon Area Hospital | 0 | 412 | 0 | 0 | 0 | 0 | **412** |
| | | Consultant | Daisy Hill Hospital | 68 | 284 | 56 | 0 | 0 | 0 | **408** |
| | | Doctor | Craigavon Area Hospital | 0 | 389 | 1 | 0 | 0 | 0 | **390** |
| | | Doctor | Daisy Hill Hospital | 12 | 349 | 19 | 0 | 0 | 0 | **380** |
| | | Doctor | Craigavon Area Hospital | 6 | 346 | 20 | 0 | 0 | 0 | **372** |
| | | | **Grand Total** | **1402** | **13821** | **1778** | **46** | **12** | **16** | **17075** |

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# LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

## SECTION 1

| | |
|---|---|
| **1. ORGANISATION:** SHSCT | **2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: Complaint** |
| **3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:** | **4. DATE OF INCIDENT/ EVENT: 8t April 2019** |
| **5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS:** No | **6. IF 'YES' TO 5. PLEASE PROVDE DETAILS:** |
| **7. DATE OF SEA MEETING / INCIDENT DEBRIEF:** | **7 August 2019** |

**8. SUMMARY OF EVENT**:

Personal Information redacted by attended the Emergency Department (ED) at Craigavon Area Hospital (CAH) on 8 April 2019 at 13.35. Her presenting complaint was that of nausea, query dehydration, diarrhoea and vomiting. Personal Information was passing fresh or altered blood PR. She had bloods taken and was diagnosed with query gastroenteritis and query overflow diarrhoea. There was no evidence of a clinical obstruction and Personal Information's abdominal examination was noted as unremarkable.

Personal Information was discharged with advice to return if her condition deteriorated. Personal Information was taking laxido at home and she was to attend her General Practitioner (GP) for a review in 1 weeks' time who was to make the necessary referrals if there were ongoing concerns.

Personal Information re-attended ED CAH on 9 April 2019 at 01:20, brought in by ambulance with severe abdominal pain. On examination her abdomen was rigid and she complained of chest pain radiating to her back which was worse on inspiration. She was given a triage priority of 2 (to be seen within 10mins of arrival). An abdominal x-ray was carried out followed by a computerised tomography (CT) scan of her abdomen and pelvis with contrast which showed an obstructing para umbilical hernia.

Following the CT scan Personal Information was admitted to the Ward. Personal Information developed hypoxemic respiratory failure on the ward and was transferred to the Intensive Care Unit (ICU).

Personal Information went to theatre on 10 April 2019 for a laparotomy and the findings were complete bowel obstruction. Personal Information returned to ICU but despite intensive care and support Personal Information redacted s condition continued to deteriorate. Attempts were made to extubate Personal Information on 3 occasions but were unsuccessful and Personal Information passed away on 19 April 2019.



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## SECTION 2

| 9. SEA FACILITATOR / LEAD OFFICER: | 10. TEAM MEMBERS PRESENT: |
|---|---|
| **Dr D Mawhinney -Consultant in Emergency Medicine** | **Dr R Thompson - Consultant Surgeon**<br>**Mr P Smyth - Lead Nurse Emergency Department**<br>**Ruth McParland- Nurse ICU**<br>**Carly Connolly – Acute Governance Manager** |

**11. SERVICE USER DETAILS**:
Personal Inform **year old female**

**12. WHAT HAPPENED?**

Personal Information presented to the ED at CAH on 8 April 2019 at 14:12. Her presenting complaint was that of nausea, query dehydration, diarrhoea and vomiting. It was noted that Personal Information had been passing fresh or altered blood PR and that she had been vomiting. Personal Information advised that her last episode of diarrhoea had been 4 days earlier and it was black in colour. She confirmed that she had not opened her bowels since the previous Thursday. Personal Information advised that she was able to tolerate some food/fluids. A note was also made of Personal Information experiencing crampy abdominal pain. She was given a triage priority of 2, which recommends Personal Information should be seen by a doctor within 10 minutes. Her blood pressure (BP) was 168/101, respiratory rate (RR) 18, temperature 37.5ºc, oxygen saturations ($SpO_2$) 96%, blood sugar (BM) 5.8. Personal Information was alert and her National Early Warning Score (NEWS determines the degree of illness of a patient and prompts critical care intervention.) was recorded 0. Personal Information redacted s BM was repeated at 14:18 and it remained at 5.8.

At 15:30 Personal Information was seen by Dr 1 who noted that Personal Information was a Personal Information year old female with gastro intestinal (GI) upset. Personal Information was wheelchair bound and since the previous Thursday she had been suffering lower crampy abdominal pain and had 2 episodes of black diarrhoea on Thursday. Personal Information advised there was no obvious blood and that she had not had any bowel movement since then although she had passed flatus. Personal Information was noted to have had one episode of vomiting on the previous day and there was no blood in this. It was queried if Personal Information had been having intermittent temperatures at home. Personal Information was not sure about this but stated that she felt hot. It was noted that Personal Information was passing urine normally and she had no lower urinary tract symptoms. Personal Information advised that she had on and off episodes of constipation in the last few weeks. Personal Information advised that she had a decreased appetite for the last few days although she was noted to be drinking well (diarolyte). Personal Information had no cough although she was short of breath at baseline and she had no rash.

On examination, Dr 1 noted that Personal Information's Glasgow coma scale was 15/15 and that she was not in any distress. She had no bleeding in the ED. It was recorded that she did have bilateral leg lymphedema at baseline and there was no change in this. Personal Information was noted to be short of breath on moving to the bed but her chest was clear. She had no cough or wheeze, no creps/cyanosis. Her heart sounds (HS) were normal and a capillary refill time of 2 seconds was noted. Her heart rate (HR) was regular at a rate of 70 beats per minute. Dr 1 noted Personal Information's abdomen was soft and non-tender and there was no evidence of a clinical obstruction. It was noted that Personal Information had a high body habitus and central obesity. Bowel sounds were present. Whilst Personal Information was difficult to examine due to her high body habitus, a midline reducible hernia was felt and noted to be non-tender. There were no other obvious masses. A PR examination took place which confirmed a hard stool at rectum only-faecal impaction, there were no masses and no blood on finger was reported.
Personal Information's past medical history was noted to include, low thyroid function, obesity, cellulitis, oesophageal



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stricture, depression/anxiety, lymphedema, ex-smoker and a para umbilical hernia repair. Personal Information stated that she was treated for "gut strangulation" many years ago, however there was nothing on the clinical system reporting this. Personal Information had a previous paraumbilical hernia repair and her lactate was noted to be 0.9mmol/L.

At 16:20 the results of blood samples were available and confirmed the following:

| Test | Result |
|---|---|
| serum sodium | 137(mEq/l (normal range 135-1450) |
| serum potassium | 4.1(normal range 3.5 -5 mEq/L) |
| serum chloride | 96 (normal range 96-106 mEq/L |
| serum urea | level 4.4 (normal range 2.5 – 7.1 mmol/L) |
| serum creatinine | *43 (normal range 45- 84 umol/L) |
| GFR calculated abbreviated MDRD >60 | (normal range 60 – 150Ml/min) |
| Haemoglobin (Hb) | 126 (normal range 115-160 g/L) |
| Liver Function Test | normal |
| Platelets (plts) | PLts 295 e9/l (normal range 150-150 e9/l) |
| White Cell Count (WCC) | 10.6 e9/l (normal range 4-11e9/l) |
| CRP | 17.76 (normal range 0-5 mg/L) |

At 17:00 Personal Information was reviewed again by Dr 1 who had discussed Personal Information's history and clinical findings with the Specialist Registrar (SR). Dr 1 noted the blood results available. Dr 1 advised Personal Information that they had discussed her case with the SR and that they were happy to allow her home. Personal Information was advised that she needed to return if she had any bleeding, dark stools, temperatures, reduced oral intake, vomiting or signs of dehydration. Personal Information was also advised to double up on her laxative over next few days and make arrangements to attend her GP for review within the next week to ensure resolution, faecal occult blood test (FOB is a test that looks for early signs of bowel cancer) and onward referral if necessary.

At 17:14 hours the results of the ECG were reported as follows, "N*ormal sinus rhythm. Left axis deviation. Moderate low voltage criteria for LVH, may be normal variant. T wave abnormality, consider lateral ischaemia. Abnormal ECG. Noted no CP."* A handwritten note was added to the report 'no chest pain reviewed with registrar'.

There was no NEWS chart commenced and there were no observations documented prior to Personal Information's discharge. The time that Personal Information left the ED is not documented within her notes.

Personal Information re-attended CAH ED at 01:20 on 9 April 2019 brought in by ambulance. Her presenting complaint was severe abdominal pain. Triage noted Personal Information's abdomen feels rigid and she complained of chest pain radiating to her back which was worse on inspiration. At 01:47 her observations were noted as HR 110, BP 113/53, RR 19, temperature 37.2$^{o}$c, $SpO_2$ 96%. Personal Information redacted by was alert and her pain score was 7. Personal Information was triaged as a priority 2 (priority 2 to be seen within 10 minutes).

At 02:00 Personal Information's blood tests were taken. Her serum amylase level was 19u/l (normal range 28-100 u/l and her c-reactive protein (CRP) was 22.08mg/L. She was given 2 Co-codamol 8/500 orally at 05:40.

At 05:47 Personal Information had an abdominal x-ray carried out as well as a chest x-ray.

At 06:40 Personal Information was seen by Dr 2 and her history was noted. Dr 2 noted Personal Information to be a re-attender and unwell for 4-5 days. At this time Personal Information denied any chest pain and was noted to have long standing back



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pain. She had not opened her bowels for 4 days, query passing wind, abdominal distension was noted and 1 episode of faecal vomiting was reported. Her abdomen was soft, distended and tender throughout. The plan was to await the report from the abdominal x-ray and chest x-ray. Her WCC was noted as 14.5 (10.6) and CRP 22 (17) (a blood test markers for inflammation in the body).

The abdominal x-ray reported: *"The examination is poorly penetrated probably due to patient habitus. There are multiple loops of dilated bowel, probably small bowel. The appearances suggest small bowel obstruction."*

Personal Information was referred to the surgical team at 06:50 and at 07:20 Personal Information was assessed by Dr 3 ST1 Speciality Registrar from the surgical team. Dr 3 noted feculent vomiting and that Personal Information had no bowel movements for 5 days. She was still passing flatus. Dr 3 noted that Personal Information had intermittent vomiting which was brown in colour, foul smelling and the last episode was the day previously. Personal Information advised that she was nauseated and had nil by mouth since. Personal Information was clammy and feverish. She had no recent weight loss. Personal Information's past medical history was noted. An abdominal examination noted Personal Information had a distended tympanic (gas filled) and a tender upper abdomen. Her left upper quadrant was guarded and an upper midline laparotomy was noted. The results of her bloods were noted as, HB 142, WCC 14.5, Platelets 385, CRP 22, Na 135, K 3.8, Urea 4.6, CR 63, eGFR >60 and lactate 2.1mmol/L (normal range 0.5-1mmol/L).

A differential diagnosis was made of a small bowel obstruction with a cause of query adhesions.

The management plan was that Personal Information would have IV fluids, nil by mouth, analgesia, and PR when appropriate. Arrangements were made for a computerised tomography of abdomen and pelvis (CTAP) with contrast and that she would be prescribed Tazocin (anti-biotic) given her increased WCC and feelings of being clammy.

At 10:10 Personal Information was seen during the post take ward round by Dr 4 Consultant Surgeon. Personal Information redacted's medical history was revisited and an abdominal examination revealed a soft non tender abdomen. The management plan included CTAP, intravenous fluids, analgesia and the placement of an NG tube if Personal Information had further vomiting.

At 11:55 Personal Information left the ED for her CTAP. Her NEWS score was 2, with HR 92bpm, BP 140/70, RR 17, $SpO_2$ 95%. The CT was completed at 12;22.

At 12:45 Personal Information was admitted to ward 4 North by Nurse 1 under the care of Dr 6 Consultant Surgeon. A nursing assessment and plan of care form was completed Observations were checked on arrival and thereafter and noted as:

| TIME | Temp | Pulse | Resp Rate | Blood Pressure | Sp02 | SupO2 | AVPU | Pain Score | NEWS |
|---|---|---|---|---|---|---|---|---|---|
| Arrival 12:45 | 37 | 102 | 48 | 137/75 | 88 RA | NO | A | 2/3 | 7 |
| 13:00 | 37.5 | 102 | 36 | 170/85 | 99 | 10L | A | | 6 |
| 13:30 | 37.2 | 108 | 40 | 135/70 | 96 Neb | N | A | | 6 |
| 14:00 | 36.5 | 107 | 44 | 120/70 | 92 Neb | N | A | | 6 |
| 14:15 | 37 | 106 | 44 | 109/76 | 95 Neb | N | A | | 8 |
| 15:30 | | | | | | | | | |



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| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 14:45 | 37 | 116 | 40 | 120/70 | 95 | 4L | A | | 8 |
| 15:00 | 37 | 109 | 40 | 97/67 | 96 | 4L | A | | 8 |
| 15:15 | 36.8 | 104 | 40 | 101/68 | 96 | 4L | A | | 7 |
| 15:30 | 36.8 | 107 | 40 | 96/63 | 96 | 4L | A | | 8 |
| 15:45 | 36.5 | 108 | 40 | 118/65 | 99Neb | 4L | A | | 6 |

Nursing documentation on post admission to the ward at 14:20, noted that Personal Information redacted by was a new admission, Personal Information was a Personal Inform year old female presenting with faecal vomiting and the impression was that of a small bowel obstruction. On admission Personal Information's NEWS score had raised to 7. Dr 5 (Surgical Senior House Officer) was on the ward and made aware of Personal Information's raised NEWS score and deterioration on arrival. Bloods including lactate were obtained. Saline and salbutamol nebulisers were given and Personal Information was started on 10 litres of oxygen and the plan was to wait on the CT report.

When Dr 5 Surgical Senior House Officer (SHO) reviewed Personal Information she was alert and fully orientated with a Glasgow coma scale (GCS) of 15/15 (The Glasgow Coma Scale is a neurological scale which aims to give a reliable and objective way of recording the state of a person's consciousness for initial as well as subsequent assessment.) Dr 5 advised that Personal Information's intravenous fluids should be stopped and an NG tube should be inserted and furosemide 40mg was to be given intravenously. Normal saline nebulisers were given as was morphine 2.5mg intravenously. When the NG tube was inserted, Dr 5 aspirated 200ml of faecal liquid from the NG tube and then 100mls free drainage.

The findings of the CT were noted and reported as *"Significant reduction in image quality due to patient habitus and marked artefact from touching side walls. Generally large abdominal girth with generous fatty deposition both within and outside the abdominal musculature. 3.4 cm defect in anterior abdominal wall causing small bowel obstruction. Bilateral pleural effusions with lower lobe pneumonias more prominent on the left than the right. Multiple low attenuating lesions in a poorly visualised liver suggestive of cysts. Generalised degenerative changes but no bony destruction. No further significant pathology identified within the limitations of the examination*." The CT scan confirmed that there was an obstructing para umbilical hernia. Dr 5 asked for a further ECG to be carried out along with weight measurement and left a message for the surgical registrar.

The ECG was carried out at 15:09 and confirmed "Accelerated junctional rhythm. Left axis deviation. Inferior infarct, age undetermined. Abnormal ECG."

At 15:15 Personal Information had a chest x-ray carried out which was reported on as "*Expiratory examination of limited diagnostic value. Possible left basal collapse/consolidation. The tip of the nasogastric tube is not well demonstrated and may be within the region of the gastro-oesophageal junction*."

At 15:20 Personal Information was discussed with the ICU registrar who agreed to come and see Personal Information redacted by

At 15:40 Personal Information was reviewed by Dr 4 and Dr 6, consultant surgeons who noted the findings of the CT scan and documented that Personal Information was on intravenous antibiotics, that she denied abdominal pain, and had an NG tube insitu. An abdominal examination revealed a soft non tender abdomen. It was noted Personal Information was not passing wind, HR was 108, BP 118/65, RR 40 and her $SpO_2$ was 99% on 4 litres of oxygen. The plan was to continue with her antibiotics, nebulisers, chest physio, with a query for theatre. Dr 6 discussed Personal Information's care and plan for an anaesthetic review with Personal Information's husband. It was noted Dr 6 explained to Personal Information's husband that surgery may not be appropriate at the moment and explained the increased risk of surgery due to Personal Information redacted s co-morbidities and surgery may be possible at a later date.

Clinical observations were continued by nursing staff every 15 minutes and recorded as follows:



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| TIME | Temp | Pulse | Resp Rate | Blood Pressure | $Sp0_2$ | SupO2 | AVPU | Pain Score | NEWS |
|---|---|---|---|---|---|---|---|---|---|
| 16:00 | 36.8 | 109 | 40 | 96/62 | 96 | 4L | A | | 8 |
| 16:15 | 36.5 | 107 | 41 | 92/58 | 96 | 4L | A | | 8 |
| 16:30 | 37 | 108 | 41 | 83/57 | 97 | 4L | A | | 9 |
| 16:45 | 37.2 | 114 | 38 | 84/62 | 95 | 4L | A | | 10 |
| 17:00 | 37.2 | 106 | 40 | 110/70 | 96 | 4L | A | | 6 |

At 16:00 an ICU assessment was carried out by Dr 7 Consultant Anaesthetist who noted Personal Information's past medical history and the findings from the CTAP. Dr 7 noted that Personal Information became hypoxic on the ward. The plan was to admit Personal Information to High Dependency Unit (HDU) for Airvo (Airvo is a humidifier with integrated flow generator that delivers warmed and humidified respiratory gases to spontaneously breathing patients) and inotropes support.

At 16:45 nursing documentation noted a NEWS score of 9 taken at 16:30 due to a RR 41; $Sp0_2$ of 97% on 4L of oxygen via nasal specs; BP was 83/57 and a HR of 108. This was escalated again to the surgical registrar. Nil was ordered as Personal Information was accepted by ICU team and staff were awaiting transfer. At 16:45 nursing documentation noted Personal Information stated she felt 'comfortable at present'.

Personal Information was admitted to HDU at 17:09 for AIRVO and inotrope support of hypoxia. The primary diagnosis was respiratory failure and small bowel obstruction due to strangulated hernia, Type 1 diabetes, collapsed bases and obesity hypoventilation. A further review concluded that Personal Information was to be put first on the emergency list the following morning for surgery. A management plan was put in place for AIRVO, to keep flows at >40, aim $p0_2$>9 ($p0_2$ oxygen partial pressure), chest x-ray, Central Venous Catheter (CVC), aim Mean Arterial Pressure (MAP) >70, Personal Information was to remain nil by mouth, NG on free drainage, chest physio, intravenous fluids (IVF), 2 hourly aspirates, bloods and to be consented for theatre.

At 20:00 Personal Information was reviewed by Dr 8 Consultant intensivist Personal Information's history was revisited. Abdominal examination revealed a soft non tender abdomen, no peritonism. Dr 8 discussed Personal Information with Dr 6 and a decision was made to hold off laparotomy until the following morning to be first on the list.

Prior to surgery on 10 April 2019 at 9:30 Personal Information was reviewed by Dr 6 Consultant Surgeon who noted that Personal Information was a very high risk patient who was short of breath even on high flow oxygen. Dr 6 noted that Personal Information was morbidly obese and the associated high risks of surgery were explained to Personal Information and her husband by Dr 6. Dr 6 discussed Personal Information with the ICU team.

On the 10 April 2019 Personal Information proceeded to have a laparotomy, small bowel resection and anastomosis repair of ventral hernia. The findings were that of a complete small bowel obstruction with a scant ventral hernia. The post-operative plan was to nurse Personal Information in ICU. NG tube to stay in for drainage and to suck 4 hourly. Personal Information could have small sips of water and to continue with IV antibiotics.

The post-operative plan was for Personal Information to be nursed in ICU and that her NG tube was to stay in for drainage and "suck" 4 hourly. Personal Information was allowed to have usual sips if capable and she was to be continued on IV antibiotics. Personal Information was transferred back to ICU post operatively.

Post procedure Personal Information remained intubated. Personal Information failed a trial extubation on 12 April 2019 due to basal collapse and hypoventilation. She was subsequently re-intubated for a further 7 days but unfortunately failed a second extubation attempt to non-invasive ventilation due to hypoventilation, comfort



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measures were put in place and Personal Information sadly passed away with her family in attendance on 19 April 2019. Her cause of death was reported on the death certificate as 1a) Cor Pulmonale, b) High Body Mass Index, 2) Para-umbilical Hernia.

## SECTION 3 - LEARNING SUMMARY

**13.** WHAT HAS BEEN LEARNED:

Patient factors

Personal Information was a Personal Inform year old female who was referred to CAH ED by her GP on the 8 April 2018. Her presenting complaint was that of nausea, query dehydration, diarrhoea and vomiting. It was noted that Personal Information had been passing fresh or altered blood PR. Personal Information had a past medical history of anxiety and depression, high Body Mass Index (BMI), hypothyroidism, lymphedema, para umbilical hernia, a hernia repair (1995), and angina. It was noted Personal Information was a wheelchair user due to her multiple co morbidities.

First ED presentation

On Personal Information's first ED attendance medical staff treated Personal Information for gastroenteritis and queried overflow diarrhoea with no clinical obstruction and discharged Personal Information home with laxatives and gave clear advice of when she should return to the ED and to contact her GP for a GI referral. Personal Information re attended CAH ED approximately seven hours after her previous discharge with increased abdominal pain, 1 episode of faecal vomiting and constipation and chest pain radiating to her back which was worse on inspiration.

The Review Team reviewed Personal Information redacted's ED notes on her first attendance to CAH ED. It was agreed Personal Information was triaged 37 minutes after arrival as a priority 2 and seen by medical staff an hour and 17 minutes after triage, outside the Manchester Triage guidelines (10 minutes).The review team recognise there was delay in triage and a delay in the time Personal Information was reviewed by a medical doctor but do not consider this had an impact on the final outcome. The Review Team recognise the ED was overcrowded on the day of 8 April 2019, although there were normal staffing levels, there were 323 patient attendances and 30 bed waits which caused the delay in Personal Information's triage and medical review.

The Review Team acknowledges doctor 1 (Speciality Trainee) completed a detailed history, examination and investigations were requested, this was clearly documented in Personal Information redacted's ED notes. There is no documentation made by ED receptionist or Triage nurse indicating Personal Information had presented with chest pain. It was noted that on doctor 1's examination Personal Information was short of breath on moving but her chest was clear and pulse was regular. It was documented Personal Information had no chest pain symptoms. Personal Information had an ECG completed which was reported normal and a hand written note was made on the report 'no chest pain'. Dr 1 noted the report was reviewed with the registrar.

The Review Team acknowledge Personal Information had a large habitus and that an abdominal examination may have been difficult. However, given Personal Information redacted's symptoms and doctor 1's examination documentation '*benign abdomen examination unremarkable' and 'no clinical* obstruction' the review team concluded a differential diagnosis of gastroenteritis with query overflow diarrhoea was appropriate. The review team considered Doctors 1' decision for discharge was therefore appropriate at this time. The review team concluded doctor 1 gave Personal Information a clear set of instructions for when she should return to the ED and to also attend her GP for follow up; again this was evidently documented in detail by doctor 1 in the ED notes.



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The Review Team are aware a meeting was held with Personal Information redacted's husband and he has enquired why his late wife was discharged home when she was in so much pain. Personal Information redacted's husband also advised Personal Information had an x-ray on her first attendance but she was never given the result prior to her discharge. The Review Team have reviewed the medical notes from Personal Information's first ED attendance and note there is no medical record documented by medical staff that Personal Information was in pain at any time on her first presentation. Additionally the review team acknowledge there was no NEWS chart commenced and there were no clinical observations recorded prior to Personal Information's discharge and therefore no pain score was recorded. The Review Team have identified a NEWS chart should have been commenced and discharge observations recorded prior to discharge and a pain score noted. The Review Team cannot determine had this had happened that the outcome would have been different. The Review Team reviewed Personal Information redacted's medical notes, Northern Ireland electronic care record (NIECR), and picture archiving and communication system (PACS) and there was no record of Personal Information having an x-ray on her first ED attendance. The Review Team can confirm Personal Information redacted by had an abdominal x-ray on her second attendance to ED on 09/04/2019.

2nd ED Attendance.

The Review Team note Personal Information re-attended CAH ED department brought in by ambulance, in the early hours of the following day 9 April 2019 at 01:20 with severe abdominal pain, faecal vomiting, and chest pain radiating to her back which was worse on inspiration. Personal Information was triaged at 01:47 as priority 2 and blood tests and an ECG were performed. The review team note there was a delay in medical review and Personal Information was not reviewed by medical doctor 2 until 06:40, outside the recommended Manchester Triage guidelines.

The Review Team recognises there was a delay in a medical review on Personal Information's second attendance to ED. Again it was noted ED was overcrowded with 39 beds waits at the time of Personal Information's admission and a total of 254 patients presenting to the department on the day. However the review team has determined had Personal Information been seen earlier it would not have changed the management plan or outcome. The review team are of the understanding that Personal Information's symptoms at this time did not warrant immediate surgical intervention and conservative management was appropriate at this time. Personal Information denied any chest pain, but reported longstanding back pain and the appropriate tests and investigations were carried out which confirmed a small bowel obstruction. A plan was made for blood tests, for an abdominal and chest x-ray and surgical review.

The Review Team note doctor 2 completed a full medical examination and followed up with appropriate investigations. The Review Team has determined Personal Information would not have been taken to Theatre during the night due to her presentation at the time. The Review Team recognises Personal Information redacted by's saturations and NEWS score were stable at 2 throughout her time in ED and there was nothing in the medical notes to suggest Personal Information had deteriorated or there was a need for urgent escalation to the surgical team at the time. The Review Team have determined doctor 2's plan for bloods and x-rays and surgical review was appropriate.

The Review Team reviewed doctor 3's medical notes and agree treatment and care and a conservative management plan was appropriate at the time. A differential diagnosis of small bowel obstruction was reasonable and CT CAP was arranged to confirm this.

The Review Team note Personal Information was reviewed by the surgical team again at 10:10 on the post take ward round by doctor 4 and again confirm treatment and care and management plan was appropriate for small bowel obstruction. Personal Information's medical history was revisited and an abdominal examination revealed a soft non tender abdomen. A plan for CT AP, IV fluids, analgesia and nasal gastric (NG) tube if further vomiting was all appropriate at this time. There was nothing untoward documented to escalate for urgent surgical intervention at this time.



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The Review Team acknowledged Personal Information redacted's medical condition suddenly deteriorated following her CT scan. At 11:55 Personal Information attended the X-ray department for a CT. It was recognised by the Review Team it was from this time Personal Information's saturations began to deteriorate, Personal Information was transferred to the ward post CT scan. The Review Team recognises for CTAP to be carried out Personal Information would have had to lie flat and due to her co-morbidities including high BMI, this may have caused Personal Information redacted's saturations to deteriorate and consequent hypoxic state.

The Review Team recognises nursing staff on the ward appropriately escalated Personal Information for medical review on arrival due to a NEWS score of 7. Personal Information was reviewed by doctor 5 Surgical Senior House Officer (SHO) on the ward following admission. Dr 5 revisited Personal Information's history and carried out a thorough examination, reviewed blood results, the CT scan result and observations and recorded a detailed documentation of all. On examination Personal Information was alert and fully orientated with a GCS score of 15/15. However Dr 5 noted Personal Information was unable to complete sentences. Personal Information's airway was noted to be patent, chest examination noted a reduced air entry in the lower base and bilateral wheeze. Personal Information's respiratory rate was noted as 36 and oxygen levels were recorded at 99% on nebuliser. Heart sounds were recorded as normal. Dr 5 noted Personal Information's abdominal examination was difficult due to her body mass, but noted Personal Information had discomfort and tenderness but no guarding was reported. The CT scan confirmed that there was an obstructing para umbilical hernia. The Review Team identified Dr 5's management and care and escalation for an ICU and surgical review was all appropriate given Personal Information's deteriorating medical condition and CT findings of an obstructing para umbilical hernia.

Dr 6 Consultant Surgeon reviewed Personal Information at the request of Dr 5. Dr 6 noted CT findings, clinical observations, and NG tube and antibiotics had commenced. Dr 6 noted Personal Information had a soft non tender abdomen. The Review Team acknowledge that following assessment Dr 6's management plan for continuation of antibiotics and nebulisers, chest physiotherapy, a query for theatre, and for anesthetic review was an appropriate management plan. The ICU team reviewed Personal Information and given Personal Information's deteriorating condition on the ward post CT, a plan was made for Personal Information to transfer to ICU for AIRVO (treatment for spontaneously breathing patients who would benefit from receiving high flow warmed and humidified respiratory gases) and inotrope support (Intensive care patients often require inotropic support to stabilise circulation and to optimise oxygen supply) due to Personal Information's continued hypoxic state.

Overall the Review Team has reviewed the treatment and care provided to Personal Information on the ward by all medical staff and has deliberated all management and care to be appropriate in addressing Personal Information's sudden deteriorating respiratory hypoxic state. Personal Information was transferred appropriately to ICU for intensive care.

At 20:00 Personal Information was reviewed again in ICU by Dr 9 ST4 (Specialty registrar). Personal Information redacted by'S medical history was revisited. Dr 9 noted Personal Information's CT report and bilateral lower lobe pneumonia and a new Acute Kidney Injury (AKI). Dr 9 discussed Personal Information with Dr 6 and the decision was made to hold off on surgery until the following morning given that Personal Information was stable and currently being optimised. A plan was made for Personal Information to be the first on the emergency list following morning.

Personal Information was reviewed the following morning 10 April 2019 by Dr 6 who noted Personal Information was a very high risk patient who was short of breath even on high flow oxygen. Dr 6 explained the risks involved to Personal Information and her husband and documented this.

The Review Team identified Personal Information's medical condition had deteriorated in ICU and the decision was made to hold of laparotomy surgery until the following morning. The Review Team acknowledges Personal Information had multiple co morbidities and was a high risk candidate for surgery. The Review Team acknowledges the risks associated with surgery were explained in detail by Dr 6 and consent was



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obtained for same. The Review Team has reviewed treatment and care in ICU prior to surgery and agrees the decision to hold off surgery until the following morning was appropriate in this case. It was noted by Dr 9 Personal Information's condition was stable although she did need ICU care.

The Review Team has reviewed Personal Information's ICU medical notes post-surgery and acknowledges Personal Information's condition continued to deteriorate despite intensive care and support. Attempts were made to extubate Personal Information on the 12 April 2019 on to AIRVO but failed, it was noted Personal Information became more short of breath and lethargic throughout the day. Following a chest x-ray reporting significant bilateral collapse Personal Information was re-intubated the following day and remained intubated with a further failed attempt to extubate on the 16 April. Personal Information's potassium levels dropped and Personal Information was treated for hypernatremia. It was noted in medical notes by Dr 10 (Consultant Intensivist) that Personal Information's primary issue was failure to breath and cough due to ongoing bibasal collapse and that there was no convincing evidence of active heart failure, this appears to be mechanical failure/ obesity hyperventilation. Dr 10 discussed Personal Information's lack of progress with her husband and explained that there was little chance of reversibility and a further attempt to extubate would be made, however if Personal Information was to fail extubation again it would not be in Personal Information redacted's best interests to re-intubate. It was noted Personal Information's husband agreed as he did not want to prolong Personal Information redacted's suffering.

On the 19 April 2019 a further attempt to extubate to noninvasive ventilation (NIV) was made given the level of support required throughout ICU admission. This was explained to Personal Information and her husband. Regrettably Personal Information failed extubation and passed away later that same day at 15:57. (RIP) A medical death certificate was issued with the cause of death recorded as 1a) Cor Pulmonale, b) High Body Mass Index, 2) Para-umbilical Hernia.

The Review Team would like address Personal Information redacted's husband's question regarding the cause of Personal Information's death stated on the death certificate. To address the question the Review Team requested an opinion from Dr 11, Consultant Intensivist. Dr 11 reviewed Personal Information's medical notes made on the ICU clinical information system and confirmed the clinical diagnosis of 'cor pulmonale' (effectively right ventricular failure) was due to obesity hypoventilation. Dr 11 explained that often 'cor pulmonale' is considered due to an intrinsic lung problem, however in Personal Information redacted's case the problem was not intrinsically Personal Information's lungs but her elevated Body Mass Index (BMI). This was recorded on admission to ICU as 55. Dr 11 determined in his opinion that investigations during Personal Information redacted's ICU stay were unfortunately unhelpful. The echocardiogram was unable to visualise Personal Information's right heart due to body habitus, and brain natriuretic peptide (BNP) was only modestly elevated (BNP test is a blood test that measures levels of a protein called BNP that is made by your heart and blood vessels. BNP levels are higher than normal when you have heart failure). Personal Information redacted's respiratory problem was the reason Personal Information was admitted to HDU/ICU and this was also why Personal Information failed an initial trial of extubation. Dr 11 concluded that hypoventilation over a prolonged period of time ultimately causes right heart failure which in his opinion is impossible to reverse. The medical death certificate lists the issues from a clinical point of view that led to Personal Information's death.

**14.** WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

The report will be shared with all staff involved in Personal Information's treatment and care for reflection and learning.

**15. RECOMMENDATIONS (please state by whom and timescale)**

1. Morbidly obese patients attending the SHSCT radiology departments **must** be accompanied and monitored by a doctor familiar with the patient. The patient should be transferred with appropriate monitoring equipment to maintain patient safety and facilitate rapid turnaround



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within the department.'

2. The report will be presented at ED, Surgical and Medical mortality and morbidity (M&M) meeting for learning.

3. The report will be shared with nursing ED staff to highlight the importance of commencing a NEWS chart and recording of observations prior to discharge.

**16.** INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

**17.** FURTHER REVIEW REQUIRED? NO
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

**SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)**

**18.** PLEASE INDICATE LEVEL OF REVIEW:
LEVEL 2 / LEVEL 3
**Please select as appropriate**

**19.** PROPOSED TIMESCALE FOR COMPLETION:
DD / MM / YYYY

**20.** REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:

**21.** TERMS OF REFERENCE *(If known or submit asap)*:

**SECTION 5**

**APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR**

**22.** NAME: Melanie McClements

**23.** DATE APPROVED:

**24.** DESIGANTION:

Interim Director of Acute Services



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**SECTION 6**

**25. DISTRIBUTION LIST:**

Personal Information redacted's husband via Patient Client Council.
Director of Acute Services.
Assistant Director for Medicine and Unscheduled Care
Assistant Director for Surgery
Assistant Director for ED.
Heads of Service for ED, Medicine and Unscheduled Care and Surgery
The Review Team
Staff involved in Personal Information's management and care.

DRAFT



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## Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

| Reporting Organisation SAI Ref Number: | | HSCB Ref Number: | |
|---|---|---|---|

| SECTION 1 | | | | | |
|---|---|---|---|---|---|
| **INFORMING THE SERVICE USER[1] / FAMILY / CARER** | | | | | |
| 1) Please indicate if the SAI relates to a single service user, or a number of service users.<br>**Please select as appropriate (✓)** | **Single Service User** | | **Multiple Service Users*** | | |
| | **Comment:**<br>***If multiple service users are involved please indicate the number involved*** | | | | |
| 2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| | If **YES**, insert **date informed**: | | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI | | | | |
| | a) No contact or Next of Kin details or Unable to contact | | | | |
| | b) Not applicable as this SAI is not 'patient/service user' related | | | | |
| | c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | | | |
| | d) Case involved suspected or actual abuse by family | | | | |
| | e) Case identified as a result of review exercise | | | | |
| | f) Case is environmental or infrastructure related with no harm to patient/service user | | | | |
| | g) Other rationale | | | | |
| | **If you selected c), d), e), f) or g) above please provide further details:** | | | | |
| 3) Was this SAI also a Never Event?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| 4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event?<br>**Please select as appropriate (✓)** | **YES** | If **YES**, insert **date informed**: DD/MM.YY | | | |
| | **NO** | If **NO**, provide details: | | | |
| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)** | | | | | |
| **Content with rationale?** | **YES** | | **NO** | | |

| SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER<br>*(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)* | | | | |
|---|---|---|---|---|
| 5) Has the Final Review report been shared with the Service User[1] / Family / Carer?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert date informed: | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer: | | | |
| | a) Draft review report has been shared and further engagement planned to share final report | | | |

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| SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER<br>*(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)* | | |
|---|---|---|
| | b) Plan to share final review report at a later date and further engagement planned | |
| | c) Report not shared but contents discussed<br>(***if you select this option please also complete 'l' below***) | |
| | d) No contact or Next of Kin or Unable to contact | |
| | e) No response to correspondence | |
| | f) Withdrew fully from the SAI process | |
| | g) Participated in SAI process but declined review report | |
| | ***(if you select any of the options below please also complete 'l' below)*** | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer | |
| | i) case involved suspected or actual abuse by family | |
| | j) identified as a result of review exercise | |
| | k) other rationale | |
| | l) If you have selected **c), h), i), j), or k)** above please provide further details: | |

| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)** | | | | |
|---|---|---|---|---|
| **Content with rationale?** | **YES** | | **NO** | |

| SECTION 2 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)* | | | | | | | |
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | | | |
| | If **YES**, insert **date informed**: | | | | | | |
| | If **NO**, please provide details: | | | | | | |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | | | |
| | If **YES**, insert **date report shared**: | | | | | | |
| | If **NO**, please provide details: | | | | | | |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | **N/A** | | **Not Known** |
| | If **YES**, insert **date informed**: | | | | | | |
| | If **NO**, please provide details: | | | | | | |

| **DATE CHECKLIST COMPLETED** | |
|---|---|

[1] *Service User or their nominated representative*



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# LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

## SECTION 1

| | |
|---|---|
| **1. ORGANISATION:** SHSCT | **2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Personal Information redacted by USI |
| **3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:** | **4. DATE OF INCIDENT/ EVENT: 17 July 2018** |
| **5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS:** No | **6. IF 'YES' TO 5. PLEASE PROVDE DETAILS:** |
| **7. DATE OF SEA MEETING / INCIDENT DEBRIEF: 07 August 2019** | |

**8. SUMMARY OF EVENT**:

Patient 92 was referred to Craigavon Area Hospital Emergency Department on 2 November 2017 by her GP for a productive cough, lethargy, sweats and back pain for 2 months. Patient 92 was admitted to the ward and treated for a urinary tract infection (UTI) and poor diabetic control. Patient 92 was discharged home the following day with a plan for an outpatient renal tract ultrasound scan (USS). Patient 92 had her USS on 16 November 2017 which reported further investigation was required to exclude renal malignancy.

Patient 92 had a follow up CT renal abdominal scan on the 28 November 2017. The CT scan reported that appearances most likely represented areas of renal inflammation, and likely infected renal cysts with probable abscess formation and that the appearances were not typical for underlying malignancy (cancer).

Patient 92 was contacted and advised to attend CAH ED for treatment of same. Patient 92 attended CAH ED and was admitted to the ward for treatment of an infected renal cyst. Prior to her discharge a follow up outpatient urology review appointment was arranged for 6 weeks and a repeat CT renal abdominal scan in 3 months' time.

Patient 92 never received a follow up urology outpatient review appointment. Patient 92 had a repeat CT scan on 13 March 2018 which reported a solid nodule suspicious of renal cell carcinoma. There was no follow up following CT report.

Patient 92 attended her GP on the 10 July 2018 complaining of right sided abdominal pain. Patient 92's GP noted the overlooked CT report and immediately forwarded a red flag urology referral to Craigavon Area Hospital.

## SECTION 2

| | |
|---|---|
| **9. SEA FACILITATOR / LEAD OFFICER:** | **10. TEAM MEMBERS PRESENT:** |
| Dr Damian Gormley –Consultant Physician | **Ms Wendy Clayton- Operational Lead**<br>**Mrs Katherine Robinson -Booking and Contact** |



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| | |
|---|---|
| | **Centre Manager**<br>**Mrs Carly Connolly -Clinical Governance Manager** |

**11. SERVICE USER DETAILS**:
H&C [redacted]

**12. WHAT HAPPENED?**

[redacted] is a [redacted] year old female who was referred by her GP to Craigavon Area Hospital Emergency Department (CAH) (ED) on 2 November 2017. [redacted]'s presenting complaint was a productive cough, lethargy, sweats and a 2 month history of back pain. [redacted] complained of chest tightness at times, and was noted to have a high temperature with a CRP of 100 (a blood test to check for inflammation). [redacted] was reviewed by Dr 1 and was transferred to the ward for treatment of a urinary tract infection (UTI) and poor diabetic management. [redacted] was treated with antibiotic Trimethoprim and discharged home later the same day with a plan for an abdominal and renal tract ultrasound scan (USS) to be carried out as an outpatient on the 16 November 2017.

On the 16 November 2017 [redacted] attended CAH X-ray department for an ultrasound scan of the abdomen and renal tract. The report concluded a '*solid mass measuring 2.5cm at the upper pole of the left kidney required further investigation and to exclude renal malignancy'*. A urology review and CT imaging was advised.

On the 23 November 2017 [redacted] was added to the cancer tracker system following her recent ultrasound result on 16 November 2017. [redacted] was offered an outpatient urology appointment for 4 December 2017 at 09:00.

On the 28 November 2017 [redacted] attended CAH X-ray department for a CT renal and abdomen scan. The CT report concluded the following:

"*Two areas of altered enhancement within the left kidney as described with surrounding inflammatory change. Appearances are most likely to represent areas of renal inflammation likely infected renal cysts with probable abscess formation. Appearances are not typical for underlying malignancy.*
*In absence of significant left-sided hydro nephrosis (swelling of the kidney) the areas of calcification within the pelvis are unlikely to represent ureteric calcification (stones) and likely to represent phelboliths (*calcification within a vein*). A clinical correlation is advised and follow up ultrasound following appropriate treatment is advised."*

On the 29 November 2017 [redacted] was contacted at home by Dr 2 with regards to the CT scan result and advised [redacted] to attend CAH ED and that she would be under the care of the urology team. [redacted] was admitted to the gynaecology ward under the care of Dr 3, Consultant Urologist and treated with IV Gentamicin for an infected renal cyst. [redacted] complained of an ongoing chronic cough during her admission which was noted that her GP was already investigating. A recent chest x-ray taken on 2 November 2017 was reviewed which showed no acute suspicious lung abnormality. [redacted] was discharged on 7 December 2017 on oral antibiotics with a plan for follow up at Dr 3's outpatient clinic in 6 weeks and a CT renal scan for 3 months' time.

Due to lengthy waiting lists [redacted] never received a review appointment at Dr 3's outpatient urology clinic.



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On the 13 March 2018 Patient 92 attended CAH X-ray department for a CT renal with contrast. The CT scan was reported on 20 March 2018. Result below:

*"Routine multi plane imaging of the kidneys.*
*No evidence of renal or ureteric calculi (stones). The right kidney is normal. The 4.9 cm cystic area with surrounding inflammation and posterior aspect of the left kidney has resolved. There is very minimal residual soft tissue change. The 2.6 cm enhancing nodule in the left mid-pole is unchanged and more keeping in keeping with the solid nodule rather than an abscess. No localised lymphadenopathy (inflammation/swelling). No free fluid in the upper abdomen. The pancreas and liver appear unremarkable. The lung bases are clear. No focal bony abnormality".*

*Conclusion:*
*"The abscess has resolved. The solid nodule is suspicious for a Renal cell carcinoma*."

On 20 March 2018 the Radiology Department forwarded an email to Dr 3 and his secretary (sec1) and secretary 2 for follow up of the CT report.

On the 7 July 2018 Patient 92 contacted the General Practitioner Out Of Hours (GP OOH). Personal Infor presenting complaint was abdominal pain which had increased. Patient 92 was advised to attend CAH ED as there was no doctor in the GP OOH Craigavon base.

On the 10 July 2018 Patient 92 attended CAH ED and was reviewed by Dr 4. It was noted in the ED triage notes Patient 92 had moderate right sided abdominal pain for 2 days, with no vomiting and no diarrhoea. She was treated for a urinary tract infection (UTI) and discharged home with antibiotics and referred back to her GP.

On the 17 July 2018 Patient 92 attended her GP with mild right sided pain. On examination the GP noted her abdomen was soft, with very mild tenderness on deep palpation only. Patient 92's GP accessed Personal Inf Northern Ireland electronic care record (NIECR) (a database which contains patient health information) and noted the CT scan in March 2018 which suggested a 2.5cm solid nodule suspicious for renal cell carcinoma (cancer). Patient 92's GP immediately forwarded a red flag (suspect cancer referral) urology referral to CAH.

On the 6 August Patient 92 was reviewed at the outpatient urology clinic and was reviewed by Dr 5. Dr 5 discussed the CT scan result carried out in March 2017 and a plan was made for a Magnetic Resonance Imaging (MRI) renal and for Patient 92 to be reviewed again with the result.

On the 17 August 2018 Person attended CAH for a MRI. The report concluded:

CONCLUSION: "No subtraction imaging. 2.3 cm left renal tumour. There are no features to allow reliable categorisation but some increased T2 signal change suggests it may represent a clear cell carcinoma."

On the 30 August Patient 92 was discussed at the urology Multi -Disciplinary Meeting (MDM). A plan was made to review Person at urology outpatients and discuss a biopsy.

On the 25 September Patient 92 had a CT chest. The conclusion was no metastatic disease within the thorax.

On the 4 October 2018 Patient 92's case was discussed at urology MDM. It was agreed Patient 92 was suitable for all treatment options and to proceed with a partial nephrectomy in CAH.



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On 15 October 2018 Patient 92 was admitted to CAH for partial laparoscopic nephrectomy (partial kidney removed) for a 2.8cm renal mass. It was reported Patient 92 recovered well on the ward with no complications. Patient 92 was deemed medically fit for discharge home on 19 October 2018 with a plan for urology MDM review and histopathology.

Histopathology reported the following :

Histological examination shows a circumscribed and predominantly encapsulated tumour demonstrating features in keeping with papillary renal cell carcinoma, type I.

## SECTION 3 - LEARNING SUMMARY

**13.** WHAT HAS BEEN LEARNED:

The review team reviewed Patient 92's first CAH ED attendance on 3 November 2017. The Review Team concluded treatment and care provided in CAH ED and on the ward was appropriate given Patient 92's presenting symptoms and the plan for an outpatient ultrasound scan was considered appropriate. The Review Team acknowledges Patient 92 had her ultrasound scan 13 days post discharge. This was considered by the Review Team an appropriate time frame for follow up.

The Review Team recognise the result of the ultrasound scan was appropriately followed up the following day by Dr 2 and arrangements were made for Patient 92 to have an urgent CT abdomen and pelvis scan to exclude renal malignancy on the 28 November 2017. The report was available the following day.

The Review Team identified Patient 92 was appropriately referred on to the cancer tracker system on the 23 November but unfortunately did not attend her appointment on 4 December 2017 due to her inpatient status under the care of the Urology Team.

The review team has reviewed Patient 92's medical notes from her admission on 29 November 2017 to her discharge on the 7 December 2017, and considers treatment and care during this period was appropriate. The Review Team recognises results were appropriately followed up by doctor 2 and appropriate arrangements were made for Patient 92 to re-attend CAH ED and to be admitted under the care of the urology team. Patient 92 was admitted to the Gynecology ward under the care of doctor 3, Consultant Urologist. Patient 92 was treated for an infected cyst with antibiotics. Patient 92 was discharged home with antibiotics on the 7 December 2017 with a plan to be followed up at Dr 3's outpatient clinic in six weeks and a follow up CT renal scan in three months' time. The Review Team has concluded a differential diagnosis of an infected renal cyst was appropriate following the CT report on 29 November 2017 and has therefore considered treatment and care, and discharge arrangements were all appropriate at the time.

The Review Team has reviewed the Patient Administration System (PAS) and confirmed Patient 92 was added to Dr 3's urgent urology outpatient waiting list following discharge on 7 December 2017. The Review Team acknowledges there are demand and capacity issues with Urology outpatient appointments, and waiting lists are extremely lengthy (currently 3 years). The Review Team acknowledge clinics are scheduled in advance, and recognise doctor 3's clinics may not have been



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scheduled that far ahead. With no outpatient clinic scheduled it would have being impossible for medical staff to ascertain Patient 92 would be appointed an outpatient appointment in six weeks' time. Patient 92 was therefore added to Dr 3's urgent urology waiting list which at the time had a waiting time of 96 weeks. Conversely, the Review Team concluded had Patient 92 been reviewed six weeks post discharge the management plan may not have changed given the recent CT scan result reporting an infected renal cyst and treatment received.

On 13 March 2018 Patient 92 attended CAH X-ray department for a CT renal with contrast. The Review Team note the report was finalised on the 20 March 2019 at 14:05. The Review Team have confirmed communication was emailed to the referring Consultant Urologist Dr 3 and his secretary (secretary 1) and an additional secretary 2 (secratary1 was off on leave) on the same day 20 March 2018 at 14:54.The email advised all correspondents an urgent report for Patient 92 was available on Sectra Radiology Information System (RIS). The Review Team have identified Patient 92's report was completed in a timely manner and escalated to the referring consultant immediately by the Radiology Team. The Review Team on the other hand cannot confirm Dr 3 read the report. Secretary 2 has advised the Review Team that in incidents like this one whereby an urgent report is emailed, the secretary would print off the report and leave in the consultant's office for follow up. The Review Team therefore can neither confirm or rule out Dr 3 received the email or a paper copy of the actual report.

The Review Team acknowledge the Trust has an escalation policy for urgent/ significant or unexpected findings and although the Radiology Department did notify the referring consultant (Dr 3) that same day, the Radiology Department did not escalate Patient 92's CT report to the Cancer Tracker Team as per Trust policy. The Review Team note this was a missed opportunity for follow up of Patient 92's urgent CT report. The Review Team concluded had Dr 3 acknowledged and responded to the email from the Radiology Department and had the Radiology department escalated the result to the Cancer Tracker Team Patient 92 would have received treatment for her cancer at an earlier stage.

The Review Team are aware the Trust has no formal process for tracking letters or emails to ensure they have been received, acknowledged, reviewed or actioned. Although the Radiology Team communicated the CT findings to Dr 3 and the 2 secretaries there was no follow up from the Radiology Department to ensure the correspondence was actually received and actioned. The Review Team recognises consultants receive numerous emails each day and this in itself presents difficulty in identifying priority correspondence. The Review Team therefore conclude the SHSCT should consider updating its current policy to ensure all correspondence relating to urgent/ significant findings are received and actioned by recipients. The Review Team also contemplate consultant secretaries should ensure the consultant has received any paper correspondence left out for them, especially when it is an urgent report needing immediate action.

Current practice regarding tests results is that the clinician who orders the test is responsible for reviewing, following up and signing off the result even if the patient is discharged. The Review Team recognise the SHSCT does not have a single formal process for following up of test results and electronic sign off and therefore conclude the SHSCT should consider developing a system and process that will enable referring consultants to manage requested test results electronically. The system should report back to the referring clinician, highlighting any urgent results and offer options for follow up and electronic sign off. The system should be capable of providing assurance that results are viewed and actioned.



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The Review Team acknowledges Patient 92 attended CAH ED hospital on the 10 July 2018 and was reviewed by Dr 4. Patient 92 was treated for a urinary tract infection (UTI) and discharged home with antibiotics and referred back to her GP. It was only when Patient 92 attended her GP a few days later with the same complaint, was the missed CT scan report identified and appropriate action was taken by the GP via red flag referral for follow up.

The Review Team conclude there were a number of failings in the Trust's systems and processes which ultimately lead to a delay in diagnosis and treatment and care of Patient 92's cancer. Exacerbated waiting lists, no single formal processes for following up test results, and no formal process for tracking letters or emails were undoubtedly contributing factors. The review team concluded that treatment and care was appropriate following Patient 92's new GP referral on the 17 July 2018 which highlighted Patient 92's overlooked CT report.

**14.** WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

The report will be shared with all staff involved in Patient 92's treatment and care for reflection and learning.

**15.** RECOMMENDATIONS (please state by whom and timescale)

1. The SHSCT to review its current processes of communicating, recording and signing off suspected cancer diagnosis to patient's consultants. The Trust is to consider a system in which results can be communicated to referring clinicians and electronically signed off by the referring consultant.

2. The Radiology Department is to review their procedure for 'Reporting & Communicating of Critical, Urgent & Significant Unexpected Radiological Findings' to include guidance to outline the processes required to ensure all correspondence is appropriately received and acknowledged.

3. The Review Team acknowledges Urology waiting lists are extensive and this was a contributing factor in this incident. The Review Team therefore advises the Trust to consider implementing a management plan to reduce Urology waiting times.

4. The SHSCT needs to cautiously review and update its current practice for tracking clinical correspondence.

**16.** INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

**17.** FURTHER REVIEW REQUIRED? NO
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.



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| **SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A <u>FURTHER REVIEW IS</u> REQUIRED)** | |
|---|---|
| **18.** PLEASE INDICATE LEVEL OF REVIEW:<br>LEVEL 2 / LEVEL 3<br>**Please select as appropriate** | **19.** PROPOSED TIMESCALE FOR COMPLETION:<br>DD / MM / YYYY |
| **20.** REVIEW TEAM MEMBERSHIP *(If known or submit asap)*: | |
| **21.** TERMS OF REFERENCE *(If known or submit asap)*: | |

| **SECTION 5** | |
|---|---|
| **APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR** | |
| **22.** NAME: | **23.** DATE APPROVED: |
| **24.** DESIGANTION: | |

**SECTION 6**

**25.** DISTRIBUTION LIST:

Patient 92
Director of Acute Services
Assistant Director of Acute Service
Medical Director for Surgery and Elective Care
Assistant Director of Surgery and Elective Care
Head of Service for Urology
Head of Service for Radiology
The review team.
Staff involved in Patient 92's care.



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## Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

| | | | |
|---|---|---|---|
| **Reporting Organisation SAI Ref Number:** | | **HSCB Ref Number:** | |

| **SECTION 1** | | | | | |
|---|---|---|---|---|---|
| **INFORMING THE SERVICE USER[1] / FAMILY / CARER** | | | | | |
| 1) Please indicate if the SAI relates to a single service user, or a number of service users.<br>**Please select as appropriate (✓)** | **Single Service User** | | **Multiple Service Users*** | | |
| | **Comment:**<br>***If multiple service users are involved please indicate the number involved*** | | | | |
| 2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| | If **YES**, insert **date informed**: | | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI | | | | |
| | a) No contact or Next of Kin details or Unable to contact | | | | |
| | b) Not applicable as this SAI is not 'patient/service user' related | | | | |
| | c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | | | |
| | d) Case involved suspected or actual abuse by family | | | | |
| | e) Case identified as a result of review exercise | | | | |
| | f) Case is environmental or infrastructure related with no harm to patient/service user | | | | |
| | g) Other rationale | | | | |
| | **If you selected c), d), e), f) or g) above please provide further details:** | | | | |
| 3) Was this SAI also a Never Event?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| 4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event?<br>**Please select as appropriate (✓)** | **YES** | If **YES**, insert **date informed**: DD/MM.YY | | | |
| | **NO** | If **NO**, provide details: | | | |
| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)**) | | | | | |
| **Content with rationale?** | **YES** | | **NO** | | |

| **SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER**<br>***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*** | | | | |
|---|---|---|---|---|
| 5) Has the Final Review report been shared with the Service User[1] / Family / Carer?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert date informed: | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer: | | | |



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| SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER<br>*(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)* | | |
|---|---|---|
| | a) Draft review report has been shared and further engagement planned to share final report | |
| | b) Plan to share final review report at a later date and further engagement planned | |
| | c) Report not shared but contents discussed<br>***(if you select this option please also complete 'l' below)*** | |
| | d) No contact or Next of Kin or Unable to contact | |
| | e) No response to correspondence | |
| | f) Withdrew fully from the SAI process | |
| | g) Participated in SAI process but declined review report | |
| | ***(if you select any of the options below please also complete 'l' below)*** | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer | |
| | i) case involved suspected or actual abuse by family | |
| | j) identified as a result of review exercise | |
| | k) other rationale | |
| | l) If you have selected **c), h), i), j), or k)** above please provide further details: | |

| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate** (✓)) | | | | |
|---|---|---|---|---|
| **Content with rationale?** | **YES** | | **NO** | |

| SECTION 2 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)** ***(complete this section for all death related SAIs)*** | | | | | | | |
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death?<br>**Please select as appropriate** (✓) | **YES** | | **NO** | | | | |
| | If **YES**, insert **date informed**: | | | | | | |
| | If **NO**, please provide details: | | | | | | |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner?<br>**Please select as appropriate** (✓) | **YES** | | **NO** | | | | |
| | If **YES**, insert **date report shared**: | | | | | | |
| | If **NO**, please provide details: | | | | | | |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed?<br>**Please select as appropriate** (✓) | **YES** | | **NO** | | **N/A** | | **Not Known** |
| | If **YES**, insert **date informed**: | | | | | | |
| | If **NO**, please provide details: | | | | | | |

| **DATE CHECKLIST COMPLETED** | |
|---|---|

[1] *Service User or their nominated representative*



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**APPENDIX 4**

Revised November 2016 (Version 1.1)

**Commented [KP1]:** No anaesthetist on the panel and recommendations have implications for anaesthetist.

## LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

### SECTION 1

| | |
|---|---|
| **1.** ORGANISATION:<br>**SH&SCT** | UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: **ID:** Personal Infor |
| **2.** HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:<br>Personal Information | **3.** DATE OF INCIDENT/EVENT:<br>**02/10/2019** |
| **4.** PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / **NO**<br>***Please select as appropriate*** | **5.** IF 'YES' TO 5. PLEASE PROVDE DETAILS: |

**6.** DATE OF SEA MEETING / INCIDENT DEBRIEF:

30 October 2019, 12 November 2019, 11 December 2019

**7.** SUMMARY OF EVENT:

Personal year old female had a severe dental phobia and required dental treatment in hospital under general anaesthetic (GA). The permanent teeth planned for extraction were un-restorable due to extensive dental decay or were of poor long-term prognosis. The upper right second molar (UR7) was extracted in error as it was mistaken for the upper right first molar (UR6). This was caused by the upper right first molar (UR6) being mistaken for the upper right second deciduous (baby tooth) molar (URE) which had already fallen out.

### SECTION 2

| | |
|---|---|
| **8.** SEA FACILITATOR / LEAD OFFICER:<br><br>Marita Magennis, Clinical & Social Care Governance Co-ordinator, CYPS | **9.** TEAM MEMBERS PRESENT:<br><br>Marita Magennis, Clinical & Social Care Governance Co-ordinator, CYPS<br>Sarah Foy, Clinical Director of Community Dental Services<br>Emma Jane Kearney, Lead Nurse, Theatres |

**10.** SERVICE USER DETAILS:

DOB: Personal Information redacted by the USI
Gender: F
Age: Personal years

**11.** WHAT HAPPENED?

XX was referred to the Community Dental Service (CDS) by her General Dental Practitioner (GDP) requesting treatment on three adult molar teeth and two adult incisor teeth under inhalation sedation. The GDP had provided treatment on XX's upper right first molar, under local anaesthetic in surgery, however XX had found it difficult to co-operate for this treatment. The GDP was also unable to take bitewing radiographs to fully assess the extent of decay due to XX's level of co-operation.

Following an initial assessment by CDS a plan was agreed to provide the restorative treatment (fillings) that XX required under inhalation sedation and XX would then have a general anaesthetic to have the extraction of the upper right 6 and lower left 6.

XX had several appointments with the CDS between 5 September 2018 and 10 April 2019, when a referral was made to place her on the list for all remaining treatment, including fillings and extractions, under general anaesthetic.

On 10 April 2019 XX and her mother reported to CDS further pain and infection to lower left 6. It was noted that XX had four courses of amoxicillin. XX was provided with treatment under inhalation sedation, on administration of local anaesthetic XX was observed to be tearful. Treatment of upper right 1 could not be completed as XX reported pain on decay removal. XX also found the sensation of local anaesthetic to be difficult to tolerate and perceived this as painful. The Community Dentist 1 advised XX and her mother that it would be appropriate to have a general anaesthetic for extraction of upper right 6, upper left 6 and lower left 6, and filling of upper right 1 and lower right 6. A general anaesthetic was deemed appropriate due to multiple extractions, XX's anxiety and potential difficult extractions.

A referral was made to Special Care Dentistry General Anaesthetic list at the General District Hospital. The theatre listing form was completed with patient details. A note was made for an urgent appointment due to XX's severe pain and previous courses of antibiotics. The listing form was reviewed by two Senior Dental Officers. Teeth for extraction were amended on the form to include the upper right E (first baby molar) "from charting". XX was listed for general anaesthetic at the General District Hospital.

On 2 October 2019 XX attended the General District Hospital with her mother for treatment under general anaesthetic. XX was second on the list. It was noted by Dental Nurse 1 (DN1) that XX was very anxious prior to the general anaesthetic. Community Dentist 2 re-confirmed consent with XX and her mother regarding treatment required to be carried out. Pre-op checks were completed and pre-med analgesia given to XX by Theatre Nurse 1. XX was then seen by the Anaesthetist. Gas induction was commenced with support of mum. Laryngeal mask airway applied. World Health Organisation checklist/Time out completed. Charting was not completed and treatment was commenced. DN1 enquired if charting was going to be carried out, however it was decided a charting was not required for the following reasons:

1. XX had previously co-operated to have charting completed in the dental clinic on 10 April 2019.
2. Radiographs were available.
3. No additional needs, other than dental phobia, were identified.

Community Dentist 2 queried whether there was possible decay in upper left 7 on radiographs. Community Dentist 3 was in agreement that no decay was present and this tooth did not require restoration/treatment. Upper right 1 and lower right 6 restored.

Community Dentist 2 discussed with Community Dentist 3 that the "upper right 6" was restored, however this discussion was being carried out under the mistaken identification of this tooth as the upper right E (baby molar). This tooth had a metal filling present on the radiograph. Both the upper right E and upper right 6 had previously had metal fillings.

Community Dentist 2 and Community Dentist 3 discussed using the radiograph (dated 19/09/18) and queried whether there would be space for the adult tooth following extraction of the upper right 6 and upper right E.

Upper right 7 was extracted under the belief it was the upper right 6. Upper right 6 was extracted under the belief it was the upper right E.

Following extraction of the 'upper right 6', Community Dentist 2 realised that the root morphology (shape) was not that of a deciduous tooth and that two adult molars had been removed rather than one adult molar and one deciduous molar. Dental Nurse 1 realised from Community Dentist 2's reaction that something wasn't right and Community Dentist 2 then asked Community Dentist 3 to confirm the remaining extractions. Community Dentist 3 reported that she was aware at this point that something was unusual, however was unsure what the issue was and confirmed remaining teeth for extraction.

Community Dentist 2 asked Dental Nurse 2 to look at the extracted teeth again and then finally asked the anaesthetist if she could check the patient again to confirm to herself the teeth that had been removed.

XX recovered from the procedure without any further concerns. Community Dentist 2 informed XX's parents regarding the extraction of an adult tooth by mistake. This communication occurred prior to XX's parents being brought round to recovery. Community Dentist 2 reaffirmed to XX's parents that an adult tooth had been removed in error and this may have orthodontic implications.

XX and her parents received post-operative instructions and, following review by Community Dentist 2, XX was discharged from General District Hospital.

**12. WHY DID IT HAPPEN?**

The audit identified that XX's upper right E had fallen out naturally prior to the general anaesthetic appointment. The upper right 6 was then mistakenly identified as the upper right E. Due to this error the upper right 7 was identified as the upper right 6 and was extracted. The upper right 6 was extracted (mistakenly identified as the upper right E).

The audit team conclude that the removal of the upper right 7 was caused by the misidentification of the upper right 6 as the upper right E. The audit team consider that there were several points where this mistake could have been identified if additional checks had been implemented or different processes were in place.

Prior to XX attending for her general anaesthetic, paperwork had been completed to place her on the list. The audit team noted that this had been annotated, after the referring dentist had completed it, by another senior dentist who reviewed the chart to confirm that a general anaesthetic at the General District Hospital was appropriate. The audit team noted that the upper right E was added for extraction and consider that this entry introduced an element of confusion. In addition the entry was not dated and the audit team consider that had a date been in place, it may have raised a question on the day of surgery, as it was several months

prior to the GA.

The audit team identify that the theatre listing form should be specific for each type of list the Community Dental service runs, rather than a generic template to cover all three types of list. This template should not have any of the information altered after it has been sent to General District Hospital for processing.

The audit team note that the treatment plan was completed on the template several months prior to XX's general anaesthetic appointment due to the waiting list times. As such, it was not acknowledged that XX's mouth could have changed between examination and treatment. This is of particular importance when children are in the mixed dentition phase (both adult and baby teeth) as XX was, and also for those children requiring a general anaesthetic for their dental treatment.

It is recognised that a patient's oral health and treatment needs have the potential to change, in particular when there is a longer wait for a general anaesthetic. The treatment required on the day should be confirmed following a dental charting when the patient is under general anaesthetic.

## SECTION 3 - LEARNING SUMMARY

1. WHAT HAS BEEN LEARNED:

Task Factors

1. Length of time from initial referral to treatment under general anaesthetic.

   The audit team considered the fact that while there appeared to be a lengthy wait between 31/08/18 to 02/10/19, XX had several appointments during this time where treatment was being completed under inhalation sedation and a plan had been agreed to try to restore XX's teeth prior to a general anaesthetic for extractions. This had been progressing however, due to XX's anxiety, this was not completely successful.

   Commented [KP2]:

2. There was appropriate treatment planning and XX was referred for her remaining treatment under general anaesthetic at an appropriate time.

3. The audit team note that the theatre listing form was reviewed by six different clinicians who had annotated this form, however dates were not noted by three of the clinicians and it was not clear who or what their role was. The upper right E had been added to teeth for extraction based on charting by a dentist who did not have any direct contact with XX.

4. World Health Organisation Checklist/Timeout was completed. Essential imaging recorded as not applicable. The audit team note that this was inaccurate as radiographs were available.

5. The radiograph used was taken on 19 September 2018. Discussion occurred in theatre relating to the continued eruption of teeth following the removal of the upper right E (present on the film), and whether there would be room for the permanent tooth to come through. By this stage the upper right E had already fallen out. The audit team note that the there was a lack of acknowledgment by dental staff in relation to the potential for change in the child's mouth since the radiograph was taken.

6. Full dental charting was not completed. This was discussed and the decision was made that this was not required for the following reasons: XX was able to co-operate for a dental exam in clinic; there were radiographs available; and no additional needs that could have made a dental exam in clinic more difficult. The dental charting and treatment was taken from the theatre listing form. The audit team note that in the absence of charting on the day, there was no confirmation of the teeth present.

Working Conditions Factor

1. Due to a power cut over night, equipment alarms in theatre were sounding and required to be checked prior to list starting, which delayed the starting time of the list.

2. A work experience student was present to observe the general anaesthetic list and approval documentation was required to be completed by dental staff. This reduced the amount of time available to dental staff to review XX's notes prior to the general anaesthetic.

3. The audit team note that an additional urgent patient had been added to the special care dentistry list prior to XX, which usually only contains two patients. This additional patient was agreed in advance with operating clinicians and included in the team brief at the beginning of the list and as such did not impact on the treatment of XX.

4. Dental Nurse 1 was arranging cover for other clinics due to bereavement absence and was occupied doing this.

Communication Factors

1. Documentation: Paediatric Theatre Nursing Care Pathway. The cover page has a section for Nurse, Anaesthetist and Dentist to tick to confirm child has been reviewed prior to being brought to theatre. The audit team note that this was not completed by the nursing and anaesthetic staff.

2. The WHO checklist. The audit team note that this checklist was not fully completed by the responsible member of the theatre team.

3. Following the wrong tooth extraction, Theatre staff was not informed that this had occurred. Community Dentist 2 made this decision to prevent disruption to the running of the remaining list.

4. XX's parents were informed of the error prior to being brought to see XX in recovery. This potentially caused additional worry to XX's parents as they could have been concerned there had been an issue with the general anaesthetic aspect of her care.

Policy & Procedures

The audit team consider that the National and Local Safety Standards for Invasive Procedures (LocSIPP) are relevant in relation to this incident. The audit team acknowledge that whilst the LocSIPP are endorsed by the National Health Service in England, they are not operational in Northern Ireland. The audit team consider that the LocSIPP provide a recognised standard of good practice which is referenced in the General Dental Council guidance for good practice. These standards have been introduced to promote patient safety and prevent never events, including wrong tooth extraction. These standards provide structure for the treating clinician to check they are removing the correct tooth and empower other staff to challenge if they have concerns about what is happening. The audit team recommend that use of these standards will improve patient safety and reduce the risk of wrong tooth extraction.

The audit team have identified that there was good practice in relation to the team brief prior to commencing the list and effective communication between all staff regarding the patients to be treated on that day. The WHO checklist was used and Time Out carried out. There is evidence that all pre-operative checks were completed. The dental and theatre notes are detailed and thorough. In addition, the review team note that staff involved in the incident were open and honest with the family, in line with the requirements of duty of candor. The dental team also followed up with XX's General Dentist, Orthodontist and referring community dentist in relation to potential future orthodontic complications.

- WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

The audit team commend the staff who engaged in the audit process for their open and honest reflections on their practice. The audit team consider that a number of human factors contributed to the incident occurring and recommend training for staff in relation to human factors and their impact on patient safety.

The audit team recommend that National and Local Safety Standards for Invasive Procedures (LocSIPP) are fully implemented in accordance with Royal College of Surgeon England guidance. Many of the changes identified below will be addressed through the implementation of LocSIPP.

**Task Factor:**

The audit team have established that the template for theatre listing is used for three different GA lists.

The audit team recommend that:

- A different template is used for each general anaesthetic list.
- When the template has been completed and forwarded to the scheduler, no amendments will be made to any treatment plan on the template or any other details.
- There will be space for senior dental officers and anaesthetists to sign and date to confirm patient suitable for general anaesthetic.
- Staff member completing WHO checklist needs to ensure they confirm with operating surgeon if essential imaging is available and it has been displayed where the surgical team can view images.
- Date radiograph taken should be confirmed verbally during timeout regarding

essential imaging.
- All sections of care pathway to be completed by all relevant professionals, including sections which are "not applicable/no".

**Environmental factors:**

The audit team recommend:

- Staff to reflect and consider outside influences that may affect concentration in theatre in accordance with LocSIPP.
- Work experience staff should only be facilitated in theatre if there is a dental nurse to accompany them who would be surplus to the list.
- Tasks associated with the general anaesthetic list will be given priority.

**Clinical Practice:**

The audit team recommend:

- Dental charting to be completed for all patients under general anaesthetic prior to beginning treatment.
- Treatment plan to be confirmed in theatre, following dental charting.
- Confirmed treatment plan will be transcribed in a highly visible way so all surgical/theatre team are able to view clearly, in accordance with LocSIPP.

**Communication:**

The audit team recommend:

- Staff to ensure good communication by adhering to sign out and LocSIPP. This should include review of what went well, what could be improved/what did we learn after every case. Dentist to communicate any issues identified.
- Parents should be reunited with patients as soon as they are ready in recovery to reduce potential for undue distress.

7. RECOMMENDATIONS (please state by whom and timescale)

1. Review Standard operating procedure for dental treatment of patients under general anesthetic in the community dental service to incorporate changes to practice as detailed above. Primarily the need for full dental charting and implement Local Safety Standards for Invasive Procedures.

   By whom: Head of Community Dental Service by March 2020.

2. Learning from audit to be shared with the Community Dental Service and theatre.

   By whom: Head of Community Dental Service and Head of Theatres by February 2020.

3. Human Factors training for all staff involved in the theatre dental list.

   By whom: Head of Community Dental Service by April 2020.

**Commented [KP3]:** Difficulty with this recommendation – from anaesthetic view point. Don't need a GA to look at patients teeth. This will impact the length of time of the procedure.
The longer the procedure – more intervention will be required. It's the ALL patients is the problem should be targeted for patients at risk only.

**Commented [KP4]:** Not workable for all staff

| |
|---|
| 4. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:<br><br>Introduction of Local Safety Standards for Invasive Procedures. |
| 5. FURTHER REVIEW REQUIRED? **NO**<br>Please select as appropriate<br><br>If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6. |

| **SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)** | |
|---|---|
| 6. PLEASE INDICATE LEVEL OF REVIEW:<br>LEVEL 2 / LEVEL 3<br>**Please select as appropriate** | 7. PROPOSED TIMESCALE FOR COMPLETION:<br>DD / MM / YYYY |
| 8. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*: | |
| 9. TERMS OF REFERENCE *(If known or submit asap)*: | |

| **SECTION 5** | |
|---|---|
| **APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR** | |
| 10.NAME: CYPS & Acute Services Senior Management Team (SMT) | 11.DATE APPROVED: |
| 12.DESIGANTION:<br><br>Senior Management Team | |

| **SECTION 6** |
|---|
| 13.DISTRIBUTION LIST:<br><br>Director of CYPS and Director of Acute Services, Southern Health & Social Care Trust (SHSCT), the staff associated with the care of XX, the Health & Social Care Board (HSCB), Public Health Agency (PHA), and XX's parents. |

**Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident**

| | | | |
|---|---|---|---|
| **Reporting Organisation SAI Ref Number:** | **ID:** Personal Inform | **HSCB Ref Number:** | Personal Inform |

| **SECTION 1** | | | | | | |
|---|---|---|---|---|---|---|
| **INFORMING THE SERVICE USER[1] / FAMILY / CARER** | | | | | | |
| 1) Please indicate if the SAI relates to a single service user, or a number of service users.<br>**Please select as appropriate (✓)** | **Single Service User** | x | **Multiple Service Users*** | | | |
| | **Comment:**<br>***If multiple service users are involved please indicate the number involved*** | | | | | |
| 2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI?<br>**Please select as appropriate (✓)** | **YES** | x | **NO** | | | |
| | If **YES**, insert **date informed**:<br>**11.10.19 & 17.10.19** | | | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI | | | | | |
| | a) No contact or Next of Kin details or Unable to contact | | | | | |
| | b) Not applicable as this SAI is not 'patient/service user' related | | | | | |
| | c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | | | | |
| | d) Case involved suspected or actual abuse by family | | | | | |
| | e) Case identified as a result of review exercise | | | | | |
| | f) Case is environmental or infrastructure related with no harm to patient/service user | | | | | |
| | g) Other rationale | | | | | |
| | **If you selected c), d), e), f) or g) above please provide further details:** | | | | | |
| 3) Was this SAI also a Never Event?<br>**Please select as appropriate (✓)** | **YES** | **x** | **NO** | | | |
| 4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event?<br>**Please select as appropriate (✓)** | **YES** | 26/11/19 | | | | |
| | **NO** | If **NO**, provide details: | | | | |
| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)** | | | | | | |
| **Content with rationale?** | **YES** | | **NO** | | | |

| **SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER**<br>***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*** | | | | |
|---|---|---|---|---|
| 5) Has the Final Review report been shared with the Service User[1] / Family / Carer?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | x |
| | If **YES**, insert date informed: | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer: | | | |
| | a) Draft review report has been shared and further engagement planned to share final report | | | |
| | b) Plan to share final review report at a later date and further engagement planned | | | x |

| SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER<br>*(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)* | | |
|---|---|---|
| | c) Report not shared but contents discussed<br>***(if you select this option please also complete 'l' below)*** | |
| | d) No contact or Next of Kin or Unable to contact | |
| | e) No response to correspondence | |
| | f) Withdrew fully from the SAI process | |
| | g) Participated in SAI process but declined review report | |
| | ***(if you select any of the options below please also complete 'l' below)*** | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer | |
| | i) case involved suspected or actual abuse by family | |
| | j) identified as a result of review exercise | |
| | k) other rationale | |
| | l) If you have selected **c), h), i), j), or k)** above please provide further details: | |

| **For completion by HSCB/PHA Personnel Only** (Please select as appropriate (✓)) | | | | |
|---|---|---|---|---|
| **Content with rationale?** | **YES** | | **NO** | |

| SECTION 2<br>**INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)* | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | x | | | |
| | If **YES**, insert **date informed**: | | | | | | |
| | If **NO**, please provide details: | | | | | | |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | | | |
| | If **YES**, insert **date report shared**: | | | | | | |
| | If **NO**, please provide details: | | | | | | |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | **N/A** | | **Not Known** |
| | If **YES**, insert **date informed**: | | | | | | |
| | If **NO**, please provide details: | | | | | | |

| **DATE CHECKLIST COMPLETED** | **11 February 2020** |
|---|---|

[1] *Service User or their nominated representative*

**LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST**

**SECTION 1**

| | |
|---|---|
| **1. ORGANISATION:** SHSCT | **2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Personal Info |
| **3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:** | **4. DATE OF INCIDENT/ EVENT: 23/05/2019** |
| **5. PLEASE INDICATE IF THIS SAI IS**<br>**6. INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS:** No | **7. IF 'YES' TO 5. PLEASE PROVDE DETAILS:** |
| **8. DATE OF SEA MEETING / INCIDENT DEBRIEF:** | **13/09/2019** |

**9. SUMMARY OF EVENT**:

Personal Information is a Personal year old male who presented to Daisy Hill Hospital (DHH) Emergency Department (ED) on 21 May 2019 with shortness of breath and hematemesis (vomiting of blood) with a query of aspiration (breathing in a foreign object). Personal Information was reviewed and admitted to male surgical ward for treatment for upper gastro intestinal bleed (UGIB) and aspiration under the care of the medical team.

On the 23rd May 2019 at 02:00 Personal Information's condition deteriorated and it was reported Personal Information had a constant high NEWS score (determines the degree of illness of a patient and prompts critical care intervention) between 8-10 throughout the day. Nursing staff highlighted their concerns to the medical team and Personal Information was reviewed by a number of junior doctors during the day. Personal Information's condition continued to deteriorate despite commencing on RUSH system (high flow oxygen therapy). At 23:50 it was noted Personal Information was hypoxic and the decision was made to change treatment from RUSH system to AIRVO system (treatment for spontaneously breathing patients who would benefit from receiving high-flow warmed and humidified respiratory gases). The physiotherapy team were contacted to instigate AIRVO treatment.

It was reported there were no beds available in high dependency unit (HDU) for Personal Information and staff were advised to set up the Aivro system on the ward in the side room Personal Information was occupying. Nursing staff highlighted their concerns regarding the appropriateness and risks associated with managing an AIRVO patient on the ward. It was reported to the bed manager that staff were not competently trained on the AIRVO system nor did they have adequate staffing levels to provide one to one monitoring and care. Despite nursing concerns a decision was made to set up the AIRVO system on the ward, and a HDU nurse was transferred to assist Personal Information on Airvo. Personal Information was to remain under the care of the ward nurses care.

The following day 24 May 2019 the issue was highlighted to day staff and Personal Information was immediately transferred to HDU for management and care on the AIRVO system as per Trust procedure.

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**SECTION 2**

| **10. SEA FACILITATOR / LEAD OFFICER:** | **11. TEAM MEMBERS PRESENT:** |
|---|---|
| Kay Carroll- Head of Cardiology | *Caroline Bagnel Bed manager*<br>*Maria Meagher – Staff nurse*<br>*Sharon Smith - Staff nurse*<br>*Marion Bullers – Clinical Sister*<br>*Josie Matthews – Lead Nurse*<br>*Carly Connolly- Clinical Governance Manager* |

**12. SERVICE USER DETAILS**: Personal Information

**13. WHAT HAPPENED?**

Personal Information is a Personal year old male patient who presented to Daisy Hill Hospital (DHH) Emergency Department (ED) on 21 May 2019 with shortness of breath, hematemesis with a query of aspiration and an abnormal pulse (115). Personal Information was triaged and seen by ED Doctor 1 who then contacted the medical on call consultant for review. Personal Information was reviewed by the medical and surgical teams and was subsequently admitted to a side room in the male surgical ward under the care of the medical team for treatment for an upper gastro intestinal bleed (UGIB) and aspiration.

At 02:00 on the 23 May 2019 Personal Information's condition deteriorated and a NEWS score of 8 and the nurse escalated her concerns to the medical doctor and awaited a review.

Personal Information was reviewed by Dr 2 junior doctor (first year trainee doctor) at 3:00, Personal Information's NEWS score was reported to be 8. Dr 2 noted he discussed Personal Information with Dr 3 who advised to continue with the same management plan, repeat bloods, repeat Atrial Blood Gas (ABG), and to give paracetamol 500mg. Dr 3 advised to re-contact if there were any concerns.

Personal Information was reviewed by Dr 4 at 11:40. Personal Information's history was revisited. Personal Information'S ABG bloods were noted, it was noted Personal Information's NEWS was 8. Dr 4 noted Personal Information denied any chest pain and palpitations and it was noted Personal Information was SOB and had an ongoing cough. Dr 4's plan was to continue with antibiotic tazocin, aim $SpO_2$ at 88-92% ($SpO_2$ is an estimated amount of oxygen in the blood), to recheck arterial blood gas (ABG) (AGC is blood levels of oxygen and carbon dioxide in the arteries), repeat bloods the next day and for a chest x-ray. A 12:10 nursing documentation noted Personal Information's NEWS score was 8. Medication and IV antibiotics were given as prescribed. It was noted Personal Information was reviewed by the medical team and aware of Personal Information's NEWS score and the plan was for a chest x-ray, chest physiotherapy and repeat ABG.

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| Date | Time | Respiratory Rate (RR) | Oxygen Saturations ($SpO_2$) | Temperature | Blood Pressure (BP) | Heart Rate(HR) | NEWS SCORE |
|---|---|---|---|---|---|---|---|
| 23/05/2019 | 02;00 | 20 | 88%on 40% $O_2$ | 38.1 | 180/90 | 114 | 8 |
| 23/05/2019 | 02:15 | 20 | 95% on 40 % | 38 | 160/70 | 105 | 5 |
| 23/05/2019 | 02:45 | 20 | 94% on 60% | 38.2 | 158/86 | 115 | 7 |
| 23/05/2019 | 03:45 | 20 | 94% on 60% | 38.7 | 159/84 | 115 | 7 |
| 23/05/2019 | 04:45 | 20 | 91% on 60% | 39.1 | 135/70 | 125 | 9 |
| 23/05/2019 | 05:45 | 20 | 94% on 60% | 39 | 135/70 | 120 | 8 |
| 23/05/2019 | 06:45 | 20 | 95% on 60% | 39 | 135/65 | 125 | 8 |
| 23/05/2019 | 07:30 | 20 | 97% on 60% | 39 | 135/60 | 118 | 6 |
| 23/05/2019 | 08:10 | 20 | 92%on 60% | 39.1 | 155/70 | 128 | 8 |
| 23/05/2019 | 09:10 | 20 | 95% on 60% | 38.2 | 154/69 | 128 | 6 |
| 23/05/2019 | 10:35 | 20 | 92% on 60% | 38.4 | 145/70 | 132 | 8 |
| 23/05/2019 | 11:40 | 20 | 92% on 60% | 38.4 | 145/60 | 132 | 8 |
| 23/05/2019 | 12:10 | 20 | 91% on 60% | 38.8 | 150/70 | 127 | 8 |
| 23/05/2019 | 14:10 | 20 | 82% on 60% | 37.1 | 140/70 | 127 | 7 |
| 23/05/2019 | 15:20 | 20 | 82% on 60% | 37.6 | 130/70 | 130 | 8 |
| 23/05/2019 | 16:40 | 20 | 88% on 90% | 38.2 | 135/70 | 122 | 8 |
| 23/05/2019 | 17:20 | 20 | 88 on 90% | 38 | 145/70 | 125 | 8 |
| 23/05/2019 | 18:20 | 20 | 88 on 90% | 37.9 | 108/55 | 120 | 8 |
| 23/05/2019 | 20:45 | 20 | 92 on 90% | 37.6 | 160/80 | 106 | 5 |
| 23/05/2019 | 21:45 | 20 | 88 on 90% | 37.3 | 155/80 | 115 | 7 |
| 23/05/2019 | 22:45 | 20 | 93 on 90% | 37.4 | 155/80 | 105 | 5 |
| 23/05/2019 | 23:45 | 20 | 88 on 90% | 37 | 160/90 | 115 | 7 |

Personal Information was reviewed by the pharmacist and advised Personal Information needed a review of his electrolytes. Following the pharmacist's review Personal Information was seen again by Dr 4. Personal Information's blood results were noted. Doctor 4 noted a plan for Intravenous (IV) magnesium and IV phosphate and to repeat bloods again the following morning.

Personal Information was reviewed at 15:40 by Dr 5, It was noted Personal Information's NEWS score remained high. Doctor 5 planned for a review of the chest x-ray and to continue with same treatment for now. Personal Information was reviewed again at 16:00 by Dr 5. Personal Information's high NEWS score of 8 was noted. Dr 5 noted she had



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discussed [redacted] with Dr 6 and the physiotherapists. The decision was then made to commence [redacted] on RUSH system as his $p0_2$ level (reflects the amount of oxygen gas dissolved in the blood) was still reduced and there was no indication of $CO_2$ retention. A plan was made for a repeat ABG that evening and Dr 5 would handover this to the F1 doctor to do. At 16:20 [redacted] was reviewed by the physiotherapist who noted [redacted] was discussed with medics and to aim stats at 94%, on RUSH 80%, $0_2$ at 10 litres. ABG was to be repeated that evening. The plan was if $pO_2$ was still reduced, then to increase oxygen to 90% and repeat ABG. It was recorded that if [redacted] remained hypoxic to consider AIRVO treatment.

[redacted] was reviewed by Dr 7 at 19:15. Dr 7 noted [redacted] was handed over to repeat ABG at 8pm but the nurse had requested and earlier review as [redacted] remained hypoxic on RUSH at 90%. Dr 7 noted [redacted] reported ongoing left iliac fossa (LIF) pain, and there was no change in shortness of breath. Dr 7 noted coarse crackles in the left lung. An abdominal examination was done and it was noted to be soft, tender suprapubically, there was no guarding, a supra umbilical hernia was noted to be reducible, bowel sounds were present, and cough impulse was present. Dr 7's impression was query aspiration secondary to vomiting/ hematemesis. Doctor 7's plan was to continue with IV antibiotics, repeat ABG and discuss with senior house officer (SHO) to consider a repeat chest x-ray.

[redacted] was reviewed by Dr 2 at 23:50. Dr 2 documented a hand over had been given advising to repeat ABG. Doctor 2 noted [redacted] was non-compliant with the RUSH system. Doctor 2 noted she returned to complete ABG after [redacted] had tolerated the RUSH system for 1 hour. Doctor 2 noted an increase in $pCO_2$ levels and $pO_2$ reduced, it was noted [redacted] was not acidotic, and stats had reduced to 85.6%. Dr 2 stated [redacted] was for AIRVO as he was still hypoxic despite RUSH system at 90%. Dr 2 discussed [redacted] with specialist registrar (SpR) Dr 8 and following this call, the Out of Hours Physiotherapist was contacted and agreed to set up AIRVO system.

On the 24 May 2019 at 00:05 nursing documentation noted the bed manager was informed of the decision for [redacted] to be managed on AIRVO and his high dependency needs. Nursing notes documented awaiting HDU bed availability.

On 24 May 2019 at 1:00 [redacted] was reviewed by senior Dr 8. Doctor 8 noted [redacted]'s history was known, [redacted] had deteriorated on RUSH system and therefore a decision was made for AIRVO. Dr 8 documented in his notes there was 'no bed in HDU and that [redacted] was to remain in the side room on ward'.

At 2:45 nursing notes documented that the AIRVO system was set up by the physiotherapist. It was noted [redacted] remained in a side room and that the bed manager was informed of [redacted]'s high dependency needs for monitoring and observation and that he was not tolerating AIRVO. It was noted nurse 1 was informed by the bed manager there was no possibility that [redacted] would be moved to HDU or extra staff would be provided to monitor. The nurse informed the bed manager that she was not trained on AIRVO system nor was she able to provide one to one care as she had 8 other patients to nurse. It was reported [redacted] was reviewed by the medical registrar Dr 8 and due to no beds available in HDU the decision was made for [redacted] to remain in the side room on the ward. The bed manager was informed and advised to facilitate appropriate staff to manage AIRVO system. It was finally agreed a HDU nurse would facilitate the management of [redacted] alternating from HDU to ward.

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At 04:10 Personal Information was reviewed by Dr 9. Dr 9 noted Personal Information 's history was known. Dr 9 noted issues with desaturating stats at 85.6% on RUSH system at 90%. Dr 9's plan was to continue with AIRVO, add in saline nebs and for a chest physiotherapy review in the morning. Dr 9 advised to transfer Personal Information to HDU when a bed was available, repeat ABG, and to continue with antibiotics and aim for stats between 88-92%.

Personal Information was reviewed again at 07:00 by Dr 2. Dr 2 noted AVIRO (BS) 35L and ABG results . Dr 2 noted he/she was advised by the senior nurse and HDU nurse that Personal Information was non-compliant with AIRVO. The importance of ARVIO was stressed to Personal Information again by Dr 2. Dr 2 advised nurses to use a urinal instead of mobilising Personal Information to the bathroom without AIRVO and to repeat ABG again at 9:00.

Personal Information was reviewed by the ward physiotherapist. It was noted Personal Information was on AIRVO 35L at 80% $O_2$. It was noted he was to be transferred to HDU.

At 10:30 nursing documentation noted Personal Information was transferred to HDU on AIRVO 35L 78% $0_2$. NEWS was noted to be 9.

**SECTION 3 - LEARNING SUMMARY**

**14.** WHAT HAS BEEN LEARNED:

**Patient Factors**

Personal Information was a Personal year old male at the time of the incident. Personal Information presented to DHH ED with shortness of breath, an abnormal pulse, and hematemesis with query aspiration.

**Regional Policy**

It was brought to the review team's attention that there is no regional policy for the management of patients on Airvo system. It was highlighted during the meeting that this is a work in progress and anticipates the presentation of a new policy in the future. The Trust's current practice for management of patients on Airvo system is that patients are to be transferred to HDU for AIRVO monitoring and management. The Airvo system must be set up by a competently trained nurse/ physiotherapist and the patient is to remain in HDU for continuous oxygen saturation monitoring by competently trained nursing staff.

**Communication**

The review team have identified Personal Information 'S condition deteriorated on the 23 May 2019 in DHH Male Surgical Ward. Personal Information 's NEWS score was noted to be high (NEWS 8) by nursing staff in the early hours of the morning and remained high throughout the day. The review team identified Personal Information 's NEWS score remained high and was reviewed by a number of junior doctors at the request of nursing staff. However junior doctors and nursing staff did not escalate to a Senior Consultant for review.



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Personal Information was subsequently commenced on RUSH system at 16:00 as his oxygen levels remained low. The review team recognise that following commencement of the RUSH system, Personal Information's condition did not improve and his NEWS score continued to remain high. It was ascertained by the review team junior doctors did not escalate their concerns to a senior member of staff earlier in the day. The review team acknowledge Personal Information was reviewed by junior doctor 2 at 23:50 who then finally contacted a senior member of staff (Dr 8) who advised Personal Information was still hypoxic despite RUSH at 90% and to commence on AIRVO. Following discussion with Dr 8, Dr 2 appropriately contacted the Out of Hours Physiotherapist to commence AIRVO treatment as per Trust procedure.

After reviewing Personal Information's medical notes the review team conclude the junior doctors should have prioritised and escalated their concerns to a more senior doctor earlier in the day for advice. In hindsight this would have allowed time for medical staff to plan ahead for AIRVO treatment and secure a bed in HDU before handover had taken place. The review team concluded Dr 8 should have prioritised and reviewed Personal Information following his telephone discussion with Dr 2 regarding Personal Information's deteriorating hypoxic state and expedited transfer to HDU for AIRVO.

The review team acknowledge that following the decision to commence AIRVO treatment, Dr 2 appropriately contacted the Physiotherapy Department to commence AIRVO and nursing staff contacted the bed manager to advise of the plan and that Personal Information required a bed in HDU for AVIRO management and treatment. However following this discussion the bed manager advised nursing staff there were no beds available in HDU for Personal Information and advised he would have to remain on the ward side room whilst on AIRVO. The review team acknowledge nursing staff appropriately escalated their concerns to the bed manager about the risks involved, i.e. nursing staff on the ward were not competently trained on the AIRVO system and there were inadequate staffing levels on the ward to provide one to one care and monitoring. The review team recognise AIRVO patients should be managed and cared for in HDU for one to one continuous monitoring of oxygen saturations and management and that the decision to manage Personal Information in a side room on the ward was inappropriate and unsafe practice.

Following the review meeting with all staff involved it became apparent that there was a potential bed available in HDU for Personal Information to be appropriately managed on AIRVO system. It was reported at the bed managers meeting earlier that evening that there was one suitable patient (patient x) in HDU with an infection who could potentially be transferred to an isolated ward side room. HDU nursing staff were made aware following handover earlier in the night that patient X could potentially be transferred out to a ward side room but advised the review team they were not contacted on the night of the 23 May 2019 regarding a HDU bed availability for Personal Information.

Following discussion it was highlighted that the bed manager attended the bed meeting earlier that evening and was conscious of HDU bed availability. However, the bed manager advised she was hesitant to transfer an infectious patient on to a ward due to infection control purposes and the risks involved and therefore did not contact HDU nursing staff. After discussion it was unanimously agreed by all staff that transferring patient X into an isolated room on the ward would have been appropriate and safe and presented less risk compared to managing a hypoxic patient on AIRVO system in a ward side room under the care of nursing staff neither competently trained or able to provide one to one monitoring and care.



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As per the Trust's standard practice for continuous oxygen monitoring and management of AIRVO system on the DHH site, the review team concluded arrangements should have been made for patient X to be transferred from HDU to the isolated side room on the ward to allow Personal Information s transfer to the HDU for AIRVO management and care.

The Trust's standard operating procedure is that every ward completes a night report prior to handover. The purpose of this is to highlight patients who require an urgent senior review prior to handover. Personal Information had a NEWS score of 8 and therefore should have been highlighted in the report for a senior consultant review and an earlier management plan. After review of the incident the review team concluded that Personal Information had a high NEWS score throughout the day and ideally should have had a senior review earlier in the day. This would have allowed earlier anticipation of the need for AIRVO treatment and a proactive plan for implementation of same. The review team conclude Personal Information should have been discussed and prioritised at medical handover and escalated to a senior consultant for urgent review.

**15.** WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

Patients on Airvo should always be managed in HDU for continuous oxygen saturation monitoring by competently trained staff as per Trust procedure.

**16.** RECOMMENDATIONS (please state by whom and timescale)

1. The Trust to review its current practice for escalation of NEWS score to senior consultants. In view of the findings regarding lack of senior consultant review in this incident the report is to be shared with all staff involved for reflection and learning.
2. The SHSCT to review its current practices for AIRVO treatment and monitoring at DHH and Craigavon Area Hospital and to standardise its practice across both sites.
3. Communication is to be sent to all patient flow Staff by Team Lead / Head Of Service patient flow that all DHH patients considered to be requiring AIRVO must be nursed in the HDU DHH site.

**17.** INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA: none

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**Commented [KP1]:** Escalation to senior consultant, changed to consultant only

**Commented [KP2]:** Airvo patients should be managed by patie who are appropriately trained.

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| **18.** FURTHER REVIEW REQUIRED? NO<br>Please select as appropriate<br><br>If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6. |

| **SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)** | |
|---|---|
| **19.** PLEASE INDICATE LEVEL OF REVIEW:<br>LEVEL 2 / LEVEL 3<br>**Please select as appropriate** | **20.** PROPOSED TIMESCALE FOR COMPLETION:<br>DD / MM / YYYY |
| **21.** REVIEW TEAM MEMBERSHIP *(If known or submit asap)*: | |
| **22.** TERMS OF REFERENCE *(If known or submit asap)*: | |

| **SECTION 5** | |
|---|---|
| **APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR** | |
| **23.** NAME: | **24.** DATE APPROVED: |
| **25.** DESIGANTION: | |

| **SECTION 6** |
|---|
| **26.** DISTRIBUTION LIST:<br><br>Personal Information<br>The Review Team<br>Staff involved in Personal Information care<br>Director of Acute Services<br>Assistant Director of Acute Services.<br>Head of Service for Medicine and Unscheduled Care.<br>Head of Allied Health Professionals |



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**LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST**

**SECTION 1**

| | |
|---|---|
| **1. ORGANISATION:** SHSCT | **2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Personal Info |
| **3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:** | **4. DATE OF INCIDENT/ EVENT: 21/03/2019** |
| **5. PLEASE INDICATE IF THIS SAI IS**<br>**6. INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS:** No | **7. IF 'YES' TO 5. PLEASE PROVDE DETAILS:** |
| **8. DATE OF SEA MEETING / INCIDENT DEBRIEF:** | **04/11/2019** |

**9. SUMMARY OF EVENT**:

Personal Information was an Personal year old man who had multiple comorbidities which included prostatic cancer, chronic myeloid leukaemia and diabetes mellitus. He was referred to cardiology in the Belfast Trust with cardiac systems. A decision was made for him to have tissue aortic valve replacement (AVR) and coronary artery bypass graft (CABG) in Blackrock Clinic, Dublin on 12 February 2019. Personal Information was an inpatient in ICU for 10 days post procedure and spent a further two weeks in hospital. Personal Information was discharged home on 5 March 2019. Personal Information was given a handwritten discharge letter to be forwarded to his GP with a note added 'he would benefit from early post up cardiology review'.

Personal Information presented to Craigavon Area Hospital (CAH) Emergency Department (ED) the following day, 6 March 2019 with a painful red right arm following CABG and AVR in Dublin. Personal Information was reviewed by ED doctor and following examination and tests was diagnosed with right arm cellulitis. Personal Information was admitted to 4 North (surgical ward) as a medical outlier for IV antibiotic treatment and monitoring.

Personal Information remained as an inpatient and on the 20 March 2019 Personal Information's condition deteriorated. A bedside ECHO was carried out which showed a large pericardial effusion. Personal Information suffered a cardiac arrest, this was Pulseless Electrical Activity (PEA) and return of spontaneous circulation was achieved after 15mins of cardiopulmonary resuscitation (CRP). The consultant cardiologist tried to drain the pericardial effusion at this time. Personal Information was transferred to theatres for central line insertion and arterial line and then to Intensive Care Unit (ICU) for intensive support and care. Despite invasive intensive support Personal Information continued to deteriorate, he was profoundly acidotic with multi organ failure. Following discussion with Personal Information 's family a decision was made to withdraw intensive support which was felt to be futile. Personal Information passed away on 21 March 2019 (RIP).

A post mortem was carried out which confirmed cause of death as I (a) myocardial infarction due to (b) coronary artery disease and aortic valve disease (operated) II Pneumonia, cirrhosis of the liver, diabetes mellitus, chronic myeloid leukaemia and chronic kidney disease.

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**SECTION 2**

| 10. SEA FACILITATOR / LEAD OFFICER: | 11. TEAM MEMBERS PRESENT: |
|---|---|
| Dr Anna Todd | Dr Anna Todd –Consultant P<br>Dr Artur Mlodzianowski - Consultant Cardiologist<br>Mrs Carly Connolly- Clinical Governance Manager |

**12. SERVICE USER DETAILS**:
Personal Information H&C : Personal Information redacted by the USI Age : Personal

**13. WHAT HAPPENED?**

On the 11 February 2019 Personal Information was discharged from CAH to Blackrock Clinic, Dublin for AVR and CABG. His surgery was performed on 12 February 2019.

On the 5 March 2019 Personal Information was discharged home. Personal Information's Blackrock Clinic discharge letter noted Personal Information had an uneventful procedure but had significant renal function impairment for which he required nephrology (kidney) review and inotrope support (drugs to maintain blood pressure). Personal Information was commenced on IV drugs to reduce his fluid retention. It was noted Personal Information had a pericardial effusion which required tapping twice (removal of fluid) and a left sided pigtail drain. It was documented Personal Information had a slow recovery and remained in ICU for 10 days due to kidney failure with low urinary output.

The discharge letter noted Personal Information was stable at discharge. Follow up arrangements noted 'secretary will contact patient with appointment details'. There was a hand written note 'he would benefit from an early post operation cardiology review for his heart failure follow up'. Personal Information was discharged on 5 March 2019 with a discharge letter to give to his GP.

On 6 March 2019 Personal Information was referred by his General Practitioner (GP) to Craigavon Area Hospital (CAH) Emergency Department (ED) at 19:00 via ambulance with a painful red right arm following CABG and AVR in Dublin. At 21:30 Personal Information was reviewed by Doctor 1(Speciality doctor). On examination it was noted Personal Information had a significant area of cellulitis (inflammation) in his right arm. There were creps noted (indicating chest infection) in both lung bases. Personal Information had a NEWS score of 2 (national early warning score is used to detect a deteriorating patient 0 – 18). His observations were noted; pulse108; BP125/70; RR18; $Sp0_2$ 94% (oxygen saturation). Personal Information had a chest x-ray which confirmed a chest infection. Personal Information was admitted to 4 North (Surgical Ward) as a medical outlier the following day for IV antibiotic treatment and monitoring.

At 23:45 Personal Information was reviewed by Doctor 2 (CT1). Personal Information 's history was revisited and noted. Dr 2 noted Personal Information had increased urinary frequency with no dysuria (difficulty passing urine). There was no shortness of breath, and some cough with white sputum. On examination Doctor 2 noted Personal Information 's pulse was regular, heart sounds were normal, moderate oedema (fluid) was noted in his knee. Chest examination noted crepes lower base of lungs and abdominal examination noted a soft non tender abdomen. Right arm spreading cellulitis was documented, with no entry points and no oozing identified. Chest x-ray reported a left pleural effusion, recent sternotomy; there was no sign of pulmonary oedema. Bloods results were also noted. Dr 2's plan was for antibiotics, send Mid-Stream Specimen Urine (MSSU), catheter insertion for comfort (risk of falling during night) and for Multi-Disciplinary Team discussion. A Venous Thromboembolism Risk Assessment (VTE) was carried out by Doctor 2 and Personal Information was noted to be a high risk patient of VTE and thromboprophylaxis was



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prescribed on his kardex.

Personal Information was reviewed daily by medical staff. Nursing documentation noted Personal Information had a stable NEWS score. It was noted by medical staff that Personal Information continued to complain of right arm pain, erythema present with little improvement for which analgesia and IV antibiotics were prescribed. It was noted Personal Information complained of increased frequency in passing urine. On the 10 March 2019 bloods were taken and it was noted Personal Information had an acute kidney injury (AKI) for which Intravenous fluids were prescribed. It was noted Personal Information was feeling sick and ondansetron (anti sickness medication) was prescribed. On the 11 March 2019 it was noted Personal Information reported his arm had not improved over the weekend and reported pain on palpation. Personal Information 's antibiotics were changed and a Doppler was completed which ruled out deep vein thrombosis (DVT is a blood clot). It was noted Personal Information had a reduced appetite, and no nausea or vomiting was reported, observations were noted to be stable.

On the 13 March 2019 blood results reported Personal Information kidney function and inflammatory markers were improving and his NEWS remained stable. It was noted Personal Information complained of left leg pain and was reviewed by Doctor 3. It was noted Personal Information had no chest pain, no shortness of breath and no radiation pain. On examination Doctor 3 documented the right calf had no sign of changes, no leg swelling, no palpable mass and no oedema. Sensation was all intact in his lower limbs, power was recorded 5/5 and full ROM in both lower limbs. Doctor 3's plan was for D-dimer blood test (blood **test** used to help rule out the presence of a blood clot) and to continue with regular observations, and to re-contact if further concerns.

On the 14 March 2019 Doctor 4 noted Personal Information was feeling a lot better and noted events from the previous night, no further calf pain was reported. Doctor 4 noted Personal Information was walking with the physiotherapist that day. Doctor 4 documented Personal Information reported the pain in his right arm had improved a lot; he could move it and use it more. Doctor 6 noted erythema was improving and CRP had reduced to 78. Doctor 4's plan was to continue with antibiotics and for discussion at the MDT meeting.

On 15 March 2019 Personal Information was reviewed by Doctor 5. Doctor 5 noted erythema was improving, there was mild erythema noted on the posterior aspect of the forearm and that Personal Information 's pain had greatly improved. Doctor 5 Noted Personal Information 's bloods also continued to improve and his NEWS score was stable at 0. Doctor 5's plan was to review antibiotics over the weekend for consideration of switching to oral and for discussion at MDT meeting.

Medical records indicate Personal Information had no medical review over the bank holiday weekend from 16 March until Tuesday 19 March 2019.

On the 19 March 2019 Personal Information was reviewed on the ward round by Doctor 6. Doctor 6 noted it was day 13 since Personal Information hospital admission. Doctor 6 noted Personal Information 's surgery in Blackrock Clinic in Dublin. Doctor 6 documented Personal Information 's problems and past medical history. On examination Doctor 6 noted Personal Information was haemodynamically stable. It was reported Personal Information was eating and drinking, bowels had moved that morning, no cough was reported, no shortness of breath (SOB) reported, no chest pain reported and no temperature was reported. Doctor 6 noted Personal Information 's right arm was still heavy and hot, no tenderness was reported. On examination the wound on the right leg was noted to be healing, wound on mid sternum was healing, right arm was warm to touch, erythema, and no mobility issues were reported. Doctor 6's plan was to continue with antibiotic treatment, bloods to be checked tomorrow.

On 20 March 2019 at 7:00 Nurse 1 documented Personal Information was very unsettled overnight and slept very little and that MMcQ had complained of nausea. It was noted Personal Information 's urinary output was very poor. Bloods were repeated as requested by Doctor 6 the previous day.





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Personal Information was reviewed by Doctor 6 (no time recorded). Doctor 6 noted Personal Information's past medical history and discharge on 5 March 2019 from Blackrock Clinic post 3xCABG and AVR and admitted to CAH the following day. Doctor 6 noted Personal Information's current issues were cellulitis and acute kidney injury, increased potassium (6.0 mmols/litre normal range is 3.5-5.3mmols/l). It was noted Personal Information's ECG was satisfactory. On examination Doctor 6 noted Personal Information had no cough, his chest was clear, oral intake was poor and Personal Information had vomited once. Doctor 6 noted Personal Information's arm cellulitis had improved and that Personal Information had difficulty passing urine that morning. Abdominal examination noted tender suprapubically, soft, bowel sounds present and palpable bladder. Doctor 6's plan was for spironolactone and ace inhibiter to be held in view of acute kidney injury. The plan was to continue with antibiotics and tamsulosin, catheterise and monitor intake and output. A plan for an ultrasound of the renal tract and repeat bloods tomorrow.

At 8:40 Nurse 2 noted Personal Information complained of being tired and weak. Personal Information was independent with hygiene needs and managed a small amount of breakfast. Personal Information's NEWS score was noted to be 3 due to hypotension BP 83/57 and pulse of 91bpm. Nurse 2 documented Personal Information was encouraged to take oral fluids. Nurse 2 reported she informed the Senior House Officer (SHO) who advised to hold frusemide and spironolactone due to low BP and check observations again in one hour. Personal Information's observations were checked every hour and the SHO (no name recorded) was contacted and informed. IV fluids were erected as per SHO instructions to treat Personal Information's hypotension and an ECG was completed. It was noted Personal Information passed small amounts of urine.

Personal Information was reviewed by the medical doctors and it was decided Clindamycin and Iminatab were to be stopped. At 17:45 Nurse 3 reported Personal Information was complaining of nausea and had a vacant episode witnessed by the student nurse. It was noted Personal Information appeared unresponsive for a couple of seconds but was rousable on shaking. Oxygen was applied 15 litres/minute, the crash team was called and arrived promptly. Personal Information's NEWS score was recorded as 5 and arranged transfer to I North (Cardiology ward).

Personal Information was reviewed by Doctor 7 General Medical Registrar. Doctor 7 noted Personal Information was alert at 17:39 and on arrival Personal Information was sitting in a chair. Personal Information reported he was feeling very unwell and he had abdominal pain. A comprehensive examination was performed by Dr 7, ECG was abnormal and a bedside echo was performed. Doctor 7 noted the findings as cardiomegaly (enlarged heart), left pleural effusion (fluid around the heart) with increased vasculature (provide definition). Arterial Blood Gas (ABG) results were taken and Doctor 7 noted metabolic acidosis.

Personal Information's bedside echo was discussed with Doctor 8 (consultant cardiologist), a pleural effusion was confirmed. Doctor 7 noted that Personal Information was currently haemodynamically stable and was likely dehydrated. The pleural effusion had most likely accumulated over the last four weeks. Doctor 12's plan was for transfer to Coronary Care Unit (1 North); IV fluids; close monitoring; repeat ABG in 1 hour; repeat ECHO in the morning and consider pericardial tap/ drain, check bloods and hold nephrotoxics (drugs which can interfere with renal function). Personal Information was transferred to 1 North at 19:30.

Personal Information was reviewed by the ICU and surgical team for consideration for transfer to theatre for a TAP (drainage of fluid from pleural effusion). During review by both speciality teams it was noted Personal Information became unwell with agonal breathing and no pulse. CPR was immediately commenced and the cardiac arrest team was called. It was documented that CPR was performed as per adult life support (ALS) procedure with a return of his pulse. After intubation a pericardiocentesis (drainage of fluid) was carried out and 650mls was drained but there was still significant residual fluid. It was noted Personal Information had haemodynamically improved. The plan was for Personal Information to transfer to theatre for arterial line insertion and a repeat ECHO and clinical assessment in the morning.



Personal Information

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On the 21 March 2019 Personal Information was reviewed at 01:50 by Doctor 9. Doctor 9 noted Personal Information was in theatre awaiting transfer to ICU.

At 02:17 Personal Information was transferred to ICU. He was reviewed again by Doctor 10 Consultant Cardiologist. Personal Information's past medical history events to date were noted. The plan was for the pericardial drain to remain insitu and he would liaise with cardiology surgeons in the RVH. If the effusion was to persist he may need a pericardial window and advised to chase the results of the pericardial fluid.

Personal Information continued to deteriorate and despite all efforts Personal Information remained very unwell and was profoundly acidotic. Personal Information's family were informed that despite maximum ICU support Personal Information was still deteriorating, and that it would not be in his best interests to resuscitate in the event of another cardiac arrest, a DNAR was therefore put in place. Personal Information passed away at 21:26 with his family in attendance. RIP.

## SECTION 3 - LEARNING SUMMARY

### 14. WHAT HAS BEEN LEARNED:

**Patient Factors**

Personal Information was an 81 year old male at the time of admission to CAH on the 05 March 2019. Personal Information had multiple comorbidities: type 2 diabetes mellitus; hypertension; Chronic Kidney Disease; Myeloid leukemia and prostate cancer. Personal Information had a recent AVR and CABG procedure carried out in Blackrock Clinic Dublin. It was noted Personal Information had a difficult post-operative period and was managed in ICU for 2 weeks and treated for an AKI and a pericardial effusion which required tapping twice and a pigtail drain. It was reported Personal Information was discharged from Blackrock on the 5 March 2019 and was then subsequently referred by his GP to CAH ED the following day with a painful right arm following his AVR and CABG procedure. Personal Information was admitted to CAH for treatment of right arm cellulitis.

**Blackrock Clinic, Dublin**

The Review Team acknowledges Personal Information was referred from CAH to the RVH for his CABG and AVR procedure as this procedure is not performed in the Southern Health Social Care Trust. Due to extensive waiting lists the RVH referred Personal Information to the Independent Sector i.e. Blackrock Clinic, Dublin for his procedure and was transferred to Blackrock Clinic from CAH by ambulance. Personal Information had an AVR and CABG performed on the 13 February 2019 and was discharged from Blackrock Clinic to home on 5 March 2019.

The Review Team acknowledges Personal Information had a difficult post-operative period following his procedure which required a 2 week stay in ICU. On Personal Information's discharge letter from Blackrock Clinic it was noted Personal Information would benefit from an early cardiology review. A copy of the letter was given to Personal Information to forward to his GP. This contained contact details in the case of emergency. The review team acknowledges the general procedure for discharge from Blackrock Clinic is that in addition to the patient's letter, a discharge letter would be sent to the referrer (in this case RVH) within 10 days. This information would then be forwarded to CAH and uploaded on to Northern Ireland Electronic Care Record (NIECR).The review team recognises this is an inefficient process delaying vital communication between hospitals and subsequently impacting patient safety. The review team acknowledges when Personal Information attended CAH ED on the 6 March 2019, medical staff did not have any documentation on Personal Information's recent procedure and difficult post-operative recovery in Blackrock Clinic.



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Medical staff were unaware Blackrock had advised Personal Information would benefit from an early cardiology review.

Personal Information's family have advised no package of care was provided nor ambulance transport. His family has advised that Personal Information had a difficult lengthy car journey home from Blackrock Clinic which caused him some distress. Family advised Personal Information had 2 falls during the night when he got up to go to the toilet and when the community nurse arrived the following morning she was concerned and contacted Personal Information's GP. Personal Information was then referred to CAH ED by his GP with a query of cellulitis. Personal Information's family report Personal Information complained of right arm pain during his stay in Blackrock Clinic.

**ED attendance**

The Review Team has reviewed Personal Information's medical notes from Personal Information's admission on 6 March 2019 and agreed Personal Information presented to ED with symptoms of right arm cellulitis. The Review Team can confirm it was noted at triage that Personal Information had a recent discharge from Blackrock Clinic Dublin for CABG and AVR. Doctor 2 documented Personal Information had a pericardial effusion following his AVR and CABG procedure which required tapping twice and a pigtail stent, AKI, and hyponatremia. The Review Team reviewed Doctor 1's medical notes and agreed a full medical history and examination was completed and the necessary tests and investigations were done and that a diagnosis of right arm cellulitis and transfer to the ward for treatment of same was appropriate given Personal Information's presentation at the time.

It was documented Personal Information's NEWS score was recorded as 1 at handover to the medical team. The Review Team are aware Personal Information's case was discussed at the medical morbidity and mortality (M&M) meeting and it was noted Personal Information's chest x-ray taken in ED was reviewed and it was agreed the heart size was reported normal suggesting a pericardial effusion was not evident at this time. However the Review Team acknowledged that Doctor 1 documented and acknowledged Personal Information had a very recent CABG and AVR procedure and a very difficult post-operative recovery requiring a 2 week stay in ICU and therefore deliberated Doctor 1 should have considered contacting the cardiology team for a cardiology review or opinion. The Review Team accept Doctor 1 did not have access to Personal Information's discharge letters from Blackrock Clinic and was therefore unaware Blackrock had recommended Personal Information would benefit from an early cardiology review. The Review Team concluded if ED staff had a copy of the Blackrock discharge letter it would have prompted a request for a cardiology review at initial presentation.

**Commented [KP1]:** This comment is not accurate – would not have prompted cardiology review at 09:30pm remove

**Patient Flow**

Following a review of Personal Information's notes it was identified by the Review Team that Personal Information was a medical outlier on a surgical ward (4 North) for the first 9 days then was moved to elective admissions ward (EAW). The Review team recognises the ward operates with one SHO and one consultant, compared to 4 SHOs and one consultant on a medical ward. The Review Team deliberated was this the best place for Personal Information to receive the treatment and care warranted to him following AVR and CABG procedure and deliberated should medical staff have considered an earlier transfer to a medical ward the following day or at the next bed availability. The Review Team did review medical notes and acknowledge Personal Information was presenting with no other symptoms other than that of right arm cellulitis and his NEWS score was 1 at transfer and appreciate there may have been other patients with a higher priority at the time for a bed in a medical ward. Again staff did not have access to Personal Information's discharge letter and therefore were unaware an early cardiology review was recommended by Blackrock Clinic.

**Management and Care on 4 North**

The Review Team reviewed Personal Information's medical notes during his admission as a medical outlier. Following review of the medical notes the Review Team acknowledge Personal Information's right arm cellulitis was



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treated with IV antibiotics flucoloxicillin and benzylpenicllin. It was documented [redacted] complained of right arm pain, and it was documented erythema was present throughout his stay, inflammatory markers were noted to be raised, but there were no other symptomatic symptoms noted. [redacted]s NEWS score was stable and therefore would be normal for no review over the weekend

Following the meeting with [redacted]'s family, the family advised [redacted] did not receive any of his Blackrock Clinic post discharge medications on admission, the family advised they questioned this with medical staff and family provided a copy of [redacted]'s medication listed on his discharge letter. Pharmacy was contacted who arrived and processed a prescription for [redacted]s medication to be administered. The Review Team acknowledge [redacted] had invasive cardiac surgery prior to his admission to CAH which warranted a 2 week stay in ICU for a pericardial effusion which required tapping twice in Blackrock Clinic. Although medical staff did not have access to [redacted]'s Blackrock clinic notes, staff were aware of this (documented on several occasions) and therefore should have considered contacting Blackrock Clinic to acquire more information regarding medication and cardiology follow up, the Review Team believe this may have prompted an early cardiology review.

On the 11 March 2019 it was documented antibiotics were changed to clindamycin as there was no improvement in [redacted]'s symptoms, and a USS doppler was carried out the next day 12 March 2019 and excluded a DVT. The Review Team concluded [redacted] was treated appropriately for right arm cellulitis during this period of time and that there were no other symptomatic symptoms suggesting a pericardial effusion, [redacted]s NEWS score was noted to be stable during his stay. It was noted consideration was given for transfer to Lurgan Hospital for continuation of IV antibiotics on the 14 March 2019. On the 15 March it was documented by Doctor 5 that [redacted]'s pain and erythema had greatly improved.

The Review Team acknowledges [redacted] was a medical outlier and therefore had no medical review over the weekend from Friday 16 March 2019 until Tuesday 19 March 2019. The Review Team acknowledges this would not be unusual for a patient with a stable NEWS score and no other symptomatic symptoms other than right arm cellulitis. The Review Team noted [redacted]'s NEWS score was 3 on 16 March at 7:30 due to low blood pressure (3 in one parameter should be escalated to a clinician) and nursing staff should have escalated [redacted] to the medical team for assessment. [redacted]'s NEWS chart documents [redacted]'s NEWS score remained stable after this one recording and on the 17 and 18 March 2019 [redacted] had a NEWS score of 0 throughout both days and therefore a review was not indicated.

The Review Team acknowledges [redacted]'s condition deteriorated rapidly on 20 March 2019. It was reported by nursing staff that [redacted] had a restless night complaining of abdominal pain and poor urinary output. [redacted]'s NEWS score was reported as 3 (in one indicator) and nursing staff appropriately escalated this to medical staff and were advised to recheck observations and monitor. It was noted [redacted] remained hypotensive throughout the morning and into the afternoon. IVF fluids were given and an ECG was carried out and he was reviewed by the medical team.

The Review Team acknowledges [redacted] had a 'vacant episode' lasting about 5 seconds about 17:30, this was witnessed by a student nurse. Nursing staff appropriately escalated concerns to medical team and doctor 7 attended. The Review Team agree doctor 7 completed a thorough medical history and examination and a request for a beside echo was correct. Doctor 7 then contacted doctor 8 for a cardiology opinion who agreed [redacted] had a pericardial effusion and pleural effusion was present, it was documented [redacted] was hemodynamically stable at this time. Arrangements were made for [redacted] to be transferred to CCU for further management and care.

The Review Team acknowledges [redacted] arrested in CCU witnessed by the surgical and anesthetic consultants. CPR was commenced and was ongoing for 15 minutes. [redacted] was subsequently



[redacted]

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intubated and doctor 8 carried out a pericardiocentesis, draining 650mls of fluid. Personal Information was transferred to theatre then to ICU for further management and care and another pericardiocentesis. Unfortunately Personal Information did not recover despite intensive care and maximum support and remained profoundly acidotic. Personal Information's situation was explained and discussed with his family and a decision was agreed to withdraw support. Personal Information sadly passed away on 21 March 2019 @ 21:06 (RIP). The Review Team concluded treatment and care was appropriate following Personal Information's 'vacant episode'.

The Review Team recognises Personal Information's NEWS score throughout his stay from his initial presentation to ED until the 20 March 2019 was stable and possibly deceived cardiology issues. Personal Information was treated for right arm cellulitis which was reported to be slow healing requiring a change in anti-biotics and there were no clinical indications underlining any cardiology issues. The Review Team acknowledges Personal Information did not present with any cardiology symptoms during his stay until 20 March 2019. In hindsight the Review Team concluded given consideration for Personal Information's recent cardiac surgery and difficult post-operative recovery medical staff should have contacted Blackrock Clinic for updated information which may have prompted and earlier cardiology review and/or monitoring. The Review Team cannot confirm this would have changed the outcome but it may have changed Personal Information's management plan.

A meeting was held with Personal Information's wife and granddaughter on 12 December 2019 to explain the SAI process and to acquire information from the family about Personal Information's treatment and care. The family had the following questions:

1. **Why a care package or appropriate transport home was not provided prior to discharge from Blackrock Clinic?**

The Service Level Agreement between BHSCT and Independent Hospital states :

> *5.5.1*
> *'The Provider shall adhere to discharge protocols agreed with all appropriate external, interested organisations including the BHSCT, the Patients' GP, AHP Services, Social Services where appropriate and shall work with such organisations and/or the Patient's family and/or carer to ensure continuing care of the Patient.'*
>
> *6.2*
> *'For travel outside Northern Ireland, the Provider will be responsible for arranging transport & accommodation, subject to prior agreement with the BHSCT in respect of the transportation and accommodation costs. These costs will be reimbursed upon validation of receipts submitted by Provider.'*

The Review Team acknowledge Blackrock Clinic had a responsibility to arrange suitable transport and follow up arrangements for continuing care. However the Review Team have reviewed the discharge letter from Blackrock Clinic and it is noted that Personal Information's was mobile, independent and self-caring at time of discharge. The discharge letter also states 'patient confirms suitable travel arrangements, family will collect'.

2. **Was Personal Information's heart monitored whilst he was a patient in CAH 4 North and 1 West? Mrs Personal Information reports she had asked a doctor about his heart and was advised they were only treating cellulitis?**

The Review Team has reviewed Personal Information's notes from his admission to CAH ED on 06/03/2019 until his untimely death on the 21/03/2019. The Review Team acknowledges Personal Information presented to CAH ED



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with right arm cellulitis following his AVR and CABG procedure. The Review Team are aware Personal Information's case was discussed at the medical morbidity and mortality (M&M) meeting and it was noted Personal Information's chest x-ray taken in ED was reviewed and it was agreed the heart size was reported normal suggesting a pericardial effusion was not evident at the time. The Review Team acknowledge Personal Information was reviewed daily by medical staff who reported his right arm cellulitis was slow healing. Medical staff reported Personal Information was systematically well and that there were no clinical indications to warrant an escalation for cardiology review until 20 March 2019. However, in hindsight the Review Team has acknowledge consideration for a cardiology review within the first week of Personal Information's stay would have been best practice. The Review Team cannot confirm this would have changed the final outcome but it may have changed Personal Information's management plan.

3. **Why Personal Information was not given any of his post discharge medication until family queried it with staff and provided a copy of his discharge medication?**

The Review Team acknowledge Personal Information had invasive cardiac surgery prior to his admission to CAH which warranted a 2 week stay in ICU for a pericardial effusion which required tapping twice in Blackrock Clinic. Although medical staff did not have access to Personal Information's Blackrock clinic notes, staff were aware of this (documented on several occasions) and therefore should have considered contacting Blackrock Clinic to acquire more information regarding medication and cardiology follow up, the Review Team believe this may have changed Personal Information s management plan.

4. **Personal Information had 1 and half litres of fluid drained from his heart; how long would it have taken for this amount of fluid to build up?**

The Review team has reviewed Personal Information s notes and M&M presentation. Following discussion at M&M it was agreed that Personal Information's effusion was most likely a post cardiomyopathy inflammatory response, this was not a surgical complication, the fluid was not bloody, his new valve was functioning well, his ECG was not ischaemic and his LV was preserved. The Review Team acknowledge Dr 7 requested a beside echo on 20 March 2019 and discussed the findings with Doctor 8. Dr 7 noted Personal Information was hemodynamically stable at the time and that the effusion had most likely accumulated over the last 4 weeks.

**15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?**

A review of the current service level agreement (SLA).

**16. RECOMMENDATIONS (please state by whom and timescale)**

- The SHSCT and BHSCT to review its current service level (SLA) agreement between the Trusts and Blackrock Clinic especially with regards to documentation, communication and patient discharge arrangements.
- The report will be shared with all staff involved in Personal Information s treatment and care for reflection and learning. (The Governance Team )
- The report will be presented at medical and cardiology Morbidity and Mortality meetings for learning. (Governance Team)

**Commented [KP2]:** for Belfast trust

**Commented [KP3]:** no learning?? Not appropriate.

**Commented [KP4]:** Ensure recommendations answer questions.



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|---|
| **17.** INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA: |
| **18.** FURTHER REVIEW REQUIRED? NO<br>Please select as appropriate<br><br>If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6. |

| **SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)** | |
|---|---|
| **19.** PLEASE INDICATE LEVEL OF REVIEW:<br>LEVEL 2 / LEVEL 3<br>**Please select as appropriate** | **20.** PROPOSED TIMESCALE FOR COMPLETION:<br>DD / MM / YYYY |
| **21.** REVIEW TEAM MEMBERSHIP *(If known or submit asap)*: | |
| **22.** TERMS OF REFERENCE *(If known or submit asap)*: | |

| **SECTION 5** | |
|---|---|
| **APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR** | |
| **23.** NAME: | **24.** DATE APPROVED: |
| **25.** DESIGANTION: | |

| **SECTION 6** |
|---|
| **26.** DISTRIBUTION LIST:<br><br>Personal Information 's family<br>Belfast Health and Social Care Trust<br>Blackrock Clinic, Dublin<br>The Health and Social Care Board<br>The Director of Acute Services |



Personal Information

DRAFT

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The Assistant Director of Acute Services
Head of Medicine and Unscheduled Care
Staff involved in Personal Information s treatment and care
The Review Team

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**Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident**

| | | | |
|---|---|---|---|
| **Reporting Organisation SAI Ref Number:** | | **HSCB Ref Number:** | |

| **SECTION 1** | | | | | |
|---|---|---|---|---|---|
| **INFORMING THE SERVICE USER[1] / FAMILY / CARER** | | | | | |
| 1) Please indicate if the SAI relates to a single service user, or a number of service users.<br>**Please select as appropriate (✓)** | **Single Service User** | | **Multiple Service Users*** | | |
| | **Comment:**<br>***If multiple service users are involved please indicate the number involved*** | | | | |
| 2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| | If **YES**, insert **date informed**: | | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI | | | | |
| | a) No contact or Next of Kin details or Unable to contact | | | | |
| | b) Not applicable as this SAI is not 'patient/service user' related | | | | |
| | c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | | | |
| | d) Case involved suspected or actual abuse by family | | | | |
| | e) Case identified as a result of review exercise | | | | |
| | f) Case is environmental or infrastructure related with no harm to patient/service user | | | | |
| | g) Other rationale | | | | |
| | **If you selected c), d), e), f) or g) above please provide further details:** | | | | |
| 3) Was this SAI also a Never Event?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| 4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event?<br>**Please select as appropriate (✓)** | **YES** | If **YES**, insert **date informed**: DD/MM.YY | | | |
| | **NO** | If **NO**, provide details: | | | |
| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)** | | | | | |
| **Content with rationale?** | **YES** | | **NO** | | |

| **SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER**<br>***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*** | | | | |
|---|---|---|---|---|
| 5) Has the Final Review report been shared with the Service User[1] / Family / Carer?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert date informed: | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer: | | | |
| | a) Draft review report has been shared and further engagement planned to share final report | | | |

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| SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)* | | |
|---|---|---|
| | b) Plan to share final review report at a later date and further engagement planned | |
| | c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)*** | |
| | d) No contact or Next of Kin or Unable to contact | |
| | e) No response to correspondence | |
| | f) Withdrew fully from the SAI process | |
| | g) Participated in SAI process but declined review report | |
| | ***(if you select any of the options below please also complete 'l' below)*** | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer | |
| | i) case involved suspected or actual abuse by family | |
| | j) identified as a result of review exercise | |
| | k) other rationale | |
| | l) If you have selected **c), h), i), j), or k)** above please provide further details: | |

| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate** (✓)) | | | | |
|---|---|---|---|---|
| **Content with rationale?** | **YES** | | **NO** | |

| SECTION 2 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)* | | | | | | | | |
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate** (✓) | **YES** | | | | **NO** | | | |
| | If **YES**, insert **date informed**: | | | | | | | |
| | If **NO**, please provide details: | | | | | | | |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate** (✓) | **YES** | | | | **NO** | | | |
| | If **YES**, insert **date report shared**: | | | | | | | |
| | If **NO**, please provide details: | | | | | | | |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate** (✓) | **YES** | | **NO** | | **N/A** | | **Not Known** | |
| | If **YES**, insert **date informed**: | | | | | | | |
| | If **NO**, please provide details: | | | | | | | |

| **DATE CHECKLIST COMPLETED** | |
|---|---|

[1] *Service User or their nominated representative*



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**LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST**

**SECTION 1**

| | |
|---|---|
| **1. ORGANISATION:** SHSCT | **2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Patient 12 |
| **3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:** | **4. DATE OF INCIDENT/ EVENT: 30/08/2019** |
| **5. PLEASE INDICATE IF THIS SAI IS**<br>**6. INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS:** No | **7. IF 'YES' TO 5. PLEASE PROVDE DETAILS:** |
| **8. DATE OF SEA MEETING / INCIDENT DEBRIEF:** | |

**9. SUMMARY OF EVENT:**

During an internal review in 2016, following an Index Case, the Trust identified a number of GP Urology referrals who were not triaged by one particular Consultant Urologist; 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient Patient 15, discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed.

Patie nt 12 a Pers onal-year-old male was referred to Urology Outpatients on 8 Sept 2016 for assessment and advice on lower tract symptoms and elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review the referral was upgraded to Red Flag and was seen in clinic on day 152. On day 215, Patie nt 12 had a confirmed cancer diagnosis T3a with no nodal metastases. There has been a resultant 8-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Causal Factors

- Referral letters did not have their clinical priority accurately assigned by the GP.
- Referral letters were not triaged following receipt by the Hospital.

**SECTION 2**

| **10. SEA FACILITATOR / LEAD OFFICER:** | **11. TEAM MEMBERS PRESENT:** |
|---|---|
| Dr J R Johnston- Consultant Medical Advisor | Mr M Haynes - Consultant Urologist<br>Mrs K Robinson - Booking & Contact Centre Manager<br>Mrs T Reid - Acute Clinical & Social Care Governance Coordinator |



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**12. SERVICE USER DETAILS**:
Patient 12 H&C: Personal Information redacted by the USI

**13. WHAT HAPPENED?**

5.1 Triage of GP referrals - background
The general public expect that, when they engage with their GP complaining of symptoms that are potentially due to a cancer, they will be referred to the appropriate secondary care services promptly and that they will respond, also promptly, to confirm or exclude the diagnosis of cancer.

The DHSSPSNI Service Framework for cancer prevention, treatment and care (Standard 13) of 2011 indicates, “All people with signs and symptoms that might suggest cancer should be appropriately assessed by their GP and referred promptly on to hospital for further tests if needed”.

Cancer specialists, working in networks, have formulated lists of symptom and sign triggers which can signify the development of a cancer. Using these lists, primary care doctors can refer patients into secondary care; triaging a large number of patients by assigning them to different degrees of urgency (Routine, Urgent and Red-flag). If these are used as designed, this can provide an efficient referral system.

NICE have been instrumental in ensuring uniformity and the validity of these cancer recognition and referral lists of symptoms and signs. They have also formulated guidance regarding how safety nets should be setup to ensure patients are not missed. Local programmes, using this type of guidance, have been established, under the auspices of NICaN and the HSCB, to set up these triage pathways and safety nets.

5.2 Triage of GP referrals – Northern Ireland
NI Referral Guidance for Suspected Cancer (2012)
The Northern Ireland Referral Guidance for Suspected Cancer 2012 is based on the NICE clinical guideline, CG 27 - Referral guidelines for suspected cancer, published in June 2005. This has a section on Urological Cancer. It was introduced to GPs by HSCB correspondence (30/12/2012), revealing the new red-flag process and indicating in appendix A that, “triaging will take place in a timely manner, within 72 hours of receipt of referral or the referral should continue with the GP Prioritisation”.

This is still the only set of referral guidance for suspected urological cancer available online on the NICaN website (last accessed 18/11/2018).

However, the 2005 CG27 guidance has been replaced by NICE Guideline NG12 Suspected cancer: recognition and referral published in June 2015. This was endorsed by the Department of Health (NI) with HSC (SQSD) (NICE NG12) 29/15 on the 19th August 2015 which instructed the HSCB / PHA to send out the guidance to the appropriate Family Practitioners. This particular kind of guidance requires the HSCB to circulate regionally endorsed NICE guidelines to Trusts and GPs for implementation. Trusts are expected to review guidance against a base line assessment and provide HSCB with an assurance that the guidance has been implemented. If a Trust is unable to fully implement the guidance within the one-year period without regional co-ordination and/or additional resources, they should provide a formal assurance to HSCB, and this is to be managed as part of the risk management process. This assurance process does not however apply to primary care and GP’s.

NICaN Urology Cancer Clinical Guideline (2016)
The NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016), was produced regionally to support the diagnosis, treatment and management of urological cancer.



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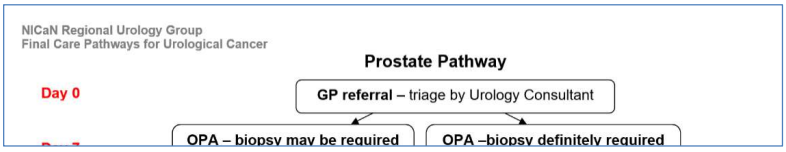
This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.

The Review Team's evaluation of the advantages of NICE NG12 (2015) over the CG27 (2005) guidelines reveals fewer cases would be red-flagged for Urology, as a result of,

- a reduction in number of non-visible haematuria patients; and
- increases in age criteria of 45 years and over.

However, rollout of NG12 by the HSCB does not appear to have happened. The Review Team understands that the reason NG12 has not been implemented lies with ongoing discussions between the HSCB and GPs.

Appendix 2 of the NICaN Urology Cancer Clinical Guideline guidelines highlights the Urology Care pathways. Cons1 was present at the workshop discussing those on 02/10/2008. It clearly indicates that, for the Prostate pathway, the GP referral would be triaged by the Urology Consultant.




**5.3 Triage of GP referrals – SHSCT**

The process of Urology triage in CAH, is based upon the NI Referral Guidance for Suspected Cancer of 2012 as described above i.e. it is based on the 2005 NICE CG27 guidelines and not the more up to date 2012 NG12 . In CAH, triage of referrals is performed by the Consultant Urologist of the week.

The SHSCT Urological Cancer multi-disciplinary team (MDT) was led at the time by Consultant 1 (Cons1), who was also a joint chair.

Over a period of decades, within the SHSCT and Craigavon AH, there were occasions when triage was not performed; certain specialities and individual Consultants were repeat offenders. Acute Services had a particular problem with this issue. Preliminary discussions by the Review Team revealed that triaging within Acute Services was a, "*very haphazard process going back for approximately 25 years. There were many Consultants who would not triage but Consultant 1 was the most persistent and there were multiple attempts to tackle this issue*".

<u>Interview with Associate Medical Director (AMD1)</u>

AMD1 first became aware of waiting list problems with Cons1 in 1996–8 when AMD1 was the lead clinician in outpatients. Cons1's OPD letters were being kept in a ring binder and were not on any waiting list. Once challenged, Cons1 would stop this practice and improve but would then slip back. There were further non-triage meetings with Cons1 when AMD1 was the Clinical Director of Surgery.

<u>Interview with Director of Acute Services (DAS2)</u>

In 2007, DAS2 (while in previous post in CAH) found a waiting list which was 10 years long. They



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worked on this with the Consultant, Cons1, and cleaned it up; they found no serious patient related issues.

Interview with Director of Acute Services (DAS1)
DAS1 indicated that the Urology Services were under various kinds of pressure during her time as Director. There was a regional transformation project in place for Regional Urology Services under Mr M. Fordham; this generated an element of pressure to modernise and change. Along with this and other issues, including the triage problem, Consultant 1 struggled to adapt to these changes and to comply with the other issues and triaging. DAS1 paints a picture of many issues with Cons1, triaging being only one of many issues but, in her opinion, not the most important issue.

Nevertheless, in April 2010, Consultant 1 (Cons1) was put under pressure to complete his triage list. The surgical Associate Medical Director (AMD1) brought concerns to DAS1. The other Urologists had been 'covering' triaging for Cons1; the Head of Service Surgery had informed AMD1 of this. They met Cons1 the next day. The European Association of Urology meeting was in Spain the following day and Cons1 wished to attend. DAS1 and AMD1 informed Cons1 he would not be attending the meeting unless he triaged all his referrals immediately. Cons1 duly addressed the triage backlog, completing them that evening. From that time on, AMD1 and the Head of Service (HoS1) monitored that Mr O'Brien was triaging the GP referral letters. However, DAS1 commented that the HoS1 had a difficult job managing Cons1.

Following interview with Head of Service (HoS1)
The Head of Service for Urology (HoS1) indicated that she inherited the problem upon appointment although she was aware that it was a long running issue, going back perhaps 25 years. She highlighted this was an ongoing issue with Cons1. He was the commonest offender and took longest to triage. There were issues with other Consultants who, on occasion, did not triage but Cons1 was the only one, when asked to triage, didn't do it. This came to head in 2010 (referred to above) and again in 2014.

Informal Default Triage (IDT) process
In May 2014, after escalation to HoS1, an Informal Default Triage (IDT) process was put in place by the Trust's booking centre. This process allowed the booking office to allocate patients, who had not been triaged in time, to be allocated to a 'waiting list' using the GP triage category. Therefore, this IDT process of putting patients on the waiting list without triage meant that they did not get missed. However, some patients, who should have been triaged as a red flag, waited on the waiting list with their 'incorrect' GP triage category. After much discussion, this detailed process was formally circulated to all specialties on the 6th November 2015 by the Assistant Director of Support Services (ADSS1).

When questioned about this IDT process, the DAS2 was not aware of it even though it started during her time in post i.e. May '14. When asked about its potential problem of leaving incorrectly triaged (by their GP) patients on a waiting list she stated, "*Completely ridiculous, because would allow a cancer patient who should have been red flagged by their GP to go unchallenged by a Consultant triage process i.e. could have to wait for 11 months*".



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**5.4 Index case**

In 2016, the SHSC Trust investigated (RCA ID 52720), in what subsequently became an 'Index case' for the cases in this RCA, the treatment and care of Patient 10 . Patient 10 was a patient who had had Ca Colon (2010), breast carcinoma (2013) and then developed renal carcinoma. During review for her Breast Ca in June 2014, a CT Scan revealed that, previously noted, renal cysts had increased in size. Further investigation by a MRI scan was reported in a limited and incomplete fashion; resulting in a 'routine' referral GP letter on 29/10/2014.

During the investigation, the Review Team identified that Patient 10 's GP referral letter had not been triaged; the Consultant Urologist with responsibility that week for triage duties was Cons1. This referral therefore waited as a 'new routine' referral till January 2016 to be seen by a Consultant Urologist.

The index case Review Panel agreed 3 main contributing factors led directly to Patient 10 's delay in diagnosis. Firstly, the content of the MRI report; secondly a letter following a CT scan did not mention important information and thirdly, the opportunity to upgrade the referral to red flag was lost by the omission of triage; this resulted in a 64-week delay to diagnosis of a suspicious renal mass.

The index case Review Panel concluded in March 2017 that, "…. *a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process (*vide infra*) continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team*".

Of the 2 lessons learnt, one indicated that,

> "*Triage of GP referral letters remains a key element in validating appropriate utilisation of specialist services and ensuring patient safety. Triage also serves as an opportunity for early intervention for patients at risk of malignant disease or clinical deterioration*."

This led to a recommendation that,

> "*This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with the Integrated Elective Access Protocol (IEAP).*
>
> *In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The Urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP.*"

The findings of this investigation, chaired by Consultant Urologist 2 (Cons2), were made available in December 2016 and formally signed off on the 15th March 2017. A letter highlighting a number of concerns was sent to the (then) lead for Acute Governance for Acute Services (AGAS1), on the 15th December 2016.



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The letter pointed out that the IDT process implied that triage non-compliance was to be expected but that this process did not have a clear escalation plan to include the individual Consultant and, indeed, had not been effective in addressing triage non-compliance. Furthermore, the letter pointed out that, from July 2015 till October 2016, there were 318 non-triaged letters which the Trust could not provide assurance that patients were not being exposed to harm by waiting as a routine or urgent appointment i.e. when they should have been red-flagged.

It is not absolutely clear who wrote this letter as it has no signature, but it appears to have been written by, or on behalf of, Cons2. On the 10th January 2017, Cons2 was requested by the Medical Director (MD3) to share the report with the 2 key Consultants involved in the SAI. One of these was Cons1. Cons2 refused, stating that he was Cons1's colleague and not his manager.

This letter was escalated to the Director of Acute Services (DAS3) and the Assistant Director of Anaesthetics & Surgery. This was further escalated to the Chief Executive of the SHSCT.

Cons1 was written to by AMD1 on the 23rd March 2016, acknowledging his hard work as a Consultant Urologist but pointing out that there were governance and patient safety concerns with regard to untriaged letters dating back over 2 years, and other important issues. Cons1 was asked to respond with a commitment and immediate plan to address these issues.

The Review Panel also determined that there were 7 other patients who were not triaged that week along with Patient 10 They subsequently performed a 'look-back' exercise (number 1) of these referrals. Of the seven referrals, six charts were available and each patient had an appropriate management plan. One set of notes were missing and efforts were made to find them.

Cons1 provided his personal review, dated 25/01/2017, of the Index Case to the Chairman of this Review Team. It provides an argued retrospective rationale that a timely triage by himself would not have altered the referral grading. However, it does not provide a sound reason for his actual lack of triage. His report is consistent in arguing his view that he does not have time to perform both Consultant of the Week (CoW) duties and triaging of non-red flag referrals.

**5.5 Look back exercise #2**

Upon realisation that the 'look-back' exercise #1 had resulted from non-triage over the week beginning the 30/10/2014, further efforts were made to investigate the size of this non-triage issue and to find missing referral letters. Cons1 was contacted and the Head of Service for Urology (HoS1) obtained permission to look for missing GP referral letters in his filing cabinet. Cons1 stated that there were referral letters in a filing cabinet in his office. During interview, he stated that he kept the referrals to ensure they would not be missed or overlooked. The Head of Service for Urology retrieved these referral letters, which numbered over 700 along with the triage lists from the booking centre.

These referrals were then reviewed by the Urology Consultant Team revealing 30 patient referrals should have been red-flagged and four of these patients, following review, were diagnosed with cancer, becoming the subject of this review.



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On the 08 September 2016 Patient 12 a Personal-year-old male was referred to Urology Outpatients for assessment and advice on lower tract symptoms and elevated PSA.
The referral was marked Urgent by the GP.
The referral was not triaged on receipt.
27/01/2017 – further GP letter – please upgrade to R/F.
30/01/2017 - as part of the internal review #2, upgraded to R/F.
06/02/2017 - seen in clinic on day 152.
11/04/2017 (D215) - confirmed cancer diagnosis T3a with no nodal metastases – high risk and there was a recommendation of treatment for a locally advanced non-metastatic prostate cancer.
**Conclusions**
Resultant 8-month delay in obtaining diagnosis.
Following Review Team consideration, it is probable that the delay is not clinically significant.

**SECTION 3 - LEARNING SUMMARY**

**14.** WHAT HAS BEEN LEARNED:

The Review Team interviewed a number of Trust staff including Directors (past and present), an Assistant Director, Head of Service and an Associate Medical Director as part of the review process. These interviews, along with clinical documents and health records systems, have helped inform the conclusions by providing the evidence and also corroboration where there appeared to be differences of opinion.

The Review Team and everybody interviewed, including Cons1, provided affirmation that a timely, efficient triage system which checked the initial GP referral was very important to patients. Comments made when interviewees were asked about the importance of triage and where the process of triaging a potential cancer patient ranked alongside other issues such as probity, patient experience and performance, were consistent,

*"Very significant". Very high up the list in terms of importance".*
*"It is fundamental people are seen in the appropriate time".*
*"Very important" ... "Important for the patient".*
*"Vital" ... "Very significant .. patients are often anxious and depend on the system to work".*

Cons1 replied,

*"It is a serious issue, very important"..... "Number one ranking in overall scheme of things"*

The Review Team established that there were factors in HSC service delivery to the 5 patients under examination that resulted in an unnecessary delay in treatment and care. In 4 patients the delay was thought not to be clinically significant but in 1 Patient 13 there probably was a significant delay.

Consideration of the causative factors to the patients' delays reveal,

- Referral letters did not have the clinical priority accurately assigned by the GP; and



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- Referral letters were not triaged following receipt by the Hospital.

**7.1 Referral letters did not have the clinical priority accurately assigned by the GP.**

**Contributory factors**

***Task Factors (policy and guidelines)***
The Review Team reviewed the GP referrals regarding the five patients listed above. They concluded, as judged from the Northern Ireland Cancer Network (NICaN) Referral Guidance for Suspected Cancer (December 2012), that all five patients should have been referred to Urology by the GP's as red flag referrals (suspected cancer) i.e. incorrect triage.

***Task Factors (decision aids)***
The current decision aid for GPs is the NI Referral Guidance for Suspected Cancer 2012 based on NICE CG 27 *Referral guidelines for suspected cancer* published in June 2005. It is clear that Secondary care, in the form of Consultant Urologists, should triage these GP referrals; by doing so, 11% of GP referrals are changed (from Review Team member). It is also clear that Cons1 would have been in no doubt as to his responsibilities; he was intimately involved in setting this standard and signed off the NICaN clinical guidelines.

However, it is clear this very important and critical triage safety net work can be considered onerous and other electronic methods which GPs can use might be more efficient and help to reduce that load.

According the HoS1, most patient referrals by GPs to Trusts for outpatient appointments are now made through the electronic Clinical Communication Gateway (CCG). However, some paper referrals are still received. CCG is a digital referral system for Primary care which can contain referral criteria that meet NICE and NICaN guidance. This would enable appropriate clinical triaging of referrals to be performed as part of the selection of referral reasons and/or symptom description.

Using the electronic CCG pathway, some clinical specialties, such as gynaecology, have worked closely with the Public Health Authority to develop a better GP referral tool e.g. using 'banner guidance' (a specialty specific banner, listing symptoms and signs) which complies with NICE/NICaN guidance. This 'banner guidance' helps by directing clinicians to use the NICE/NICaN referral criteria which allow for timely and appropriate triage of patients to clinically appropriate appointment types. It is possible when red flag symptoms are chosen that an immediate alert could go to the Red Flag booking team, to allow the appointment booking process to begin immediately. However, currently, the referral criteria fields are optional i.e. not mandatory, so opening up the possibility that fields are not completed, leading to error and delay.

***NICE NG12***
The reference CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* but, despite being endorsed by the DHSSPSNI and accepted by the Regional Urologists, it has yet to be implemented. Its use as a triage standard should result in fewer red-flagged cases which should ease some of the pressure on waiting lists. Its adoption would take place in primary care and should form the basis of the electronic CCG referral tool.



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There was a consistent medical staff view from the Review Team, the AMD1, and indeed Cons1, that GP's have a crucial and important responsibility in getting the referral criteria/urgency category correct. If the GP does not provide enough, or the correct information, the NI Electronic Care Record (NIECR) needs to be checked and that slows the whole triage process down. It was clear that the triage system works best when the initial GP referral is usually correct and the Secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

**7.2 Referral letters were not triaged following receipt by the hospital.**

**Contributory factor**

***Task Factors (policy and guidelines)***

The Integrated Elective Access Protocol (IEAP) (DHSSPS, April 2008) defines the roles and responsibilities of staff (in both primary and secondary care) when patients enter an elective care pathway. It states,

> '…*an Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to…. Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first'*.

The Principles for booking Cancer Pathway patients states,

> "clinical *teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients*".

and,

> "*Referrals will be received, registered within one working day and forwarded to Consultants for prioritisation*".

However, the IEAP states,

> *"…if clinical priority is not received from Consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency".*

Following on from the IEAP of 2008, national and regional policies and guidelines, already referred to above, have been introduced which have outlined the detailed role of the Urology Consultant in triaging referrals that have come in from Primary care e.g.,

- Service Framework for cancer prevention, treatment and care (Standard 13) 2011;
- NI Referral Guidance for Suspected Cancer 2012; and
- NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016).

These have provided agreed lists of the critical symptomatology of Urological cancers and the roles and responsibilities of Primary and Secondary care staff in ensuring patients receive prompt recognition and treatment of their cancer.

***Review of Adult Urology Services in Northern Ireland***

In March 2009, a *Review of Adult Urology Services in Northern Ireland - A modernisation and investment plan* was published. Its External Advisor was Mr Mark Fordham. SHSCT Consultant



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Urologists were represented on the committee.

Recommendation 4 states, "*Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system".* Consultants indicated that they would routinely upgrade a significant number of routine and urgent referrals (GP) to urgent or red flag. It was noted that the development of agreed referral guidelines/criteria for suspected Urological cancers was a priority piece of work for the recently formed NICaN Group. That work was led by Cons1; see page 6.

Section 3.31 of the report indicates that, "*Consultant Urologists unanimously consider that referral triage should be led by Consultants. With over 40% of referrals being cancer related (and with many not red flagged or marked urgent) they believe that they are best placed and skilled to undertake the triage process. They also believe that despite the volume of referrals, this is not a particularly time consuming process*."

**Contributory factor**

***Staff factor***

It is obvious from reading the documents referred to above that Cons1 has been aware of developments in this field and, indeed has been party to the discussions and signed some of them off. Cons1 was chair of NICaN (Urology) and was involved in drafting the NICaN regional Urology guidance, and therefore was very familiar with the requirement to triage GP referrals.

Despite all of this, and even though Cons1 agreed that this triaging role was, "*very important*", …. it was, "*a very serious matter not to be minimised, very serious"* he stated he would not triage non-red flag referrals.

When asked, *"Does triage still need done?"* Cons1 answered*, "a procedure is needed to highlight when it needs done and who does it".* When further asked, *"Who was involved in SHSCT Urology service in setting up triage"?* Cons1 answered for urological cancer, "*I was the Lead"*.

He felt triage of referral letters was too time consuming and the amount of time spent on triage, in his opinion, rendered inpatient care unsafe. He highlighted that he had previously escalated his concerns about work load to management teams and medical directors.

In relation to triage, Cons1 stated, '*I would love if we had a Trust Urology agreement on the type of triage to be conducted*'. When it was pointed out that, "*Consultant colleagues did triage for you. How did they do it?"* He stated, "*It depends on how you do it"* ..... "*Not all do advanced / enhanced triage, they compromise. It is a spectrum"... "They have not done it in the detail I felt it needed for routine/urgent non-red flag case".*

When questioned further, regarding his way of organising his own work load, Cons1 stated, '....*yes I did it my way – I wasn't cognisant of being unbending, I am very particular*'.

Cons1 highlighted to the Review Team that he currently takes annual leave each Friday and spends the weekend triaging. He stated that it is impossible to be Urologist of the Week and triage referrals



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appropriately. He stated he still can't do triage and everything else. He stated, '*I do triage entirely in my own time to allow me to do it properly*'.

When asked about using the NIECR - Electronic Referral using the Clinical Communication Gateway (CCG) method, Cons1 stated found the new CCG triage system*, "Very, very good, I wish all information was available on ECR. It is less time consuming. ECR makes it easier to check information".*

The Review Team concluded that there was a serious inconsistency between the guideline standard that a Consultant should triage GP referrals (which Cons1 helped to construct) along with his stated view of the crucial importance of triage and Cons1's actual practice.

Cons1's chosen method of triage was beyond what is required. His triage is the equivalent of a virtual clinic where he reviews NIECR and books investigations for patients. While the Review Team recognised this was a detailed triage process, they concluded that his prioritisation of work and attention to detail meant that some patients got a higher standard of triage/care, while, crucially, others were not triaged, leading to a potentially critical delay in assessment and treatment for those patients. Cons1 is aware of this.

The Review Team concluded that Cons1's prioritisation of work and attention to detail led to some patients receiving a high standard of care, while others ran the real risk of having a cancer diagnosis delayed till it was dangerously late.

**Contributory factor**

***Work load/scheduling***

In 2008, when the IEAP was published, there was a maximum waiting time of 9 weeks for a first Outpatient appointment. On 30th September 2016, there were 2012 patients on the routine Urology outpatient waiting list, with 597 patients showing as waiting 52 weeks and over. The longest waiting time was 554 days (80 weeks). Therefore, if patient referrals are incorrectly referred, or not triaged and continue to use the GP's classification of urgency, there will be a significant wait. Cons1 is aware of this reality.

The Review Team considered the Consultant of the Week (CoW) work load, including ward rounds, clinics, emergency theatre sessions as a contributory factor. Cons1 has consistently argued that he cannot triage non-red flag referrals and carry out the duties of the CoW. He has not indicated who else should carry out the triage duties. However, the Review Team note that the other Consultant Urologists were able to manage this work load and triage referral letters in a timely fashion, with other members of the consultant team also ordering investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to outcomes achieved from Cons1's 'advanced triage'.



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**Contributory factor**

***Organisationa*l**

The Review Team concluded that the non-triage of Urology referrals by Cons1 has been an ongoing problem in the Trust for many years, possibly decades. While there were pockets of non-compliance by other Consultants, when escalated, compliance improved. However, the Review Team note that Cons1 consistently did not return triage information on referrals thus not allowing the appropriate prioritisation of appointments by clinical need.

Interviews with 2 previous and the current Director of Acute Services, AMD1 and the Head of Surgery Service have highlighted that on many occasions, over a prolonged period, attempts had been made by the Trust's officers to address Cons1's non-compliance with triage. These attempts encompassed both direct face to face conversations which were often heated, correspondence and, as in 2010, study leave refusal until there was compliance. These interventions all resulted in a familiar pattern of response; temporary improvement in compliance with triage, followed by a return to non-compliance.

In 2014, due to continuing non-compliance, the Trust implemented an 'Informal' Default Triage Process to manage the referrals which were not being triaged and returned to the Booking Centre. The Review Team considered the intention of this process was to prevent any delay in patients being added to the waiting list. However, this meant the 'non-return of triage' was not individually addressed with the non-compliant clinicians. Furthermore, and most importantly, it allowed patients, who should have been red-flagged, to remain on a waiting list until review.

In 2014, the Director of Acute Service 2 (DAS2) discussed non-compliance with Cons1 and agreed that Cons1 would no longer triage referral letters. Cons1 was heavily involved with formulating the NICaN Urology guidelines at the time and was grateful to the extent that he thanked DAS2.This task was delegated to other Urology Consultants for a time. However, Cons1 does not recollect having to formally stop triage. At interview, DAS2 was not aware that he had resumed those duties; she remembered that their Cancer performance figures improved when Cons1 was not triaging.

***Escalation within Organisation***

At every interview, questions were asked whether Cons1's consistent and prolonged non-compliance with triaging was referred upwards to executive level i.e. the Medical Director and Chief Executive.

Director DAS1 considered that the problem was being managed at Service level, although as it was only one of a series of issues and considered to be a 'minor' one, it did not predominate at higher level meetings with the Medical Director (MD1); to the extent that he may not have been aware of it.

Director DAS2 considered that the problem was dealt with by agreeing with Cons1 to stop triaging. There were other issues that were flagged up to MD2, but she was not able to remember whether MD2 was made aware of the triage problem.

During DAS3's current tenure Executive members certainly knew; at CAH Oversight meeting level and at the time of the look back exercise #2 which ultimately led onto this SAI and RCA process. The Medical Director (MD3) was directly involved in the RCA process and the CEO was aware. At Trust Board level, it is thought that a non-Executive member was asked to examine the situation which



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would indicate that it had also reached that level.

Overall, the Review Team in considering whether there was a satisfactory escalation of this 'non-triage' issue have concluded that there was no evidence of consistent and proactive escalation of 'non-return of triage' either to the Medical Director or the Chief Executive until the look back exercise #2 basically forced the seriousness of the issue out into the open. Indeed, they do not appear to have appreciated the importance of triage, certainly from the patient's perspective. The Trust's officers made efforts to address Cons1's non-triage over time but were consistently thwarted by Cons1's refusal to comply. The Trust failed to put systems, processes and fail safes in place to ensure Cons1's consistently triaged patient referrals until 2017.

Systems and processes have now been put in place so that the Head of Service for Urology reviews Cons1's compliance with triage. HoS1 will check all Urology triage on an adhoc basis but, with Cons1, she will check daily when he is the Consultant of the Week. Any non-compliance with returning referrals without triage is addressed immediately. However, this process is heavily dependent on HoS1 who, when she is on leave, often has to recover non-triaged cases upon her return.

**15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?**

1. The clinical urgency category allocated by GPs to 30 patients referred to Urology were incorrect. The referrals using NICaN guidance should have been referred as a Red Flag. Four (plus 1) of these patients were subsequently shown to have cancer.
2. The process of triaging Urology cancer referrals from Primary Care to Secondary Care, under the direction of the HSCB, appears to be less efficient than it could be, bearing in mind that NICE NG12 guidance has not been adopted and electronic referral using CCG is not being used as efficiently as it could.
3. GP's are not mandated to provide HSCB with an assurance that they comply with the most up to date NICE or other guidelines. Therefore, HSCB are unaware of any risks consequent upon the non-compliance with NICE and other guidance within GP practices.
4. GP's are not mandated to refer patients using CCG clinical criteria banners; this can lead to error and delay.
5. There is no Regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters. Triage of patient referrals is obviously viewed as extremely important but does not seem to be at an equivalent level of importance when ranked alongside other clinical governance issues. Despite being an evident problem for decades and requiring considerable time and effort to find a solution, it only really surfaced within the Trust after an Index case forced the situation out into the open.
6. Despite it being absolutely clear to Consultant 1 (based upon his close proximity to the development and signing off of regional guidance) of the consequences of non-triage, he did not routinely triage referral letters. The Review Team consider that Cons1's refusal to triage to



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a level similar to other clinicians, led to patients not being triaged, and this resulted in delays in assessment and treatment. This may have harmed one patient.

7. Cons1 confirmed that despite the Trust reminding him of the requirement to triage, he did not consistently triage referrals. He argued that, due to time pressures, he felt he was unable to perform the duties of the Consultant of the Week and his triaging duties. He has highlighted those views to Trust operational and management teams over a number of years.

8. The Trust made efforts to address Cons1's non-triage over time. However, the Trust failed to put systems, processes and fail safes in place to ensure Cons1 consistently triaged patient referrals until 2017. However, this safeguarding process is heavily dependent on the Head of Service checking triage is completed when Cons1 is Consultant of the Week.

9. The Informal Default Triage process allows patients who should be red flagged to remain on a waiting list of routine or urgent cases.

From examining the triaging issue over the length of time it has existed, it is obvious that there is an unwillingness or inability within the medical hierarchy to tackle its 'difficult colleague' problem. The reasons behind this probably include not taking ownership of its own problems and poor support from senior medical management perhaps resulting in issues not being referred upwards.

**16. RECOMMENDATIONS (please state by whom and timescale)**

**Recommendation 1**
HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

**Commented [KP1]:** We need to consider when making recommendations for the HSCB. Maria to take back to the chair.

**Recommendation 2**
HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

**Recommendation 3**
HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

**HSCB, Trust and GPs**
**Recommendation 4**
GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

**TRUST**
**Recommendation 5**
Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

**Commented [KP2]:** Is already happening go straight to test.



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**Recommendation 6**
The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

**Commented [KP3]:** Need fine tuned

**Recommendation 7**
The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.

**Commented [KP4]:** This is in place

**Recommendation 8**
The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

**Commented [KP5]:** Will work for a majority of cases but not unusual to upgrade the triage in certain specialities.

**Recommendation 9**
Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

**Commented [KP6]:** In place already

**Recommendation 10**
The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

**Commented [KP7]:** approve

**CONSULTANT 1**
**Recommendation 11**
Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

**Commented [KP8]:** internal manner remove from family reports
systems in process in place not spotlighting an individual to go to families.

**Recommendation 12**
Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation

**Commented [KP9]:**

**17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:**

**18. FURTHER REVIEW REQUIRED? NO**
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.



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| **SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)** | |
|---|---|
| **19.** PLEASE INDICATE LEVEL OF REVIEW:<br>LEVEL 2 / LEVEL 3<br>**Please select as appropriate** | **20.** PROPOSED TIMESCALE FOR COMPLETION:<br>DD / MM / YYYY |
| **21.** REVIEW TEAM MEMBERSHIP *(If known or submit asap)*: | |
| **22.** TERMS OF REFERENCE *(If known or submit asap)*: | |

| **SECTION 5** | |
|---|---|
| **APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR** | |
| **23.** NAME: | **24.** DATE APPROVED: |
| **25.** DESIGANTION: | |

| **SECTION 6** |
|---|
| **26.** DISTRIBUTION LIST:<br><br>In addition to the Review Team, the following.<br>Patient Patient 12<br>Mr S Devlin, Chief Executive SHSCT.<br>Dr Maria O'Kane, Medical Director, SHSCT.<br>Mrs Melanie McClements Director of Acute Services.<br>Health & Social Care Board (HSCB).<br>Chairs of Morbidity & Mortality Groups SHSCT. |



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**Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident**

| | | | |
|---|---|---|---|
| **Reporting Organisation SAI Ref Number:** | Patient 12 | **HSCB Ref Number:** | |

| **SECTION 1** | | | | | |
|---|---|---|---|---|---|
| **INFORMING THE SERVICE USER[1] / FAMILY / CARER** | | | | | |
| 1) Please indicate if the SAI relates to a single service user, or a number of service users.<br>**Please select as appropriate (✓)** | **Single Service User** | | **Multiple Service Users*** | **X** | |
| | **Comment:**<br>***If multiple service users are involved please indicate the number involved*** | | | | |
| 2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI?<br>**Please select as appropriate (✓)** | **YES** | **X** | **NO** | | |
| | If **YES**, insert **date informed**: | | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI | | | | |
| | a) No contact or Next of Kin details or Unable to contact | | | | |
| | b) Not applicable as this SAI is not 'patient/service user' related | | | | |
| | c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | | | |
| | d) Case involved suspected or actual abuse by family | | | | |
| | e) Case identified as a result of review exercise | | | | |
| | f) Case is environmental or infrastructure related with no harm to patient/service user | | | | |
| | g) Other rationale | | | | |
| | **If you selected c), d), e), f) or g) above please provide further details:** | | | | |
| 3) Was this SAI also a Never Event?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | **X** | |
| 4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event?<br>**Please select as appropriate (✓)** | **YES** | If **YES**, insert **date informed**: DD/MM.YY | | | |
| | **NO** | If **NO**, provide details: | | | |
| **For completion by HSCB/PHA Personnel Only** (Please select as appropriate (✓)) | | | | | |
| **Content with rationale?** | **YES** | | **NO** | | |

| **SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER**<br>*(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)* | | | | |
|---|---|---|---|---|
| 5) Has the Final Review report been shared with the Service User[1] / Family / Carer?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert date informed: | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer: | | | |
| | a) Draft review report has been shared and further engagement planned to share final report | | | |



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| SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)* | | |
|---|---|---|
| | b) Plan to share final review report at a later date and further engagement planned | X |
| | c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)*** | |
| | d) No contact or Next of Kin or Unable to contact | |
| | e) No response to correspondence | |
| | f) Withdrew fully from the SAI process | |
| | g) Participated in SAI process but declined review report | |
| | ***(if you select any of the options below please also complete 'l' below)*** | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer | |
| | i) case involved suspected or actual abuse by family | |
| | j) identified as a result of review exercise | |
| | k) other rationale | |
| | l) If you have selected **c), h), i), j), or k)** above please provide further details: | |

| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)**) | | | | |
|---|---|---|---|---|
| **Content with rationale?** | **YES** | | **NO** | |

| SECTION 2 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)* | | | | | | | | |
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)** | **YES** | | **NO** | X | | | | |
| | If **YES**, insert **date informed**: | | | | | | | |
| | If **NO**, please provide details: | | | | | | | |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)** | **YES** | | **NO** | | | | | |
| | If **YES**, insert **date report shared**: | | | | | | | |
| | If **NO**, please provide details: | | | | | | | |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)** | **YES** | | **NO** | | **N/A** | | **Not Known** | |
| | If **YES**, insert **date informed**: | | | | | | | |
| | If **NO**, please provide details: | | | | | | | |

| **DATE CHECKLIST COMPLETED** | **20/01/2019** |
|---|---|

[1] *Service User or their nominated representative*



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# LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

## SECTION 1

| | |
|---|---|
| **1. ORGANISATION:** SHSCT | **2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Patient 15 |
| **3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:** | **4. DATE OF INCIDENT/ EVENT: 30/08/2019** |
| **5. PLEASE INDICATE IF THIS SAI IS**<br>**6. INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS:** No | **7. IF 'YES' TO 5. PLEASE PROVDE DETAILS:** |

**8. DATE OF SEA MEETING / INCIDENT DEBRIEF:**

**9. SUMMARY OF EVENT**:

During an internal review in 2016, following an Index Case, the Trust identified a number of GP Urology referrals who were not triaged by one particular Consultant Urologist; 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient Patient 15, discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed.

Patient 15 a Personal Inform-year-old male was referred to Urology Outpatients on 30 August 2015 for assessment and advice for an elevated Prostate specific antigen (PSA) (The blood level of PSA is often elevated in men with prostate cancer). The referral was marked Routine by the GP. The referral was not triaged on receipt. However, a second GP referral was received on 29 January 2016 marked Suspected Cancer Red Flag and had received a red flag appointment. Following this referral, he was seen in clinic on 8 February 2016 (D153). On day 166, Patient 15 was diagnosed with a confirmed cancer; a resultant 6-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

## SECTION 2

| **10. SEA FACILITATOR / LEAD OFFICER:** | **11. TEAM MEMBERS PRESENT:** |
|---|---|
| Dr J R Johnston- Consultant Medical Advisor | Mr M Haynes - Consultant Urologist<br>Mrs K Robinson - Booking & Contact Centre Manager<br>Mrs T Reid - Acute Clinical & Social Care Governance Coordinator |

**12. SERVICE USER DETAILS**:

Patient 15 H&C: Personal Information redacted by the USI



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**13. WHAT HAPPENED?**

5.1 Triage of GP referrals - background
The general public expect that, when they engage with their GP complaining of symptoms that are potentially due to a cancer, they will be referred to the appropriate secondary care services promptly and that they will respond, also promptly, to confirm or exclude the diagnosis of cancer.

The DHSSPSNI Service Framework for cancer prevention, treatment and care (Standard 13) of 2011 indicates, “All people with signs and symptoms that might suggest cancer should be appropriately assessed by their GP and referred promptly on to hospital for further tests if needed”.

Cancer specialists, working in networks, have formulated lists of symptom and sign triggers which can signify the development of a cancer. Using these lists, primary care doctors can refer patients into secondary care; triaging a large number of patients by assigning them to different degrees of urgency (Routine, Urgent and Red-flag). If these are used as designed, this can provide an efficient referral system.

NICE have been instrumental in ensuring uniformity and the validity of these cancer recognition and referral lists of symptoms and signs. They have also formulated guidance regarding how safety nets should be setup to ensure patients are not missed. Local programmes, using this type of guidance, have been established, under the auspices of NICaN and the HSCB, to set up these triage pathways and safety nets.

5.2 Triage of GP referrals – Northern Ireland
NI Referral Guidance for Suspected Cancer (2012)
The Northern Ireland Referral Guidance for Suspected Cancer 2012 is based on the NICE clinical guideline, CG 27 - Referral guidelines for suspected cancer, published in June 2005. This has a section on Urological Cancer. It was introduced to GPs by HSCB correspondence (30/12/2012), revealing the new red-flag process and indicating in appendix A that, “triaging will take place in a timely manner, within 72 hours of receipt of referral or the referral should continue with the GP Prioritisation”.

This is still the only set of referral guidance for suspected urological cancer available online on the NICaN website (last accessed 18/11/2018).

However, the 2005 CG27 guidance has been replaced by NICE Guideline NG12 Suspected cancer: recognition and referral published in June 2015. This was endorsed by the Department of Health (NI) with HSC (SQSD) (NICE NG12) 29/15 on the 19th August 2015 which instructed the HSCB / PHA to send out the guidance to the appropriate Family Practitioners. This particular kind of guidance requires the HSCB to circulate regionally endorsed NICE guidelines to Trusts and GPs for implementation. Trusts are expected to review guidance against a base line assessment and provide HSCB with an assurance that the guidance has been implemented. If a Trust is unable to fully implement the guidance within the one-year period without regional co-ordination and/or additional resources, they should provide a formal assurance to HSCB, and this is to be managed as part of the risk management process. This assurance process does not however apply to primary care and GP’s.

NICaN Urology Cancer Clinical Guideline (2016)
The NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016), was produced regionally to support the diagnosis, treatment and management of urological cancer.
This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.



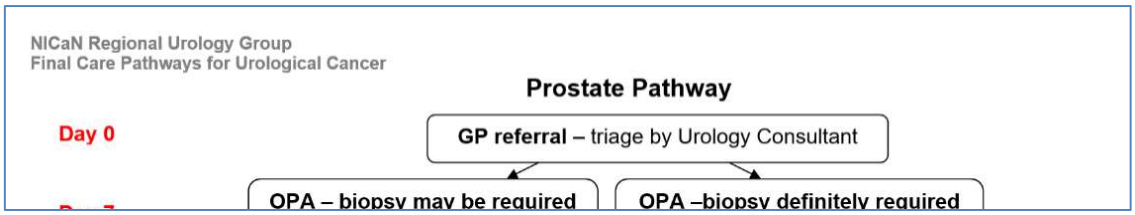
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The Review Team's evaluation of the advantages of NICE NG12 (2015) over the CG27 (2005) guidelines reveals fewer cases would be red-flagged for Urology, as a result of,

- a reduction in number of non-visible haematuria patients; and
- increases in age criteria of 45 years and over.

However, rollout of NG12 by the HSCB does not appear to have happened. The Review Team understands that the reason NG12 has not been implemented lies with ongoing discussions between the HSCB and GPs.

Appendix 2 of the NICaN Urology Cancer Clinical Guideline guidelines highlights the Urology Care pathways. Cons1 was present at the workshop discussing those on 02/10/2008. It clearly indicates that, for the Prostate pathway, the GP referral would be triaged by the Urology Consultant.




**5.3 Triage of GP referrals – SHSCT**

The process of Urology triage in CAH, is based upon the NI Referral Guidance for Suspected Cancer of 2012 as described above i.e. it is based on the 2005 NICE CG27 guidelines and not the more up to date 2012 NG12 . In CAH, triage of referrals is performed by the Consultant Urologist of the week.

The SHSCT Urological Cancer multi-disciplinary team (MDT) was led at the time by Consultant 1 (Cons1), who was also a joint chair.

Over a period of decades, within the SHSCT and Craigavon AH, there were occasions when triage was not performed; certain specialities and individual Consultants were repeat offenders. Acute Services had a particular problem with this issue. Preliminary discussions by the Review Team revealed that triaging within Acute Services was a, "*very haphazard process going back for approximately 25 years. There were many Consultants who would not triage but Consultant 1 was the most persistent and there were multiple attempts to tackle this issue*".

<u>Interview with Associate Medical Director (AMD1)</u>

AMD1 first became aware of waiting list problems with Cons1 in 1996–8 when AMD1 was the lead clinician in outpatients. Cons1's OPD letters were being kept in a ring binder and were not on any waiting list. Once challenged, Cons1 would stop this practice and improve but would then slip back. There were further non-triage meetings with Cons1 when AMD1 was the Clinical Director of Surgery.

<u>Interview with Director of Acute Services (DAS2)</u>

In 2007, DAS2 (while in previous post in CAH) found a waiting list which was 10 years long. They worked on this with the Consultant, Cons1, and cleaned it up; they found no serious patient related issues.



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Interview with Director of Acute Services (DAS1)
DAS1 indicated that the Urology Services were under various kinds of pressure during her time as Director. There was a regional transformation project in place for Regional Urology Services under Mr M. Fordham; this generated an element of pressure to modernise and change. Along with this and other issues, including the triage problem, Consultant 1 struggled to adapt to these changes and to comply with the other issues and triaging. DAS1 paints a picture of many issues with Cons1, triaging being only one of many issues but, in her opinion, not the most important issue.

Nevertheless, in April 2010, Consultant 1 (Cons1) was put under pressure to complete his triage list. The surgical Associate Medical Director (AMD1) brought concerns to DAS1. The other Urologists had been 'covering' triaging for Cons1; the Head of Service Surgery had informed AMD1 of this. They met Cons1 the next day. The European Association of Urology meeting was in Spain the following day and Cons1 wished to attend. DAS1 and AMD1 informed Cons1 he would not be attending the meeting unless he triaged all his referrals immediately. Cons1 duly addressed the triage backlog, completing them that evening. From that time on, AMD1 and the Head of Service (HoS1) monitored that Mr O'Brien was triaging the GP referral letters. However, DAS1 commented that the HoS1 had a difficult job managing Cons1.

Following interview with Head of Service (HoS1)
The Head of Service for Urology (HoS1) indicated that she inherited the problem upon appointment although she was aware that it was a long running issue, going back perhaps 25 years. She highlighted this was an ongoing issue with Cons1. He was the commonest offender and took longest to triage. There were issues with other Consultants who, on occasion, did not triage but Cons1 was the only one, when asked to triage, didn't do it. This came to head in 2010 (referred to above) and again in 2014.

Informal Default Triage (IDT) process
In May 2014, after escalation to HoS1, an Informal Default Triage (IDT) process was put in place by the Trust's booking centre. This process allowed the booking office to allocate patients, who had not been triaged in time, to be allocated to a 'waiting list' using the GP triage category. Therefore, this IDT process of putting patients on the waiting list without triage meant that they did not get missed. However, some patients, who should have been triaged as a red flag, waited on the waiting list with their 'incorrect' GP triage category. After much discussion, this detailed process was formally circulated to all specialties on the 6th November 2015 by the Assistant Director of Support Services (ADSS1).

When questioned about this IDT process, the DAS2 was not aware of it even though it started during her time in post i.e. May '14. When asked about its potential problem of leaving incorrectly triaged (by their GP) patients on a waiting list she stated, "*Completely ridiculous, because would allow a cancer patient who should have been red flagged by their GP to go unchallenged by a Consultant triage process i.e. could have to wait for 11 months*".

**5.4 Index case**
In 2016, the SHSC Trust investigated (RCA ID 52720), in what subsequently became an 'Index case'



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for the cases in this RCA, the treatment and care of Patient 10. Patient 10 was a patient who had had Ca Colon (2010), breast carcinoma (2013) and then developed renal carcinoma. During review for her Breast Ca in June 2014, a CT Scan revealed that, previously noted, renal cysts had increased in size. Further investigation by a MRI scan was reported in a limited and incomplete fashion; resulting in a 'routine' referral GP letter on 29/10/2014.

During the investigation, the Review Team identified that Patient 10's GP referral letter had not been triaged; the Consultant Urologist with responsibility that week for triage duties was Cons1. This referral therefore waited as a 'new routine' referral till January 2016 to be seen by a Consultant Urologist.

The index case Review Panel agreed 3 main contributing factors led directly to Patient 10's delay in diagnosis. Firstly, the content of the MRI report; secondly a letter following a CT scan did not mention important information and thirdly, the opportunity to upgrade the referral to red flag was lost by the omission of triage; this resulted in a 64-week delay to diagnosis of a suspicious renal mass.

The index case Review Panel concluded in March 2017 that, ".... *a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process (*vide infra*) continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team*".

Of the 2 lessons learnt, one indicated that,

> "*Triage of GP referral letters remains a key element in validating appropriate utilisation of specialist services and ensuring patient safety. Triage also serves as an opportunity for early intervention for patients at risk of malignant disease or clinical deterioration*."

This led to a recommendation that,

> "*This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with the Integrated Elective Access Protocol (IEAP).*
>
> *In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The Urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP.*"

The findings of this investigation, chaired by Consultant Urologist 2 (Cons2), were made available in December 2016 and formally signed off on the 15th March 2017. A letter highlighting a number of concerns was sent to the (then) lead for Acute Governance for Acute Services (AGAS1), on the 15th December 2016.

The letter pointed out that the IDT process implied that triage non-compliance was to be expected but that this process did not have a clear escalation plan to include the individual Consultant and, indeed, had not been effective in addressing triage non-compliance. Furthermore, the letter pointed out that,



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from July 2015 till October 2016, there were 318 non-triaged letters which the Trust could not provide assurance that patients were not being exposed to harm by waiting as a routine or urgent appointment i.e. when they should have been red-flagged.

It is not absolutely clear who wrote this letter as it has no signature, but it appears to have been written by, or on behalf of, Cons2. On the 10th January 2017, Cons2 was requested by the Medical Director (MD3) to share the report with the 2 key Consultants involved in the SAI. One of these was Cons1. Cons2 refused, stating that he was Cons1's colleague and not his manager.

This letter was escalated to the Director of Acute Services (DAS3) and the Assistant Director of Anaesthetics & Surgery. This was further escalated to the Chief Executive of the SHSCT.

Cons1 was written to by AMD1 on the 23rd March 2016, acknowledging his hard work as a Consultant Urologist but pointing out that there were governance and patient safety concerns with regard to untriaged letters dating back over 2 years, and other important issues. Cons1 was asked to respond with a commitment and immediate plan to address these issues.

The Review Panel also determined that there were 7 other patients who were not triaged that week along with Patient 10. They subsequently performed a 'look-back' exercise (number 1) of these referrals. Of the seven referrals, six charts were available and each patient had an appropriate management plan. One set of notes were missing and efforts were made to find them.

Cons1 provided his personal review, dated 25/01/2017, of the Index Case to the Chairman of this Review Team. It provides an argued retrospective rationale that a timely triage by himself would not have altered the referral grading. However, it does not provide a sound reason for his actual lack of triage. His report is consistent in arguing his view that he does not have time to perform both Consultant of the Week (CoW) duties and triaging of non-red flag referrals.

**5.5 Look back exercise #2**

Upon realisation that the 'look-back' exercise #1 had resulted from non-triage over the week beginning the 30/10/2014, further efforts were made to investigate the size of this non-triage issue and to find missing referral letters. Cons1 was contacted and the Head of Service for Urology (HoS1) obtained permission to look for missing GP referral letters in his filing cabinet. Cons1 stated that there were referral letters in a filing cabinet in his office. During interview, he stated that he kept the referrals to ensure they would not be missed or overlooked. The Head of Service for Urology retrieved these referral letters, which numbered over 700 along with the triage lists from the booking centre.

These referrals were then reviewed by the Urology Consultant Team revealing 30 patient referrals should have been red-flagged and four of these patients, following review, were diagnosed with cancer, becoming the subject of this review.

At a later date, towards the end of 2018, another patient came to the attention of the Review Team – Patient 15. This patient could also have been one of those found in Cons1 filing cabinet but appeared at an outpatient clinic before the outworking of the look back exercise #2. A Consultant Urologist realised in the clinic that this was also a Cons1 non-triaged patient who was incorrectly referred by their GP.



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On 30 August 2015 Patient 15 a Personal Inform year-old male was referred to Urology Outpatients by his GP for assessment and advice with a raised PSA.
The referral was marked Routine by the GP.
The referral was not triaged on receipt.
29/01/2016 2nd GP referral marked as Suspected Cancer – Red flag; Patient 15 was added to W/L R/F following this referral.
As part of the internal look back #2, the referral was noted.
Patient 15 had already received an appointment and was seen in clinic on day 153. Therefore, 1st GP referral was incorrect; the 2nd was a correct GP referral.
11/02/2016 (D166), following a prostate biopsy, the patient obtained a confirmed cancer diagnosis T3a and there was a recommendation for treatment of a prostate cancer.

**Conclusions**

Resultant 6-month delay in obtaining diagnosis.
Following Review Team consideration, it is felt that the delay is unlikely to be clinically significant.

## SECTION 3 - LEARNING SUMMARY

**14.** WHAT HAS BEEN LEARNED:

The Review Team interviewed a number of Trust staff including Directors (past and present), an Assistant Director, Head of Service and an Associate Medical Director as part of the review process. These interviews, along with clinical documents and health records systems, have helped inform the conclusions by providing the evidence and also corroboration where there appeared to be differences of opinion.

The Review Team and everybody interviewed, including Cons1, provided affirmation that a timely, efficient triage system which checked the initial GP referral was very important to patients. Comments made when interviewees were asked about the importance of triage and where the process of triaging a potential cancer patient ranked alongside other issues such as probity, patient experience and performance, were consistent,

*"Very significant". Very high up the list in terms of importance".*
*"It is fundamental people are seen in the appropriate time".*
*"Very important" ... "Important for the patient".*
*"Vital" ... "Very significant .. patients are often anxious and depend on the system to work".*

Cons1 replied,

*"It is a serious issue, very important"..... "Number one ranking in overall scheme of things"*

The Review Team established that there were factors in HSC service delivery to the 5 patients under examination that resulted in an unnecessary delay in treatment and care. In 4 patients the delay was thought not to be clinically significant but in 1 Patient 13 there probably was a significant delay.

Consideration of the causative factors to the patients' delays reveal,

- Referral letters did not have the clinical priority accurately assigned by the GP; and



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- Referral letters were not triaged following receipt by the Hospital.

**7.1 Referral letters did not have the clinical priority accurately assigned by the GP.**

**Contributory factors**

***Task Factors (policy and guidelines)***

The Review Team reviewed the GP referrals regarding the five patients listed above. They concluded, as judged from the Northern Ireland Cancer Network (NICaN) Referral Guidance for Suspected Cancer (December 2012), that all five patients should have been referred to Urology by the GP's as red flag referrals (suspected cancer) i.e. incorrect triage.

***Task Factors (decision aids)***

The current decision aid for GPs is the NI Referral Guidance for Suspected Cancer 2012 based on NICE CG 27 *Referral guidelines for suspected cancer* published in June 2005. It is clear that Secondary care, in the form of Consultant Urologists, should triage these GP referrals; by doing so, 11% of GP referrals are changed (from Review Team member). It is also clear that Cons1 would have been in no doubt as to his responsibilities; he was intimately involved in setting this standard and signed off the NICaN clinical guidelines.

However, it is clear this very important and critical triage safety net work can be considered onerous and other electronic methods which GPs can use might be more efficient and help to reduce that load.

According the HoS1, most patient referrals by GPs to Trusts for outpatient appointments are now made through the electronic Clinical Communication Gateway (CCG). However, some paper referrals are still received. CCG is a digital referral system for Primary care which can contain referral criteria that meet NICE and NICaN guidance. This would enable appropriate clinical triaging of referrals to be performed as part of the selection of referral reasons and/or symptom description.

Using the electronic CCG pathway, some clinical specialties, such as gynaecology, have worked closely with the Public Health Authority to develop a better GP referral tool e.g. using 'banner guidance' (a specialty specific banner, listing symptoms and signs) which complies with NICE/NICaN guidance. This 'banner guidance' helps by directing clinicians to use the NICE/NICaN referral criteria which allow for timely and appropriate triage of patients to clinically appropriate appointment types. It is possible when red flag symptoms are chosen that an immediate alert could go to the Red Flag booking team, to allow the appointment booking process to begin immediately. However, currently, the referral criteria fields are optional i.e. not mandatory, so opening up the possibility that fields are not completed, leading to error and delay.

***NICE NG12***

The reference CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* but, despite being endorsed by the DHSSPSNI and accepted by the Regional Urologists, it has yet to be implemented. Its use as a triage standard should result in fewer red-flagged cases which should ease some of the pressure on waiting lists. Its adoption would take place in primary care and should form the basis of the electronic CCG referral tool.



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There was a consistent medical staff view from the Review Team, the AMD1, and indeed Cons1, that GP's have a crucial and important responsibility in getting the referral criteria/urgency category correct. If the GP does not provide enough, or the correct information, the NI Electronic Care Record (NIECR) needs to be checked and that slows the whole triage process down. It was clear that the triage system works best when the initial GP referral is usually correct and the Secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

**7.2 Referral letters were not triaged following receipt by the hospital.**

**Contributory factor**

***Task Factors (policy and guidelines)***

The Integrated Elective Access Protocol (IEAP) (DHSSPS, April 2008) defines the roles and responsibilities of staff (in both primary and secondary care) when patients enter an elective care pathway. It states,

> '…*an Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to…. Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first'*.

The Principles for booking Cancer Pathway patients states,

> "clinical *teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients*".

and,

> "*Referrals will be received, registered within one working day and forwarded to Consultants for prioritisation*".

However, the IEAP states,

> *"…if clinical priority is not received from Consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency".*

Following on from the IEAP of 2008, national and regional policies and guidelines, already referred to above, have been introduced which have outlined the detailed role of the Urology Consultant in triaging referrals that have come in from Primary care e.g.,

- Service Framework for cancer prevention, treatment and care (Standard 13) 2011;
- NI Referral Guidance for Suspected Cancer 2012; and
- NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016).

These have provided agreed lists of the critical symptomatology of Urological cancers and the roles and responsibilities of Primary and Secondary care staff in ensuring patients receive prompt recognition and treatment of their cancer.

***Review of Adult Urology Services in Northern Ireland***

In March 2009, a *Review of Adult Urology Services in Northern Ireland - A modernisation and investment plan* was published. Its External Advisor was Mr Mark Fordham. SHSCT Consultant



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Urologists were represented on the committee.

Recommendation 4 states, "*Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system".* Consultants indicated that they would routinely upgrade a significant number of routine and urgent referrals (GP) to urgent or red flag. It was noted that the development of agreed referral guidelines/criteria for suspected Urological cancers was a priority piece of work for the recently formed NICaN Group. That work was led by Cons1; see page 6.

Section 3.31 of the report indicates that, "*Consultant Urologists unanimously consider that referral triage should be led by Consultants. With over 40% of referrals being cancer related (and with many not red flagged or marked urgent) they believe that they are best placed and skilled to undertake the triage process. They also believe that despite the volume of referrals, this is not a particularly time consuming process*."

**Contributory factor**

***Staff factor***

It is obvious from reading the documents referred to above that Cons1 has been aware of developments in this field and, indeed has been party to the discussions and signed some of them off. Cons1 was chair of NICaN (Urology) and was involved in drafting the NICaN regional Urology guidance, and therefore was very familiar with the requirement to triage GP referrals.

Despite all of this, and even though Cons1 agreed that this triaging role was, "*very important*", …. it was, "*a very serious matter not to be minimised, very serious"* he stated he would not triage non-red flag referrals.

When asked, *"Does triage still need done?"* Cons1 answered*, "a procedure is needed to highlight when it needs done and who does it".* When further asked, *"Who was involved in SHSCT Urology service in setting up triage"?* Cons1 answered for urological cancer, "*I was the Lead"*.

He felt triage of referral letters was too time consuming and the amount of time spent on triage, in his opinion, rendered inpatient care unsafe. He highlighted that he had previously escalated his concerns about work load to management teams and medical directors.

In relation to triage, Cons1 stated, '*I would love if we had a Trust Urology agreement on the type of triage to be conducted*'. When it was pointed out that, "*Consultant colleagues did triage for you. How did they do it?"* He stated, "*It depends on how you do it"* ..... "*Not all do advanced / enhanced triage, they compromise. It is a spectrum"... "They have not done it in the detail I felt it needed for routine/urgent non-red flag case".*

When questioned further, regarding his way of organising his own work load, Cons1 stated, '....*yes I did it my way – I wasn't cognisant of being unbending, I am very particular*'.

Cons1 highlighted to the Review Team that he currently takes annual leave each Friday and spends the weekend triaging. He stated that it is impossible to be Urologist of the Week and triage referrals



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appropriately. He stated he still can't do triage and everything else. He stated, '*I do triage entirely in my own time to allow me to do it properly'*.

When asked about using the NIECR - Electronic Referral using the Clinical Communication Gateway (CCG) method, Cons1 stated found the new CCG triage system*, "Very, very good, I wish all information was available on ECR. It is less time consuming. ECR makes it easier to check information".*

The Review Team concluded that there was a serious inconsistency between the guideline standard that a Consultant should triage GP referrals (which Cons1 helped to construct) along with his stated view of the crucial importance of triage and Cons1's actual practice.

Cons1's chosen method of triage was beyond what is required. His triage is the equivalent of a virtual clinic where he reviews NIECR and books investigations for patients. While the Review Team recognised this was a detailed triage process, they concluded that his prioritisation of work and attention to detail meant that some patients got a higher standard of triage/care, while, crucially, others were not triaged, leading to a potentially critical delay in assessment and treatment for those patients. Cons1 is aware of this.

The Review Team concluded that Cons1's prioritisation of work and attention to detail led to some patients receiving a high standard of care, while others ran the real risk of having a cancer diagnosis delayed till it was dangerously late.

**Contributory factor**

***Work load/scheduling***

In 2008, when the IEAP was published, there was a maximum waiting time of 9 weeks for a first Outpatient appointment. On 30th September 2016, there were 2012 patients on the routine Urology outpatient waiting list, with 597 patients showing as waiting 52 weeks and over. The longest waiting time was 554 days (80 weeks). Therefore, if patient referrals are incorrectly referred, or not triaged and continue to use the GP's classification of urgency, there will be a significant wait. Cons1 is aware of this reality.

The Review Team considered the Consultant of the Week (CoW) work load, including ward rounds, clinics, emergency theatre sessions as a contributory factor. Cons1 has consistently argued that he cannot triage non-red flag referrals and carry out the duties of the CoW. He has not indicated who else should carry out the triage duties. However, the Review Team note that the other Consultant Urologists were able to manage this work load and triage referral letters in a timely fashion, with other members of the consultant team also ordering investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to outcomes achieved from Cons1's 'advanced triage'.

**Contributory factor**

***Organisationa*l**

The Review Team concluded that the non-triage of Urology referrals by Cons1 has been an ongoing



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problem in the Trust for many years, possibly decades. While there were pockets of non-compliance by other Consultants, when escalated, compliance improved. However, the Review Team note that Cons1 consistently did not return triage information on referrals thus not allowing the appropriate prioritisation of appointments by clinical need.

Interviews with 2 previous and the current Director of Acute Services, AMD1 and the Head of Surgery Service have highlighted that on many occasions, over a prolonged period, attempts had been made by the Trust's officers to address Cons1's non-compliance with triage. These attempts encompassed both direct face to face conversations which were often heated, correspondence and, as in 2010, study leave refusal until there was compliance. These interventions all resulted in a familiar pattern of response; temporary improvement in compliance with triage, followed by a return to non-compliance.

In 2014, due to continuing non-compliance, the Trust implemented an 'Informal' Default Triage Process to manage the referrals which were not being triaged and returned to the Booking Centre. The Review Team considered the intention of this process was to prevent any delay in patients being added to the waiting list. However, this meant the 'non-return of triage' was not individually addressed with the non-compliant clinicians. Furthermore, and most importantly, it allowed patients, who should have been red-flagged, to remain on a waiting list until review.

In 2014, the Director of Acute Service 2 (DAS2) discussed non-compliance with Cons1 and agreed that Cons1 would no longer triage referral letters. Cons1 was heavily involved with formulating the NICaN Urology guidelines at the time and was grateful to the extent that he thanked DAS2.This task was delegated to other Urology Consultants for a time. However, Cons1 does not recollect having to formally stop triage. At interview, DAS2 was not aware that he had resumed those duties; she remembered that their Cancer performance figures improved when Cons1 was not triaging.

***Escalation within Organisation***

At every interview, questions were asked whether Cons1's consistent and prolonged non-compliance with triaging was referred upwards to executive level i.e. the Medical Director and Chief Executive.

Director DAS1 considered that the problem was being managed at Service level, although as it was only one of a series of issues and considered to be a 'minor' one, it did not predominate at higher level meetings with the Medical Director (MD1); to the extent that he may not have been aware of it.

Director DAS2 considered that the problem was dealt with by agreeing with Cons1 to stop triaging. There were other issues that were flagged up to MD2, but she was not able to remember whether MD2 was made aware of the triage problem.

During DAS3's current tenure Executive members certainly knew; at CAH Oversight meeting level and at the time of the look back exercise #2 which ultimately led onto this SAI and RCA process. The Medical Director (MD3) was directly involved in the RCA process and the CEO was aware. At Trust Board level, it is thought that a non-Executive member was asked to examine the situation which would indicate that it had also reached that level.

Overall, the Review Team in considering whether there was a satisfactory escalation of this 'non-



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triage' issue have concluded that there was no evidence of consistent and proactive escalation of 'non-return of triage' either to the Medical Director or the Chief Executive until the look back exercise #2 basically forced the seriousness of the issue out into the open. Indeed, they do not appear to have appreciated the importance of triage, certainly from the patient's perspective. The Trust's officers made efforts to address Cons1's non-triage over time but were consistently thwarted by Cons1's refusal to comply. The Trust failed to put systems, processes and fail safes in place to ensure Cons1's consistently triaged patient referrals until 2017.

Systems and processes have now been put in place so that the Head of Service for Urology reviews Cons1's compliance with triage. HoS1 will check all Urology triage on an adhoc basis but, with Cons1, she will check daily when he is the Consultant of the Week. Any non-compliance with returning referrals without triage is addressed immediately. However, this process is heavily dependent on HoS1 who, when she is on leave, often has to recover non-triaged cases upon her return.

## 15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

1. The clinical urgency category allocated by GPs to 30 patients referred to Urology were incorrect. The referrals using NICaN guidance should have been referred as a Red Flag. Four (plus 1) of these patients were subsequently shown to have cancer.

2. The process of triaging Urology cancer referrals from Primary Care to Secondary Care, under the direction of the HSCB, appears to be less efficient than it could be, bearing in mind that NICE NG12 guidance has not been adopted and electronic referral using CCG is not being used as efficiently as it could.

3. GP's are not mandated to provide HSCB with an assurance that they comply with the most up to date NICE or other guidelines. Therefore, HSCB are unaware of any risks consequent upon the non-compliance with NICE and other guidance within GP practices.

4. GP's are not mandated to refer patients using CCG clinical criteria banners; this can lead to error and delay.

5. There is no Regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters. Triage of patient referrals is obviously viewed as extremely important but does not seem to be at an equivalent level of importance when ranked alongside other clinical governance issues. Despite being an evident problem for decades and requiring considerable time and effort to find a solution, it only really surfaced within the Trust after an Index case forced the situation out into the open.

6. Despite it being absolutely clear to Consultant 1 (based upon his close proximity to the development and signing off of regional guidance) of the consequences of non-triage, he did not routinely triage referral letters. The Review Team consider that Cons1's refusal to triage to a level similar to other clinicians, led to patients not being triaged, and this resulted in delays in



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assessment and treatment. This may have harmed one patient.

7. Cons1 confirmed that despite the Trust reminding him of the requirement to triage, he did not consistently triage referrals. He argued that, due to time pressures, he felt he was unable to perform the duties of the Consultant of the Week and his triaging duties. He has highlighted those views to Trust operational and management teams over a number of years.

8. The Trust made efforts to address Cons1's non-triage over time. However, the Trust failed to put systems, processes and fail safes in place to ensure Cons1 consistently triaged patient referrals until 2017. However, this safeguarding process is heavily dependent on the Head of Service checking triage is completed when Cons1 is Consultant of the Week.

9. The Informal Default Triage process allows patients who should be red flagged to remain on a waiting list of routine or urgent cases.

From examining the triaging issue over the length of time it has existed, it is obvious that there is an unwillingness or inability within the medical hierarchy to tackle its 'difficult colleague' problem. The reasons behind this probably include not taking ownership of its own problems and poor support from senior medical management perhaps resulting in issues not being referred upwards.

**16. RECOMMENDATIONS (please state by whom and timescale)**

**Recommendation 1**
HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

**Recommendation 2**
HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

**Recommendation 3**
HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

**HSCB, Trust and GPs**
**Recommendation 4**
GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

**TRUST**
**Recommendation 5**
Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

**Recommendation 6**
The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week



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(CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

**Recommendation 7**
The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.

**Recommendation 8**
The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

**Recommendation 9**
Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

**Recommendation 10**
The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

**CONSULTANT 1**
Recommendation 11
Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

**Recommendation 12**
Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation

**17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:**

**18.** FURTHER REVIEW REQUIRED? NO
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

**SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A <u>FURTHER REVIEW IS</u> REQUIRED)**

| | |
|---|---|
| **19.** PLEASE INDICATE LEVEL OF REVIEW:<br>LEVEL 2 / LEVEL 3<br>**Please select as appropriate** | **20.** PROPOSED TIMESCALE FOR COMPLETION:<br>DD / MM / YYYY |



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| | |
|---|---|
| | |

**21.** REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:

**22.** TERMS OF REFERENCE *(If known or submit asap)*:

| **SECTION 5** | |
|---|---|
| **APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR** | |
| **23.** NAME: | **24.** DATE APPROVED: |
| **25.** DESIGANTION: | |

**SECTION 6**

**26.** DISTRIBUTION LIST:

In addition to the Review Team, the following.
Patient [redacted]
Mr S Devlin, Chief Executive SHSCT.
Dr Maria O'Kane, Medical Director, SHSCT.
Mrs Melanie McClements Director of Acute Services.
Health & Social Care Board (HSCB).
Chairs of Morbidity & Mortality Groups SHSCT.



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## Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

| | | | |
|---|---|---|---|
| **Reporting Organisation SAI Ref Number:** | Patient 12 [redacted] | **HSCB Ref Number:** | |

| **SECTION 1** | | | | | |
|---|---|---|---|---|---|
| **INFORMING THE SERVICE USER[1] / FAMILY / CARER** | | | | | |
| 1) Please indicate if the SAI relates to a single service user, or a number of service users.<br>**Please select as appropriate (✓)** | **Single Service User** | | **Multiple Service Users*** | **X** | |
| | **Comment:**<br>***If multiple service users are involved please indicate the number involved*** | | | | |
| 2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| | If **YES**, insert **date informed**: | | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI | | | | |
| | a) No contact or Next of Kin details or Unable to contact | | | | |
| | b) Not applicable as this SAI is not 'patient/service user' related | | | | |
| | c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | | | |
| | d) Case involved suspected or actual abuse by family | | | | |
| | e) Case identified as a result of review exercise | | | | |
| | f) Case is environmental or infrastructure related with no harm to patient/service user | | | | |
| | g) Other rationale | | | | |
| | **If you selected c), d), e), f) or g) above please provide further details:** | | | | |
| 3) Was this SAI also a Never Event?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| 4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event?<br>**Please select as appropriate (✓)** | **YES** | If **YES**, insert **date informed**: DD/MM.YY | | | |
| | **NO** | If **NO**, provide details: | | | |
| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)**) | | | | | |
| **Content with rationale?** | **YES** | | **NO** | | |

| **SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER**<br>***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*** | | | | |
|---|---|---|---|---|
| 5) Has the Final Review report been shared with the Service User[1] / Family / Carer?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | **X** |
| | If **YES**, insert date informed: | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer: | | | |
| | a) Draft review report has been shared and further engagement planned to share final report | | | |



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| SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER<br>*(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)* | | |
|---|---|---|
| | b) Plan to share final review report at a later date and further engagement planned | X |
| | c) Report not shared but contents discussed<br>(***if you select this option please also complete 'l' below***) | |
| | d) No contact or Next of Kin or Unable to contact | |
| | e) No response to correspondence | |
| | f) Withdrew fully from the SAI process | |
| | g) Participated in SAI process but declined review report | |
| | ***(if you select any of the options below please also complete 'l' below)*** | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer | |
| | i) case involved suspected or actual abuse by family | |
| | j) identified as a result of review exercise | |
| | k) other rationale | |
| | l) If you have selected **c), h), i), j), or k)** above please provide further details: | |

| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)**) | | | | |
|---|---|---|---|---|
| **Content with rationale?** | **YES** | | **NO** | |

| SECTION 2 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)* | | | | | | | |
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | | | |
| | If **YES**, insert **date informed**: | | | | | | |
| | If **NO**, please provide details: | | | | | | |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | | | |
| | If **YES**, insert **date report shared**: | | | | | | |
| | If **NO**, please provide details: | | | | | | |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | **N/A** | | **Not Known** |
| | If **YES**, insert **date informed**: | | | | | | |
| | If **NO**, please provide details: | | | | | | |

| **DATE CHECKLIST COMPLETED** | |
|---|---|

[1] *Service User or their nominated representative*



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# LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

## SECTION 1

| | |
|---|---|
| **1. ORGANISATION:** SHSCT | **2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Patient 14 |
| **3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:** | **4. DATE OF INCIDENT/ EVENT: 30/08/2019** |
| **5. PLEASE INDICATE IF THIS SAI IS**<br>**6. INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS:** No | **7. IF 'YES' TO 5. PLEASE PROVDE DETAILS:** |
| **8. DATE OF SEA MEETING / INCIDENT DEBRIEF:** | |

**9. SUMMARY OF EVENT:**

During an internal review in 2016, following an Index Case, the Trust identified a number of GP Urology referrals who were not triaged by one particular Consultant Urologist; 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient Patient 15, discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed.

Patient 14 a Personal Inform-year-old male was referred to Urology Outpatients on 3 June 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review the referral was upgraded to Red Flag and was seen in clinic on day 246. On day 304, the patient had a confirmed cancer diagnosis. There has been a resultant 10-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Causal Factors

- Referral letters did not have their clinical priority accurately assigned by the GP.
- Referral letters were not triaged following receipt by the Hospital.

## SECTION 2

| | |
|---|---|
| **10. SEA FACILITATOR / LEAD OFFICER:**<br>Dr J R Johnston- Consultant Medical Advisor | **11. TEAM MEMBERS PRESENT:**<br>Mr M Haynes - Consultant Urologist<br>Mrs K Robinson - Booking & Contact Centre Manager<br>Mrs T Reid - Acute Clinical & Social Care Governance Coordinator |

**12. SERVICE USER DETAILS**:

Patient 14 H&C: Personal Information redacted by the USI



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**13. WHAT HAPPENED?**

5.1 Triage of GP referrals - background

The general public expect that, when they engage with their GP complaining of symptoms that are potentially due to a cancer, they will be referred to the appropriate secondary care services promptly and that they will respond, also promptly, to confirm or exclude the diagnosis of cancer.

The DHSSPSNI Service Framework for cancer prevention, treatment and care (Standard 13) of 2011 indicates, “All people with signs and symptoms that might suggest cancer should be appropriately assessed by their GP and referred promptly on to hospital for further tests if needed”.

Cancer specialists, working in networks, have formulated lists of symptom and sign triggers which can signify the development of a cancer. Using these lists, primary care doctors can refer patients into secondary care; triaging a large number of patients by assigning them to different degrees of urgency (Routine, Urgent and Red-flag). If these are used as designed, this can provide an efficient referral system.

NICE have been instrumental in ensuring uniformity and the validity of these cancer recognition and referral lists of symptoms and signs. They have also formulated guidance regarding how safety nets should be setup to ensure patients are not missed. Local programmes, using this type of guidance, have been established, under the auspices of NICaN and the HSCB, to set up these triage pathways and safety nets.

5.2 Triage of GP referrals – Northern Ireland

NI Referral Guidance for Suspected Cancer (2012)

The Northern Ireland Referral Guidance for Suspected Cancer 2012 is based on the NICE clinical guideline, CG 27 - Referral guidelines for suspected cancer, published in June 2005. This has a section on Urological Cancer. It was introduced to GPs by HSCB correspondence (30/12/2012), revealing the new red-flag process and indicating in appendix A that, “triaging will take place in a timely manner, within 72 hours of receipt of referral or the referral should continue with the GP Prioritisation”.

This is still the only set of referral guidance for suspected urological cancer available online on the NICaN website (last accessed 18/11/2018).

However, the 2005 CG27 guidance has been replaced by NICE Guideline NG12 Suspected cancer: recognition and referral published in June 2015. This was endorsed by the Department of Health (NI) with HSC (SQSD) (NICE NG12) 29/15 on the 19th August 2015 which instructed the HSCB / PHA to send out the guidance to the appropriate Family Practitioners. This particular kind of guidance requires the HSCB to circulate regionally endorsed NICE guidelines to Trusts and GPs for implementation. Trusts are expected to review guidance against a base line assessment and provide HSCB with an assurance that the guidance has been implemented. If a Trust is unable to fully implement the guidance within the one-year period without regional co-ordination and/or additional resources, they should provide a formal assurance to HSCB, and this is to be managed as part of the risk management process. This assurance process does not however apply to primary care and GP’s.

NICaN Urology Cancer Clinical Guideline (2016)

The NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016), was produced regionally to support the diagnosis, treatment and management of urological cancer.

This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.



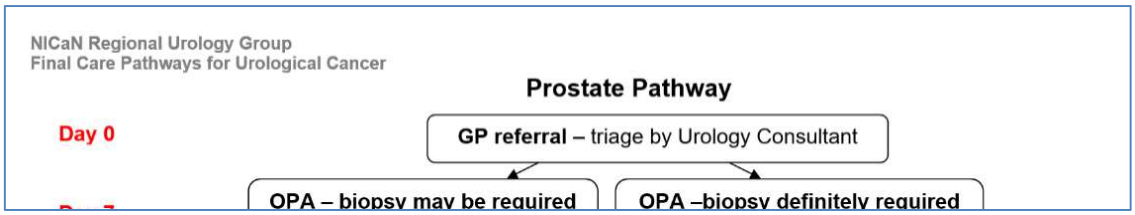
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The Review Team's evaluation of the advantages of NICE NG12 (2015) over the CG27 (2005) guidelines reveals fewer cases would be red-flagged for Urology, as a result of,

- a reduction in number of non-visible haematuria patients; and
- increases in age criteria of 45 years and over.

However, rollout of NG12 by the HSCB does not appear to have happened. The Review Team understands that the reason NG12 has not been implemented lies with ongoing discussions between the HSCB and GPs.

Appendix 2 of the NICaN Urology Cancer Clinical Guideline guidelines highlights the Urology Care pathways. Cons1 was present at the workshop discussing those on 02/10/2008. It clearly indicates that, for the Prostate pathway, the GP referral would be triaged by the Urology Consultant.




**5.3 Triage of GP referrals – SHSCT**

The process of Urology triage in CAH, is based upon the NI Referral Guidance for Suspected Cancer of 2012 as described above i.e. it is based on the 2005 NICE CG27 guidelines and not the more up to date 2012 NG12 . In CAH, triage of referrals is performed by the Consultant Urologist of the week.

The SHSCT Urological Cancer multi-disciplinary team (MDT) was led at the time by Consultant 1 (Cons1), who was also a joint chair.

Over a period of decades, within the SHSCT and Craigavon AH, there were occasions when triage was not performed; certain specialities and individual Consultants were repeat offenders. Acute Services had a particular problem with this issue. Preliminary discussions by the Review Team revealed that triaging within Acute Services was a, "*very haphazard process going back for approximately 25 years. There were many Consultants who would not triage but Consultant 1 was the most persistent and there were multiple attempts to tackle this issue*".

<u>Interview with Associate Medical Director (AMD1)</u>

AMD1 first became aware of waiting list problems with Cons1 in 1996–8 when AMD1 was the lead clinician in outpatients. Cons1's OPD letters were being kept in a ring binder and were not on any waiting list. Once challenged, Cons1 would stop this practice and improve but would then slip back. There were further non-triage meetings with Cons1 when AMD1 was the Clinical Director of Surgery.

<u>Interview with Director of Acute Services (DAS2)</u>

In 2007, DAS2 (while in previous post in CAH) found a waiting list which was 10 years long. They worked on this with the Consultant, Cons1, and cleaned it up; they found no serious patient related issues.



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Interview with Director of Acute Services (DAS1)
DAS1 indicated that the Urology Services were under various kinds of pressure during her time as Director. There was a regional transformation project in place for Regional Urology Services under Mr M. Fordham; this generated an element of pressure to modernise and change. Along with this and other issues, including the triage problem, Consultant 1 struggled to adapt to these changes and to comply with the other issues and triaging. DAS1 paints a picture of many issues with Cons1, triaging being only one of many issues but, in her opinion, not the most important issue.

Nevertheless, in April 2010, Consultant 1 (Cons1) was put under pressure to complete his triage list. The surgical Associate Medical Director (AMD1) brought concerns to DAS1. The other Urologists had been 'covering' triaging for Cons1; the Head of Service Surgery had informed AMD1 of this. They met Cons1 the next day. The European Association of Urology meeting was in Spain the following day and Cons1 wished to attend. DAS1 and AMD1 informed Cons1 he would not be attending the meeting unless he triaged all his referrals immediately. Cons1 duly addressed the triage backlog, completing them that evening. From that time on, AMD1 and the Head of Service (HoS1) monitored that Mr O'Brien was triaging the GP referral letters. However, DAS1 commented that the HoS1 had a difficult job managing Cons1.

Following interview with Head of Service (HoS1)
The Head of Service for Urology (HoS1) indicated that she inherited the problem upon appointment although she was aware that it was a long running issue, going back perhaps 25 years. She highlighted this was an ongoing issue with Cons1. He was the commonest offender and took longest to triage. There were issues with other Consultants who, on occasion, did not triage but Cons1 was the only one, when asked to triage, didn't do it. This came to head in 2010 (referred to above) and again in 2014.

Informal Default Triage (IDT) process
In May 2014, after escalation to HoS1, an Informal Default Triage (IDT) process was put in place by the Trust's booking centre. This process allowed the booking office to allocate patients, who had not been triaged in time, to be allocated to a 'waiting list' using the GP triage category. Therefore, this IDT process of putting patients on the waiting list without triage meant that they did not get missed. However, some patients, who should have been triaged as a red flag, waited on the waiting list with their 'incorrect' GP triage category. After much discussion, this detailed process was formally circulated to all specialties on the 6th November 2015 by the Assistant Director of Support Services (ADSS1).

When questioned about this IDT process, the DAS2 was not aware of it even though it started during her time in post i.e. May '14. When asked about its potential problem of leaving incorrectly triaged (by their GP) patients on a waiting list she stated, "*Completely ridiculous, because would allow a cancer patient who should have been red flagged by their GP to go unchallenged by a Consultant triage process i.e. could have to wait for 11 months*".

**5.4 Index case**
In 2016, the SHSC Trust investigated (RCA ID [redacted]), in what subsequently became an 'Index case'



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for the cases in this RCA, the treatment and care of Patient 10. Patient 10 was a patient who had had Ca Colon (2010), breast carcinoma (2013) and then developed renal carcinoma. During review for her Breast Ca in June 2014, a CT Scan revealed that, previously noted, renal cysts had increased in size. Further investigation by a MRI scan was reported in a limited and incomplete fashion; resulting in a 'routine' referral GP letter on 29/10/2014.

During the investigation, the Review Team identified that Patient 10's GP referral letter had not been triaged; the Consultant Urologist with responsibility that week for triage duties was Cons1. This referral therefore waited as a 'new routine' referral till January 2016 to be seen by a Consultant Urologist.

The index case Review Panel agreed 3 main contributing factors led directly to Patient 10's delay in diagnosis. Firstly, the content of the MRI report; secondly a letter following a CT scan did not mention important information and thirdly, the opportunity to upgrade the referral to red flag was lost by the omission of triage; this resulted in a 64-week delay to diagnosis of a suspicious renal mass.

The index case Review Panel concluded in March 2017 that, ".... *a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process (*vide infra*) continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team*".

Of the 2 lessons learnt, one indicated that,

> "*Triage of GP referral letters remains a key element in validating appropriate utilisation of specialist services and ensuring patient safety. Triage also serves as an opportunity for early intervention for patients at risk of malignant disease or clinical deterioration*."

This led to a recommendation that,

> "*This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with the Integrated Elective Access Protocol (IEAP).*
>
> *In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The Urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP.*"

The findings of this investigation, chaired by Consultant Urologist 2 (Cons2), were made available in December 2016 and formally signed off on the 15th March 2017. A letter highlighting a number of concerns was sent to the (then) lead for Acute Governance for Acute Services (AGAS1), on the 15th December 2016.

The letter pointed out that the IDT process implied that triage non-compliance was to be expected but that this process did not have a clear escalation plan to include the individual Consultant and, indeed,



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had not been effective in addressing triage non-compliance. Furthermore, the letter pointed out that, from July 2015 till October 2016, there were 318 non-triaged letters which the Trust could not provide assurance that patients were not being exposed to harm by waiting as a routine or urgent appointment i.e. when they should have been red-flagged.

It is not absolutely clear who wrote this letter as it has no signature, but it appears to have been written by, or on behalf of, Cons2. On the 10th January 2017, Cons2 was requested by the Medical Director (MD3) to share the report with the 2 key Consultants involved in the SAI. One of these was Cons1. Cons2 refused, stating that he was Cons1's colleague and not his manager.

This letter was escalated to the Director of Acute Services (DAS3) and the Assistant Director of Anaesthetics & Surgery. This was further escalated to the Chief Executive of the SHSCT.

Cons1 was written to by AMD1 on the 23rd March 2016, acknowledging his hard work as a Consultant Urologist but pointing out that there were governance and patient safety concerns with regard to untriaged letters dating back over 2 years, and other important issues. Cons1 was asked to respond with a commitment and immediate plan to address these issues.

The Review Panel also determined that there were 7 other patients who were not triaged that week along with Patient 10. They subsequently performed a 'look-back' exercise (number 1) of these referrals. Of the seven referrals, six charts were available and each patient had an appropriate management plan. One set of notes were missing and efforts were made to find them.

Cons1 provided his personal review, dated 25/01/2017, of the Index Case to the Chairman of this Review Team. It provides an argued retrospective rationale that a timely triage by himself would not have altered the referral grading. However, it does not provide a sound reason for his actual lack of triage. His report is consistent in arguing his view that he does not have time to perform both Consultant of the Week (CoW) duties and triaging of non-red flag referrals.

**5.5 Look back exercise #2**

Upon realisation that the 'look-back' exercise #1 had resulted from non-triage over the week beginning the 30/10/2014, further efforts were made to investigate the size of this non-triage issue and to find missing referral letters. Cons1 was contacted and the Head of Service for Urology (HoS1) obtained permission to look for missing GP referral letters in his filing cabinet. Cons1 stated that there were referral letters in a filing cabinet in his office. During interview, he stated that he kept the referrals to ensure they would not be missed or overlooked. The Head of Service for Urology retrieved these referral letters, which numbered over 700 along with the triage lists from the booking centre.

These referrals were then reviewed by the Urology Consultant Team revealing 30 patient referrals should have been red-flagged and four of these patients, following review, were diagnosed with cancer, becoming the subject of this review.

On the 03 June 2016 Patient 14 a Personal Inform-year-old male referred to Urology Outpatients by GP for assessment and



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advice with a raised PSA.
The referral was marked Urgent by the GP.
The referral was not triaged on receipt.
09/08/2016 - added to W/L Urgent.
27/01/2017, as part of the internal review #2, the referral was upgraded to R/F and was seen in clinic on day 246. Therefore, this was an incorrect GP referral.
05/04/2017 (D304), following U/S guided biopsy, the patient obtained a confirmed cancer diagnosis and there was a recommendation for treatment of a prostate cancer by surveillance protocol.

**Conclusions**

Resultant 10-month delay in obtaining diagnosis.
Following Review Team consideration, deemed not to be a clinically significant delay.

## SECTION 3 - LEARNING SUMMARY

**14.** WHAT HAS BEEN LEARNED:

The Review Team interviewed a number of Trust staff including Directors (past and present), an Assistant Director, Head of Service and an Associate Medical Director as part of the review process. These interviews, along with clinical documents and health records systems, have helped inform the conclusions by providing the evidence and also corroboration where there appeared to be differences of opinion.

The Review Team and everybody interviewed, including Cons1, provided affirmation that a timely, efficient triage system which checked the initial GP referral was very important to patients. Comments made when interviewees were asked about the importance of triage and where the process of triaging a potential cancer patient ranked alongside other issues such as probity, patient experience and performance, were consistent,

*"Very significant". Very high up the list in terms of importance".*
*"It is fundamental people are seen in the appropriate time".*
*"Very important" ... "Important for the patient".*
*"Vital" ... "Very significant .. patients are often anxious and depend on the system to work".*

Cons1 replied,

*"It is a serious issue, very important"..... "Number one ranking in overall scheme of things"*

The Review Team established that there were factors in HSC service delivery to the 5 patients under examination that resulted in an unnecessary delay in treatment and care. In 4 patients the delay was thought not to be clinically significant but in 1 Patient 13 there probably was a significant delay.

Consideration of the causative factors to the patients' delays reveal,

- Referral letters did not have the clinical priority accurately assigned by the GP; and



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- Referral letters were not triaged following receipt by the Hospital.

**7.1 Referral letters did not have the clinical priority accurately assigned by the GP.**

**Contributory factors**

***Task Factors (policy and guidelines)***

The Review Team reviewed the GP referrals regarding the five patients listed above. They concluded, as judged from the Northern Ireland Cancer Network (NICaN) Referral Guidance for Suspected Cancer (December 2012), that all five patients should have been referred to Urology by the GP's as red flag referrals (suspected cancer) i.e. incorrect triage.

***Task Factors (decision aids)***

The current decision aid for GPs is the NI Referral Guidance for Suspected Cancer 2012 based on NICE CG 27 *Referral guidelines for suspected cancer* published in June 2005. It is clear that Secondary care, in the form of Consultant Urologists, should triage these GP referrals; by doing so, 11% of GP referrals are changed (from Review Team member). It is also clear that Cons1 would have been in no doubt as to his responsibilities; he was intimately involved in setting this standard and signed off the NICaN clinical guidelines.

However, it is clear this very important and critical triage safety net work can be considered onerous and other electronic methods which GPs can use might be more efficient and help to reduce that load.

According the HoS1, most patient referrals by GPs to Trusts for outpatient appointments are now made through the electronic Clinical Communication Gateway (CCG). However, some paper referrals are still received. CCG is a digital referral system for Primary care which can contain referral criteria that meet NICE and NICaN guidance. This would enable appropriate clinical triaging of referrals to be performed as part of the selection of referral reasons and/or symptom description.

Using the electronic CCG pathway, some clinical specialties, such as gynaecology, have worked closely with the Public Health Authority to develop a better GP referral tool e.g. using 'banner guidance' (a specialty specific banner, listing symptoms and signs) which complies with NICE/NICaN guidance. This 'banner guidance' helps by directing clinicians to use the NICE/NICaN referral criteria which allow for timely and appropriate triage of patients to clinically appropriate appointment types. It is possible when red flag symptoms are chosen that an immediate alert could go to the Red Flag booking team, to allow the appointment booking process to begin immediately. However, currently, the referral criteria fields are optional i.e. not mandatory, so opening up the possibility that fields are not completed, leading to error and delay.

***NICE NG12***

The reference CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* but, despite being endorsed by the DHSSPSNI and accepted by the Regional Urologists, it has yet to be implemented. Its use as a triage standard should result in fewer red-flagged cases which should ease some of the pressure on waiting lists. Its adoption would take place in primary care and should form the basis of the electronic CCG referral tool.



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There was a consistent medical staff view from the Review Team, the AMD1, and indeed Cons1, that GP's have a crucial and important responsibility in getting the referral criteria/urgency category correct. If the GP does not provide enough, or the correct information, the NI Electronic Care Record (NIECR) needs to be checked and that slows the whole triage process down. It was clear that the triage system works best when the initial GP referral is usually correct and the Secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

**7.2 Referral letters were not triaged following receipt by the hospital.**

**Contributory factor**

***Task Factors (policy and guidelines)***

The Integrated Elective Access Protocol (IEAP) (DHSSPS, April 2008) defines the roles and responsibilities of staff (in both primary and secondary care) when patients enter an elective care pathway. It states,

> '…*an Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to…. Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first'*.

The Principles for booking Cancer Pathway patients states,

> "clinical *teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients*".

and,

> "*Referrals will be received, registered within one working day and forwarded to Consultants for prioritisation*".

However, the IEAP states,

> *"…if clinical priority is not received from Consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency".*

Following on from the IEAP of 2008, national and regional policies and guidelines, already referred to above, have been introduced which have outlined the detailed role of the Urology Consultant in triaging referrals that have come in from Primary care e.g.,

- Service Framework for cancer prevention, treatment and care (Standard 13) 2011;
- NI Referral Guidance for Suspected Cancer 2012; and
- NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016).

These have provided agreed lists of the critical symptomatology of Urological cancers and the roles and responsibilities of Primary and Secondary care staff in ensuring patients receive prompt recognition and treatment of their cancer.

***Review of Adult Urology Services in Northern Ireland***

In March 2009, a *Review of Adult Urology Services in Northern Ireland - A modernisation and investment plan* was published. Its External Advisor was Mr Mark Fordham. SHSCT Consultant



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Urologists were represented on the committee.

Recommendation 4 states, "*Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system".* Consultants indicated that they would routinely upgrade a significant number of routine and urgent referrals (GP) to urgent or red flag. It was noted that the development of agreed referral guidelines/criteria for suspected Urological cancers was a priority piece of work for the recently formed NICaN Group. That work was led by Cons1; see page 6.

Section 3.31 of the report indicates that, "*Consultant Urologists unanimously consider that referral triage should be led by Consultants. With over 40% of referrals being cancer related (and with many not red flagged or marked urgent) they believe that they are best placed and skilled to undertake the triage process. They also believe that despite the volume of referrals, this is not a particularly time consuming process*."

**Contributory factor**

***Staff factor***

It is obvious from reading the documents referred to above that Cons1 has been aware of developments in this field and, indeed has been party to the discussions and signed some of them off. Cons1 was chair of NICaN (Urology) and was involved in drafting the NICaN regional Urology guidance, and therefore was very familiar with the requirement to triage GP referrals.

Despite all of this, and even though Cons1 agreed that this triaging role was, "*very important*", …. it was, "*a very serious matter not to be minimised, very serious"* he stated he would not triage non-red flag referrals.

When asked, *"Does triage still need done?"* Cons1 answered*, "a procedure is needed to highlight when it needs done and who does it".* When further asked, *"Who was involved in SHSCT Urology service in setting up triage"?* Cons1 answered for urological cancer, "*I was the Lead"*.

He felt triage of referral letters was too time consuming and the amount of time spent on triage, in his opinion, rendered inpatient care unsafe. He highlighted that he had previously escalated his concerns about work load to management teams and medical directors.

In relation to triage, Cons1 stated, '*I would love if we had a Trust Urology agreement on the type of triage to be conducted*'. When it was pointed out that, "*Consultant colleagues did triage for you. How did they do it?"* He stated, "*It depends on how you do it"* ..... "*Not all do advanced / enhanced triage, they compromise. It is a spectrum"... "They have not done it in the detail I felt it needed for routine/urgent non-red flag case".*

When questioned further, regarding his way of organising his own work load, Cons1 stated, '....*yes I did it my way – I wasn't cognisant of being unbending, I am very particular*'.

Cons1 highlighted to the Review Team that he currently takes annual leave each Friday and spends the weekend triaging. He stated that it is impossible to be Urologist of the Week and triage referrals



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appropriately. He stated he still can't do triage and everything else. He stated,
'*I do triage entirely in my own time to allow me to do it properly'*.

When asked about using the NIECR - Electronic Referral using the Clinical Communication Gateway (CCG) method, Cons1 stated found the new CCG triage system*, "Very, very good, I wish all information was available on ECR. It is less time consuming. ECR makes it easier to check information".*

The Review Team concluded that there was a serious inconsistency between the guideline standard that a Consultant should triage GP referrals (which Cons1 helped to construct) along with his stated view of the crucial importance of triage and Cons1's actual practice.

Cons1's chosen method of triage was beyond what is required. His triage is the equivalent of a virtual clinic where he reviews NIECR and books investigations for patients. While the Review Team recognised this was a detailed triage process, they concluded that his prioritisation of work and attention to detail meant that some patients got a higher standard of triage/care, while, crucially, others were not triaged, leading to a potentially critical delay in assessment and treatment for those patients. Cons1 is aware of this.

The Review Team concluded that Cons1's prioritisation of work and attention to detail led to some patients receiving a high standard of care, while others ran the real risk of having a cancer diagnosis delayed till it was dangerously late.

**Contributory factor**

***Work load/scheduling***

In 2008, when the IEAP was published, there was a maximum waiting time of 9 weeks for a first Outpatient appointment. On 30th September 2016, there were 2012 patients on the routine Urology outpatient waiting list, with 597 patients showing as waiting 52 weeks and over. The longest waiting time was 554 days (80 weeks). Therefore, if patient referrals are incorrectly referred, or not triaged and continue to use the GP's classification of urgency, there will be a significant wait. Cons1 is aware of this reality.

The Review Team considered the Consultant of the Week (CoW) work load, including ward rounds, clinics, emergency theatre sessions as a contributory factor. Cons1 has consistently argued that he cannot triage non-red flag referrals and carry out the duties of the CoW. He has not indicated who else should carry out the triage duties. However, the Review Team note that the other Consultant Urologists were able to manage this work load and triage referral letters in a timely fashion, with other members of the consultant team also ordering investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to outcomes achieved from Cons1's 'advanced triage'.



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**Contributory factor**

***Organisational***

The Review Team concluded that the non-triage of Urology referrals by Cons1 has been an ongoing problem in the Trust for many years, possibly decades. While there were pockets of non-compliance by other Consultants, when escalated, compliance improved. However, the Review Team note that Cons1 consistently did not return triage information on referrals thus not allowing the appropriate prioritisation of appointments by clinical need.

Interviews with 2 previous and the current Director of Acute Services, AMD1 and the Head of Surgery Service have highlighted that on many occasions, over a prolonged period, attempts had been made by the Trust's officers to address Cons1's non-compliance with triage. These attempts encompassed both direct face to face conversations which were often heated, correspondence and, as in 2010, study leave refusal until there was compliance. These interventions all resulted in a familiar pattern of response; temporary improvement in compliance with triage, followed by a return to non-compliance.

In 2014, due to continuing non-compliance, the Trust implemented an 'Informal' Default Triage Process to manage the referrals which were not being triaged and returned to the Booking Centre. The Review Team considered the intention of this process was to prevent any delay in patients being added to the waiting list. However, this meant the 'non-return of triage' was not individually addressed with the non-compliant clinicians. Furthermore, and most importantly, it allowed patients, who should have been red-flagged, to remain on a waiting list until review.

In 2014, the Director of Acute Service 2 (DAS2) discussed non-compliance with Cons1 and agreed that Cons1 would no longer triage referral letters. Cons1 was heavily involved with formulating the NICaN Urology guidelines at the time and was grateful to the extent that he thanked DAS2.This task was delegated to other Urology Consultants for a time. However, Cons1 does not recollect having to formally stop triage. At interview, DAS2 was not aware that he had resumed those duties; she remembered that their Cancer performance figures improved when Cons1 was not triaging.

***Escalation within Organisation***

At every interview, questions were asked whether Cons1's consistent and prolonged non-compliance with triaging was referred upwards to executive level i.e. the Medical Director and Chief Executive.

Director DAS1 considered that the problem was being managed at Service level, although as it was only one of a series of issues and considered to be a 'minor' one, it did not predominate at higher level meetings with the Medical Director (MD1); to the extent that he may not have been aware of it.

Director DAS2 considered that the problem was dealt with by agreeing with Cons1 to stop triaging. There were other issues that were flagged up to MD2, but she was not able to remember whether MD2 was made aware of the triage problem.

During DAS3's current tenure Executive members certainly knew; at CAH Oversight meeting level and at the time of the look back exercise #2 which ultimately led onto this SAI and RCA process. The Medical Director (MD3) was directly involved in the RCA process and the CEO was aware. At Trust Board level, it is thought that a non-Executive member was asked to examine the situation which



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would indicate that it had also reached that level.

Overall, the Review Team in considering whether there was a satisfactory escalation of this 'non-triage' issue have concluded that there was no evidence of consistent and proactive escalation of 'non-return of triage' either to the Medical Director or the Chief Executive until the look back exercise #2 basically forced the seriousness of the issue out into the open. Indeed, they do not appear to have appreciated the importance of triage, certainly from the patient's perspective. The Trust's officers made efforts to address Cons1's non-triage over time but were consistently thwarted by Cons1's refusal to comply. The Trust failed to put systems, processes and fail safes in place to ensure Cons1's consistently triaged patient referrals until 2017.

Systems and processes have now been put in place so that the Head of Service for Urology reviews Cons1's compliance with triage. HoS1 will check all Urology triage on an adhoc basis but, with Cons1, she will check daily when he is the Consultant of the Week. Any non-compliance with returning referrals without triage is addressed immediately. However, this process is heavily dependent on HoS1 who, when she is on leave, often has to recover non-triaged cases upon her return.

## 15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

1. The clinical urgency category allocated by GPs to 30 patients referred to Urology were incorrect. The referrals using NICaN guidance should have been referred as a Red Flag. Four (plus 1) of these patients were subsequently shown to have cancer.

2. The process of triaging Urology cancer referrals from Primary Care to Secondary Care, under the direction of the HSCB, appears to be less efficient than it could be, bearing in mind that NICE NG12 guidance has not been adopted and electronic referral using CCG is not being used as efficiently as it could.

3. GP's are not mandated to provide HSCB with an assurance that they comply with the most up to date NICE or other guidelines. Therefore, HSCB are unaware of any risks consequent upon the non-compliance with NICE and other guidance within GP practices.

4. GP's are not mandated to refer patients using CCG clinical criteria banners; this can lead to error and delay.

5. There is no Regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters. Triage of patient referrals is obviously viewed as extremely important but does not seem to be at an equivalent level of importance when ranked alongside other clinical governance issues. Despite being an evident problem for decades and requiring considerable time and effort to find a solution, it only really surfaced within the Trust after an Index case forced the situation out into the open.

6. Despite it being absolutely clear to Consultant 1 (based upon his close proximity to the development and signing off of regional guidance) of the consequences of non-triage, he did not routinely triage referral letters. The Review Team consider that Cons1's refusal to triage to



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a level similar to other clinicians, led to patients not being triaged, and this resulted in delays in assessment and treatment. This may have harmed one patient.

7. Cons1 confirmed that despite the Trust reminding him of the requirement to triage, he did not consistently triage referrals. He argued that, due to time pressures, he felt he was unable to perform the duties of the Consultant of the Week and his triaging duties. He has highlighted those views to Trust operational and management teams over a number of years.

8. The Trust made efforts to address Cons1's non-triage over time. However, the Trust failed to put systems, processes and fail safes in place to ensure Cons1 consistently triaged patient referrals until 2017. However, this safeguarding process is heavily dependent on the Head of Service checking triage is completed when Cons1 is Consultant of the Week.

9. The Informal Default Triage process allows patients who should be red flagged to remain on a waiting list of routine or urgent cases.

From examining the triaging issue over the length of time it has existed, it is obvious that there is an unwillingness or inability within the medical hierarchy to tackle its 'difficult colleague' problem. The reasons behind this probably include not taking ownership of its own problems and poor support from senior medical management perhaps resulting in issues not being referred upwards.

**16. RECOMMENDATIONS (please state by whom and timescale)**

**Recommendation 1**
HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

**Recommendation 2**
HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

**Recommendation 3**
HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

**HSCB, Trust and GPs**
**Recommendation 4**
GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

**TRUST**
**Recommendation 5**
Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.



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**Recommendation 6**
The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

**Recommendation 7**
The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.

**Recommendation 8**
The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

**Recommendation 9**
Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

**Recommendation 10**
The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

**CONSULTANT 1**
**Recommendation 11**
Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

**Recommendation 12**
Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation

**17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:**

**18. FURTHER REVIEW REQUIRED? NO**
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.



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| **SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)** | |
|---|---|
| **19.** PLEASE INDICATE LEVEL OF REVIEW:<br>LEVEL 2 / LEVEL 3<br>**Please select as appropriate** | **20.** PROPOSED TIMESCALE FOR COMPLETION:<br>DD / MM / YYYY |
| **21.** REVIEW TEAM MEMBERSHIP *(If known or submit asap)*: | |
| **22.** TERMS OF REFERENCE *(If known or submit asap)*: | |

| **SECTION 5** | |
|---|---|
| **APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR** | |
| **23.** NAME: | **24.** DATE APPROVED: |
| **25.** DESIGANTION: | |

**SECTION 6**

**26.** DISTRIBUTION LIST:

In addition to the Review Team, the following.
Patient [redacted]
Mr S Devlin, Chief Executive SHSCT.
Dr Maria O'Kane, Medical Director, SHSCT.
Mrs Melanie McClements Director of Acute Services.
Health & Social Care Board (HSCB).
Chairs of Morbidity & Mortality Groups SHSCT.



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## Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

| | | | |
|---|---|---|---|
| **Reporting Organisation SAI Ref Number:** | Patient 14 | **HSCB Ref Number:** | |

| **SECTION 1** | | | | | |
|---|---|---|---|---|---|
| **INFORMING THE SERVICE USER[1] / FAMILY / CARER** | | | | | |
| 1) Please indicate if the SAI relates to a single service user, or a number of service users.<br>**Please select as appropriate (✓)** | **Single Service User** | | **Multiple Service Users*** | **X** | |
| | **Comment:**<br>***If multiple service users are involved please indicate the number involved*** | | | | |
| 2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI?<br>**Please select as appropriate (✓)** | **YES** | **X** | **NO** | | |
| | If **YES**, insert **date informed**: | | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI | | | | |
| | a) No contact or Next of Kin details or Unable to contact | | | | |
| | b) Not applicable as this SAI is not 'patient/service user' related | | | | |
| | c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | | | |
| | d) Case involved suspected or actual abuse by family | | | | |
| | e) Case identified as a result of review exercise | | | | |
| | f) Case is environmental or infrastructure related with no harm to patient/service user | | | | |
| | g) Other rationale | | | | |
| | **If you selected c), d), e), f) or g) above please provide further details:** | | | | |
| 3) Was this SAI also a Never Event?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | **X** | |
| 4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event?<br>**Please select as appropriate (✓)** | **YES** | If **YES**, insert **date informed**: DD/MM.YY | | | |
| | **NO** | If **NO**, provide details: | | | |
| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)**) | | | | | |
| **Content with rationale?** | **YES** | | **NO** | | |

| **SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER**<br>***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*** | | | | |
|---|---|---|---|---|
| 5) Has the Final Review report been shared with the Service User[1] / Family / Carer?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert date informed: | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer: | | | |
| | a) Draft review report has been shared and further engagement planned to share final report | | | |



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| SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)* | | |
|---|---|---|
| | b) Plan to share final review report at a later date and further engagement planned | X |
| | c) Report not shared but contents discussed (***if you select this option please also complete 'l' below***) | |
| | d) No contact or Next of Kin or Unable to contact | |
| | e) No response to correspondence | |
| | f) Withdrew fully from the SAI process | |
| | g) Participated in SAI process but declined review report | |
| | ***(if you select any of the options below please also complete 'l' below)*** | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer | |
| | i) case involved suspected or actual abuse by family | |
| | j) identified as a result of review exercise | |
| | k) other rationale | |
| | l) If you have selected **c), h), i), j), or k)** above please provide further details: | |

| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)** | | | | |
|---|---|---|---|---|
| **Content with rationale?** | **YES** | | **NO** | |

| SECTION 2 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)** ***(complete this section for all death related SAIs)*** | | | | | | | | |
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)** | **YES** | | **NO** | X | | | | |
| | If **YES**, insert **date informed**: | | | | | | | |
| | If **NO**, please provide details: | | | | | | | |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)** | **YES** | | **NO** | | | | | |
| | If **YES**, insert **date report shared**: | | | | | | | |
| | If **NO**, please provide details: | | | | | | | |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)** | **YES** | | **NO** | | **N/A** | | **Not Known** | |
| | If **YES**, insert **date informed**: | | | | | | | |
| | If **NO**, please provide details: | | | | | | | |

| **DATE CHECKLIST COMPLETED** | **20/01/2019** |
|---|---|

[1] *Service User or their nominated representative*



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## LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

### SECTION 1

| | |
|---|---|
| **1. ORGANISATION:** SHSCT | **2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Patient 13 |
| **3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:** | **4. DATE OF INCIDENT/ EVENT: 30/08/2019** |
| **5. PLEASE INDICATE IF THIS SAI IS**<br>**6. INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS:** No | **7. IF 'YES' TO 5. PLEASE PROVDE DETAILS:** |
| **8. DATE OF SEA MEETING / INCIDENT DEBRIEF:** | |

**9. SUMMARY OF EVENT:**

During an internal review in 2016, following an Index Case, the Trust identified a number of GP Urology referrals who were not triaged by one particular Consultant Urologist; 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient Patient 15, discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed.

Patient 13 a Personal Inform-year-old male was referred to Urology following an episode of haematuria on 28 July 2016. The referral was marked routine by the GP. The letter was not triaged and Patient 13 was placed on a routine waiting list on 30 September 2016. As part of an internal review this patient's referral letter was upgraded to a Red Flag referral. Patient 13 was reviewed at OPD on 31January 2017. Subsequent investigations diagnosed with bladder and prostate cancer. Patient 13 has locally advanced bladder cancer. There has been a resultant 6-month significant delay in obtaining a diagnosis and a recommendation of treatment for his bladder cancer.

Causal Factors

- Referral letters did not have their clinical priority accurately assigned by the GP.
- Referral letters were not triaged following receipt by the Hospital.

### SECTION 2

| **10. SEA FACILITATOR / LEAD OFFICER:** | **11. TEAM MEMBERS PRESENT:** |
|---|---|
| Dr J R Johnston- Consultant Medical Advisor | Mr M Haynes - Consultant Urologist<br>Mrs K Robinson - Booking & Contact Centre Manager<br>Mrs T Reid - Acute Clinical & Social Care Governance Coordinator |



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**12. SERVICE USER DETAILS**:
Patient 13 H&C: Personal Information redacted by the USI

**13. WHAT HAPPENED?**

5.1 Triage of GP referrals - background
The general public expect that, when they engage with their GP complaining of symptoms that are potentially due to a cancer, they will be referred to the appropriate secondary care services promptly and that they will respond, also promptly, to confirm or exclude the diagnosis of cancer.

The DHSSPSNI Service Framework for cancer prevention, treatment and care (Standard 13) of 2011 indicates, “All people with signs and symptoms that might suggest cancer should be appropriately assessed by their GP and referred promptly on to hospital for further tests if needed”.

Cancer specialists, working in networks, have formulated lists of symptom and sign triggers which can signify the development of a cancer. Using these lists, primary care doctors can refer patients into secondary care; triaging a large number of patients by assigning them to different degrees of urgency (Routine, Urgent and Red-flag). If these are used as designed, this can provide an efficient referral system.

NICE have been instrumental in ensuring uniformity and the validity of these cancer recognition and referral lists of symptoms and signs. They have also formulated guidance regarding how safety nets should be setup to ensure patients are not missed. Local programmes, using this type of guidance, have been established, under the auspices of NICaN and the HSCB, to set up these triage pathways and safety nets.

5.2 Triage of GP referrals – Northern Ireland
NI Referral Guidance for Suspected Cancer (2012)
The Northern Ireland Referral Guidance for Suspected Cancer 2012 is based on the NICE clinical guideline, CG 27 - Referral guidelines for suspected cancer, published in June 2005. This has a section on Urological Cancer. It was introduced to GPs by HSCB correspondence (30/12/2012), revealing the new red-flag process and indicating in appendix A that, “triaging will take place in a timely manner, within 72 hours of receipt of referral or the referral should continue with the GP Prioritisation”.

This is still the only set of referral guidance for suspected urological cancer available online on the NICaN website (last accessed 18/11/2018).

However, the 2005 CG27 guidance has been replaced by NICE Guideline NG12 Suspected cancer: recognition and referral published in June 2015. This was endorsed by the Department of Health (NI) with HSC (SQSD) (NICE NG12) 29/15 on the 19th August 2015 which instructed the HSCB / PHA to send out the guidance to the appropriate Family Practitioners. This particular kind of guidance requires the HSCB to circulate regionally endorsed NICE guidelines to Trusts and GPs for implementation. Trusts are expected to review guidance against a base line assessment and provide HSCB with an assurance that the guidance has been implemented. If a Trust is unable to fully implement the guidance within the one-year period without regional co-ordination and/or additional resources, they should provide a formal assurance to HSCB, and this is to be managed as part of the risk management process. This assurance process does not however apply to primary care and GP’s.

NICaN Urology Cancer Clinical Guideline (2016)
The NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016), was produced



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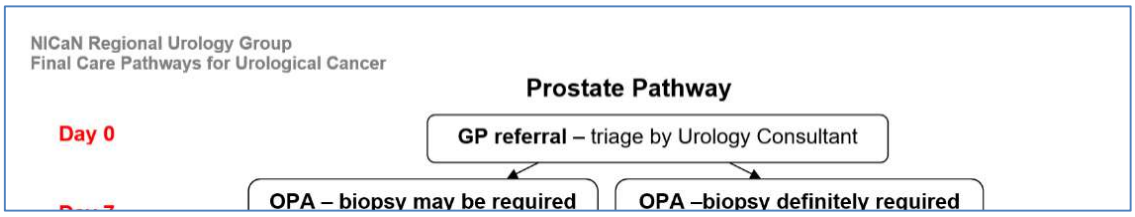
regionally to support the diagnosis, treatment and management of urological cancer.
This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.

The Review Team's evaluation of the advantages of NICE NG12 (2015) over the CG27 (2005) guidelines reveals fewer cases would be red-flagged for Urology, as a result of,

- a reduction in number of non-visible haematuria patients; and
- increases in age criteria of 45 years and over.

However, rollout of NG12 by the HSCB does not appear to have happened. The Review Team understands that the reason NG12 has not been implemented lies with ongoing discussions between the HSCB and GPs.

Appendix 2 of the NICaN Urology Cancer Clinical Guideline guidelines highlights the Urology Care pathways. Cons1 was present at the workshop discussing those on 02/10/2008. It clearly indicates that, for the Prostate pathway, the GP referral would be triaged by the Urology Consultant.




**5.3 Triage of GP referrals – SHSCT**

The process of Urology triage in CAH, is based upon the NI Referral Guidance for Suspected Cancer of 2012 as described above i.e. it is based on the 2005 NICE CG27 guidelines and not the more up to date 2012 NG12 . In CAH, triage of referrals is performed by the Consultant Urologist of the week.

The SHSCT Urological Cancer multi-disciplinary team (MDT) was led at the time by Consultant 1 (Cons1), who was also a joint chair.

Over a period of decades, within the SHSCT and Craigavon AH, there were occasions when triage was not performed; certain specialities and individual Consultants were repeat offenders. Acute Services had a particular problem with this issue. Preliminary discussions by the Review Team revealed that triaging within Acute Services was a, "*very haphazard process going back for approximately 25 years. There were many Consultants who would not triage but Consultant 1 was the most persistent and there were multiple attempts to tackle this issue*".

<u>Interview with Associate Medical Director (AMD1)</u>

AMD1 first became aware of waiting list problems with Cons1 in 1996–8 when AMD1 was the lead clinician in outpatients. Cons1's OPD letters were being kept in a ring binder and were not on any waiting list. Once challenged, Cons1 would stop this practice and improve but would then slip back. There were further non-triage meetings with Cons1 when AMD1 was the Clinical Director of Surgery.

<u>Interview with Director of Acute Services (DAS2)</u>



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In 2007, DAS2 (while in previous post in CAH) found a waiting list which was 10 years long. They worked on this with the Consultant, Cons1, and cleaned it up; they found no serious patient related issues.

Interview with Director of Acute Services (DAS1)

DAS1 indicated that the Urology Services were under various kinds of pressure during her time as Director. There was a regional transformation project in place for Regional Urology Services under Mr M. Fordham; this generated an element of pressure to modernise and change. Along with this and other issues, including the triage problem, Consultant 1 struggled to adapt to these changes and to comply with the other issues and triaging. DAS1 paints a picture of many issues with Cons1, triaging being only one of many issues but, in her opinion, not the most important issue.

Nevertheless, in April 2010, Consultant 1 (Cons1) was put under pressure to complete his triage list. The surgical Associate Medical Director (AMD1) brought concerns to DAS1. The other Urologists had been 'covering' triaging for Cons1; the Head of Service Surgery had informed AMD1 of this. They met Cons1 the next day. The European Association of Urology meeting was in Spain the following day and Cons1 wished to attend. DAS1 and AMD1 informed Cons1 he would not be attending the meeting unless he triaged all his referrals immediately. Cons1 duly addressed the triage backlog, completing them that evening. From that time on, AMD1 and the Head of Service (HoS1) monitored that Mr O'Brien was triaging the GP referral letters. However, DAS1 commented that the HoS1 had a difficult job managing Cons1.

Following interview with Head of Service (HoS1)

The Head of Service for Urology (HoS1) indicated that she inherited the problem upon appointment although she was aware that it was a long running issue, going back perhaps 25 years. She highlighted this was an ongoing issue with Cons1. He was the commonest offender and took longest to triage. There were issues with other Consultants who, on occasion, did not triage but Cons1 was the only one, when asked to triage, didn't do it. This came to head in 2010 (referred to above) and again in 2014.

Informal Default Triage (IDT) process

In May 2014, after escalation to HoS1, an Informal Default Triage (IDT) process was put in place by the Trust's booking centre. This process allowed the booking office to allocate patients, who had not been triaged in time, to be allocated to a 'waiting list' using the GP triage category. Therefore, this IDT process of putting patients on the waiting list without triage meant that they did not get missed. However, some patients, who should have been triaged as a red flag, waited on the waiting list with their 'incorrect' GP triage category. After much discussion, this detailed process was formally circulated to all specialties on the 6th November 2015 by the Assistant Director of Support Services (ADSS1).

When questioned about this IDT process, the DAS2 was not aware of it even though it started during her time in post i.e. May '14. When asked about its potential problem of leaving incorrectly triaged (by their GP) patients on a waiting list she stated, "*Completely ridiculous, because would allow a cancer patient who should have been red flagged by their GP to go unchallenged by a Consultant triage process i.e. could have to wait for 11 months*".



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**5.4 Index case**

In 2016, the SHSC Trust investigated (RCA ID 52720), in what subsequently became an 'Index case' for the cases in this RCA, the treatment and care of Patient 10. Patient 10 was a patient who had had Ca Colon (2010), breast carcinoma (2013) and then developed renal carcinoma. During review for her Breast Ca in June 2014, a CT Scan revealed that, previously noted, renal cysts had increased in size. Further investigation by a MRI scan was reported in a limited and incomplete fashion; resulting in a 'routine' referral GP letter on 29/10/2014.

During the investigation, the Review Team identified that Patient 10's GP referral letter had not been triaged; the Consultant Urologist with responsibility that week for triage duties was Cons1. This referral therefore waited as a 'new routine' referral till January 2016 to be seen by a Consultant Urologist.

The index case Review Panel agreed 3 main contributing factors led directly to Patient 10s delay in diagnosis. Firstly, the content of the MRI report; secondly a letter following a CT scan did not mention important information and thirdly, the opportunity to upgrade the referral to red flag was lost by the omission of triage; this resulted in a 64-week delay to diagnosis of a suspicious renal mass.

The index case Review Panel concluded in March 2017 that, ".... *a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process (*vide infra*) continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team*".

Of the 2 lessons learnt, one indicated that,

> "*Triage of GP referral letters remains a key element in validating appropriate utilisation of specialist services and ensuring patient safety. Triage also serves as an opportunity for early intervention for patients at risk of malignant disease or clinical deterioration*."

This led to a recommendation that,

> "*This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with the Integrated Elective Access Protocol (IEAP).*
>
> *In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The Urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP.*"

The findings of this investigation, chaired by Consultant Urologist 2 (Cons2), were made available in December 2016 and formally signed off on the 15th March 2017. A letter highlighting a number of concerns was sent to the (then) lead for Acute Governance for Acute Services (AGAS1), on the 15th December 2016.



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The letter pointed out that the IDT process implied that triage non-compliance was to be expected but that this process did not have a clear escalation plan to include the individual Consultant and, indeed, had not been effective in addressing triage non-compliance. Furthermore, the letter pointed out that, from July 2015 till October 2016, there were 318 non-triaged letters which the Trust could not provide assurance that patients were not being exposed to harm by waiting as a routine or urgent appointment i.e. when they should have been red-flagged.

It is not absolutely clear who wrote this letter as it has no signature, but it appears to have been written by, or on behalf of, Cons2. On the 10th January 2017, Cons2 was requested by the Medical Director (MD3) to share the report with the 2 key Consultants involved in the SAI. One of these was Cons1. Cons2 refused, stating that he was Cons1's colleague and not his manager.

This letter was escalated to the Director of Acute Services (DAS3) and the Assistant Director of Anaesthetics & Surgery. This was further escalated to the Chief Executive of the SHSCT.

Cons1 was written to by AMD1 on the 23rd March 2016, acknowledging his hard work as a Consultant Urologist but pointing out that there were governance and patient safety concerns with regard to untriaged letters dating back over 2 years, and other important issues. Cons1 was asked to respond with a commitment and immediate plan to address these issues.

The Review Panel also determined that there were 7 other patients who were not triaged that week along with Patient 10. They subsequently performed a 'look-back' exercise (number 1) of these referrals. Of the seven referrals, six charts were available and each patient had an appropriate management plan. One set of notes were missing and efforts were made to find them.

Cons1 provided his personal review, dated 25/01/2017, of the Index Case to the Chairman of this Review Team. It provides an argued retrospective rationale that a timely triage by himself would not have altered the referral grading. However, it does not provide a sound reason for his actual lack of triage. His report is consistent in arguing his view that he does not have time to perform both Consultant of the Week (CoW) duties and triaging of non-red flag referrals.

**5.5 Look back exercise #2**

Upon realisation that the 'look-back' exercise #1 had resulted from non-triage over the week beginning the 30/10/2014, further efforts were made to investigate the size of this non-triage issue and to find missing referral letters. Cons1 was contacted and the Head of Service for Urology (HoS1) obtained permission to look for missing GP referral letters in his filing cabinet. Cons1 stated that there were referral letters in a filing cabinet in his office. During interview, he stated that he kept the referrals to ensure they would not be missed or overlooked. The Head of Service for Urology retrieved these referral letters, which numbered over 700 along with the triage lists from the booking centre.

These referrals were then reviewed by the Urology Consultant Team revealing 30 patient referrals should have been red-flagged and four of these patients, following review, were diagnosed with cancer, becoming the subject of this review.



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At a later date, towards the end of 2018, another patient came to the attention of the Review Team.

On 28 July 2016 Patient 13 a Personal Inform-year-old male was referred to Urology by his GP following an episode of haematuria. The referral was marked Routine by the GP. The letter was not triaged.
30/09/2016 - Patient 13 was placed on a Routine waiting list.
19/01/2017 - As part of an internal review #2, upgraded to a R/F referral. Therefore, this was an incorrect GP referral.
31/01/2017 (188d) - reviewed at OPD and flexible cystoscopy.
22/02/2017 TURBT/TURP - diagnosed with bladder (locally advanced) and prostate cancer and there was a recommendation of treatment for his bladder cancer.

**Conclusions**
Resultant 6-month delay in obtaining diagnosis.
Following Review Team consideration, it is probable that the delay is clinically significant; time will tell*.

* The Review Team referred to an expert for advice.
*Delay in definitive surgical treatment beyond 12 weeks conferred an increased risk of disease-specific and all-cause mortality among subjects with stage II bladder cancer. He remains disease free as of September 2018.*

1. John L. Gore, Julie Lai, Claude M. Setodji, Mark S. Litwin, Christopher S. Saigal, and the Urologic Diseases in America Project. Mortality increases when radical cystectomy is delayed more than 12 weeks. Results from a surveillance, epidemiology, and end results–Medicare analysis. Cancer March 1, 2009.
2. Nader M. Fahmy, Salaheddin Mahmud, Armen G. Aprikian. Delay in the surgical treatment of bladder cancer and survival: Systematic Review of the Literature. *European Urology 50 (2006) 1176–1182.*

## SECTION 3 - LEARNING SUMMARY

### 14. WHAT HAS BEEN LEARNED:

The Review Team interviewed a number of Trust staff including Directors (past and present), an Assistant Director, Head of Service and an Associate Medical Director as part of the review process. These interviews, along with clinical documents and health records systems, have helped inform the conclusions by providing the evidence and also corroboration where there appeared to be differences of opinion.

The Review Team and everybody interviewed, including Cons1, provided affirmation that a timely, efficient triage system which checked the initial GP referral was very important to patients. Comments made when interviewees were asked about the importance of triage and where the process of triaging a potential cancer patient ranked alongside other issues such as probity, patient experience and



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performance, were consistent,

*"Very significant". Very high up the list in terms of importance".*
*"It is fundamental people are seen in the appropriate time".*
*"Very important" ... "Important for the patient".*
*"Vital" ... "Very significant .. patients are often anxious and depend on the system to work".*

Cons1 replied,

*"It is a serious issue, very important"..... "Number one ranking in overall scheme of things"*

The Review Team established that there were factors in HSC service delivery to the 5 patients under examination that resulted in an unnecessary delay in treatment and care. In 4 patients the delay was thought not to be clinically significant but in 1 ([redacted]) there probably was a significant delay.

Consideration of the causative factors to the patients' delays reveal,

- Referral letters did not have the clinical priority accurately assigned by the GP; and
- Referral letters were not triaged following receipt by the Hospital.

**7.1 Referral letters did not have the clinical priority accurately assigned by the GP.**

**Contributory factors**

***Task Factors (policy and guidelines)***

The Review Team reviewed the GP referrals regarding the five patients listed above. They concluded, as judged from the Northern Ireland Cancer Network (NICaN) Referral Guidance for Suspected Cancer (December 2012), that all five patients should have been referred to Urology by the GP's as red flag referrals (suspected cancer) i.e. incorrect triage.

***Task Factors (decision aids)***

The current decision aid for GPs is the NI Referral Guidance for Suspected Cancer 2012 based on NICE CG 27 *Referral guidelines for suspected cancer* published in June 2005. It is clear that Secondary care, in the form of Consultant Urologists, should triage these GP referrals; by doing so, 11% of GP referrals are changed (from Review Team member). It is also clear that Cons1 would have been in no doubt as to his responsibilities; he was intimately involved in setting this standard and signed off the NICaN clinical guidelines.

However, it is clear this very important and critical triage safety net work can be considered onerous and other electronic methods which GPs can use might be more efficient and help to reduce that load.

According the HoS1, most patient referrals by GPs to Trusts for outpatient appointments are now made through the electronic Clinical Communication Gateway (CCG). However, some paper referrals are still received. CCG is a digital referral system for Primary care which can contain referral criteria that meet NICE and NICaN guidance. This would enable appropriate clinical triaging of referrals to be performed as part of the selection of referral reasons and/or symptom description.

Using the electronic CCG pathway, some clinical specialties, such as gynaecology, have worked closely with the Public Health Authority to develop a better GP referral tool e.g. using 'banner



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guidance' (a specialty specific banner, listing symptoms and signs) which complies with NICE/NICaN guidance. This 'banner guidance' helps by directing clinicians to use the NICE/NICaN referral criteria which allow for timely and appropriate triage of patients to clinically appropriate appointment types. It is possible when red flag symptoms are chosen that an immediate alert could go to the Red Flag booking team, to allow the appointment booking process to begin immediately. However, currently, the referral criteria fields are optional i.e. not mandatory, so opening up the possibility that fields are not completed, leading to error and delay.

***NICE NG12***

The reference CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* but, despite being endorsed by the DHSSPSNI and accepted by the Regional Urologists, it has yet to be implemented. Its use as a triage standard should result in fewer red-flagged cases which should ease some of the pressure on waiting lists. Its adoption would take place in primary care and should form the basis of the electronic CCG referral tool.

There was a consistent medical staff view from the Review Team, the AMD1, and indeed Cons1, that GP's have a crucial and important responsibility in getting the referral criteria/urgency category correct. If the GP does not provide enough, or the correct information, the NI Electronic Care Record (NIECR) needs to be checked and that slows the whole triage process down. It was clear that the triage system works best when the initial GP referral is usually correct and the Secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

**7.2 Referral letters were not triaged following receipt by the hospital.**

**<u>Contributory factor</u>**

***Task Factors (policy and guidelines)***

The Integrated Elective Access Protocol (IEAP) (DHSSPS, April 2008) defines the roles and responsibilities of staff (in both primary and secondary care) when patients enter an elective care pathway. It states,

> '…*an Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to…. Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first'*.

The Principles for booking Cancer Pathway patients states,

> "clinical *teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients*".

and,

> "*Referrals will be received, registered within one working day and forwarded to Consultants for prioritisation*".

However, the IEAP states,

> *"…if clinical priority is not received from Consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency".*



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Following on from the IEAP of 2008, national and regional policies and guidelines, already referred to above, have been introduced which have outlined the detailed role of the Urology Consultant in triaging referrals that have come in from Primary care e.g.,

- Service Framework for cancer prevention, treatment and care (Standard 13) 2011;
- NI Referral Guidance for Suspected Cancer 2012; and
- NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016).

These have provided agreed lists of the critical symptomatology of Urological cancers and the roles and responsibilities of Primary and Secondary care staff in ensuring patients receive prompt recognition and treatment of their cancer.

***Review of Adult Urology Services in Northern Ireland***

In March 2009, a *Review of Adult Urology Services in Northern Ireland - A modernisation and investment plan* was published. Its External Advisor was Mr Mark Fordham. SHSCT Consultant Urologists were represented on the committee.

Recommendation 4 states, "*Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system".* Consultants indicated that they would routinely upgrade a significant number of routine and urgent referrals (GP) to urgent or red flag. It was noted that the development of agreed referral guidelines/criteria for suspected Urological cancers was a priority piece of work for the recently formed NICaN Group. That work was led by Cons1; see page 6.

Section 3.31 of the report indicates that, "*Consultant Urologists unanimously consider that referral triage should be led by Consultants. With over 40% of referrals being cancer related (and with many not red flagged or marked urgent) they believe that they are best placed and skilled to undertake the triage process. They also believe that despite the volume of referrals, this is not a particularly time consuming process*."

**<u>Contributory factor</u>**

***Staff factor***

It is obvious from reading the documents referred to above that Cons1 has been aware of developments in this field and, indeed has been party to the discussions and signed some of them off. Cons1 was chair of NICaN (Urology) and was involved in drafting the NICaN regional Urology guidance, and therefore was very familiar with the requirement to triage GP referrals.

Despite all of this, and even though Cons1 agreed that this triaging role was, "*very important*", …. it was, "*a very serious matter not to be minimised, very serious"* he stated he would not triage non-red flag referrals.

When asked, *"Does triage still need done?"* Cons1 answered*, "a procedure is needed to highlight when it needs done and who does it".* When further asked, *"Who was involved in SHSCT Urology service in setting up triage"?* Cons1 answered for urological cancer, "*I was the Lead"*.



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He felt triage of referral letters was too time consuming and the amount of time spent on triage, in his opinion, rendered inpatient care unsafe. He highlighted that he had previously escalated his concerns about work load to management teams and medical directors.

In relation to triage, Cons1 stated, '*I would love if we had a Trust Urology agreement on the type of triage to be conducted*'. When it was pointed out that, "*Consultant colleagues did triage for you. How did they do it?"* He stated, "*It depends on how you do it"* ..... "*Not all do advanced / enhanced triage, they compromise. It is a spectrum"... "They have not done it in the detail I felt it needed for routine/urgent non-red flag case".*

When questioned further, regarding his way of organising his own work load, Cons1 stated, '....*yes I did it my way – I wasn't cognisant of being unbending, I am very particular*'.

Cons1 highlighted to the Review Team that he currently takes annual leave each Friday and spends the weekend triaging. He stated that it is impossible to be Urologist of the Week and triage referrals appropriately. He stated he still can't do triage and everything else. He stated,
'*I do triage entirely in my own time to allow me to do it properly'*.

When asked about using the NIECR - Electronic Referral using the Clinical Communication Gateway (CCG) method, Cons1 stated found the new CCG triage system*, "Very, very good, I wish all information was available on ECR. It is less time consuming. ECR makes it easier to check information".*

The Review Team concluded that there was a serious inconsistency between the guideline standard that a Consultant should triage GP referrals (which Cons1 helped to construct) along with his stated view of the crucial importance of triage and Cons1's actual practice.

Cons1's chosen method of triage was beyond what is required. His triage is the equivalent of a virtual clinic where he reviews NIECR and books investigations for patients. While the Review Team recognised this was a detailed triage process, they concluded that his prioritisation of work and attention to detail meant that some patients got a higher standard of triage/care, while, crucially, others were <u>not</u> triaged, leading to a potentially critical delay in assessment and treatment for those patients. Cons1 is aware of this.

The Review Team concluded that Cons1's prioritisation of work and attention to detail led to some patients receiving a high standard of care, while others ran the real risk of having a cancer diagnosis delayed till it was dangerously late.

**<u>Contributory factor</u>**

***Work load/scheduling***

In 2008, when the IEAP was published, there was a maximum waiting time of 9 weeks for a first Outpatient appointment. On 30th September 2016, there were 2012 patients on the routine Urology outpatient waiting list, with 597 patients showing as waiting 52 weeks and over. The longest waiting time was 554 days (80 weeks). Therefore, if patient referrals are incorrectly referred, or not triaged



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and continue to use the GP's classification of urgency, there will be a significant wait. Cons1 is aware of this reality.

The Review Team considered the Consultant of the Week (CoW) work load, including ward rounds, clinics, emergency theatre sessions as a contributory factor. Cons1 has consistently argued that he cannot triage non-red flag referrals and carry out the duties of the CoW. He has not indicated who else should carry out the triage duties. However, the Review Team note that the other Consultant Urologists were able to manage this work load and triage referral letters in a timely fashion, with other members of the consultant team also ordering investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to outcomes achieved from Cons1's 'advanced triage'.

**Contributory factor**

***Organisational***

The Review Team concluded that the non-triage of Urology referrals by Cons1 has been an ongoing problem in the Trust for many years, possibly decades. While there were pockets of non-compliance by other Consultants, when escalated, compliance improved. However, the Review Team note that Cons1 consistently did not return triage information on referrals thus not allowing the appropriate prioritisation of appointments by clinical need.

Interviews with 2 previous and the current Director of Acute Services, AMD1 and the Head of Surgery Service have highlighted that on many occasions, over a prolonged period, attempts had been made by the Trust's officers to address Cons1's non-compliance with triage. These attempts encompassed both direct face to face conversations which were often heated, correspondence and, as in 2010, study leave refusal until there was compliance. These interventions all resulted in a familiar pattern of response; temporary improvement in compliance with triage, followed by a return to non-compliance.

In 2014, due to continuing non-compliance, the Trust implemented an 'Informal' Default Triage Process to manage the referrals which were not being triaged and returned to the Booking Centre. The Review Team considered the intention of this process was to prevent any delay in patients being added to the waiting list. However, this meant the 'non-return of triage' was not individually addressed with the non-compliant clinicians. Furthermore, and most importantly, it allowed patients, who should have been red-flagged, to remain on a waiting list until review.

In 2014, the Director of Acute Service 2 (DAS2) discussed non-compliance with Cons1 and agreed that Cons1 would no longer triage referral letters. Cons1 was heavily involved with formulating the NICaN Urology guidelines at the time and was grateful to the extent that he thanked DAS2.This task was delegated to other Urology Consultants for a time. However, Cons1 does not recollect having to formally stop triage. At interview, DAS2 was not aware that he had resumed those duties; she remembered that their Cancer performance figures improved when Cons1 was not triaging.

***Escalation within Organisation***

At every interview, questions were asked whether Cons1's consistent and prolonged non-compliance with triaging was referred upwards to executive level i.e. the Medical Director and Chief Executive.



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Director DAS1 considered that the problem was being managed at Service level, although as it was only one of a series of issues and considered to be a 'minor' one, it did not predominate at higher level meetings with the Medical Director (MD1); to the extent that he may not have been aware of it.

Director DAS2 considered that the problem was dealt with by agreeing with Cons1 to stop triaging. There were other issues that were flagged up to MD2, but she was not able to remember whether MD2 was made aware of the triage problem.

During DAS3's current tenure Executive members certainly knew; at CAH Oversight meeting level and at the time of the look back exercise #2 which ultimately led onto this SAI and RCA process. The Medical Director (MD3) was directly involved in the RCA process and the CEO was aware. At Trust Board level, it is thought that a non-Executive member was asked to examine the situation which would indicate that it had also reached that level.

Overall, the Review Team in considering whether there was a satisfactory escalation of this 'non-triage' issue have concluded that there was no evidence of consistent and proactive escalation of 'non-return of triage' either to the Medical Director or the Chief Executive until the look back exercise #2 basically forced the seriousness of the issue out into the open. Indeed, they do not appear to have appreciated the importance of triage, certainly from the patient's perspective. The Trust's officers made efforts to address Cons1's non-triage over time but were consistently thwarted by Cons1's refusal to comply. The Trust failed to put systems, processes and fail safes in place to ensure Cons1's consistently triaged patient referrals until 2017.

Systems and processes have now been put in place so that the Head of Service for Urology reviews Cons1's compliance with triage. HoS1 will check all Urology triage on an adhoc basis but, with Cons1, she will check daily when he is the Consultant of the Week. Any non-compliance with returning referrals without triage is addressed immediately. However, this process is heavily dependent on HoS1 who, when she is on leave, often has to recover non-triaged cases upon her return.

## 15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

1. The clinical urgency category allocated by GPs to 30 patients referred to Urology were incorrect. The referrals using NICaN guidance should have been referred as a Red Flag. Four (plus 1) of these patients were subsequently shown to have cancer.

2. The process of triaging Urology cancer referrals from Primary Care to Secondary Care, under the direction of the HSCB, appears to be less efficient than it could be, bearing in mind that NICE NG12 guidance has not been adopted and electronic referral using CCG is not being used as efficiently as it could.

3. GP's are not mandated to provide HSCB with an assurance that they comply with the most up to date NICE or other guidelines. Therefore, HSCB are unaware of any risks consequent upon the non-compliance with NICE and other guidance within GP practices.



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4. GP's are not mandated to refer patients using CCG clinical criteria banners; this can lead to error and delay.

5. There is no Regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters. Triage of patient referrals is obviously viewed as extremely important but does not seem to be at an equivalent level of importance when ranked alongside other clinical governance issues. Despite being an evident problem for decades and requiring considerable time and effort to find a solution, it only really surfaced within the Trust after an Index case forced the situation out into the open.

6. Despite it being absolutely clear to Consultant 1 (based upon his close proximity to the development and signing off of regional guidance) of the consequences of non-triage, he did not routinely triage referral letters. The Review Team consider that Cons1's refusal to triage to a level similar to other clinicians, led to patients not being triaged, and this resulted in delays in assessment and treatment. This may have harmed one patient.

7. Cons1 confirmed that despite the Trust reminding him of the requirement to triage, he did not consistently triage referrals. He argued that, due to time pressures, he felt he was unable to perform the duties of the Consultant of the Week and his triaging duties. He has highlighted those views to Trust operational and management teams over a number of years.

8. The Trust made efforts to address Cons1's non-triage over time. However, the Trust failed to put systems, processes and fail safes in place to ensure Cons1 consistently triaged patient referrals until 2017. However, this safeguarding process is heavily dependent on the Head of Service checking triage is completed when Cons1 is Consultant of the Week.

9. The Informal Default Triage process allows patients who should be red flagged to remain on a waiting list of routine or urgent cases.

From examining the triaging issue over the length of time it has existed, it is obvious that there is an unwillingness or inability within the medical hierarchy to tackle its 'difficult colleague' problem. The reasons behind this probably include not taking ownership of its own problems and poor support from senior medical management perhaps resulting in issues not being referred upwards.

## 16. RECOMMENDATIONS (please state by whom and timescale)

**Recommendation 1**
HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

**Recommendation 2**
HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

**Recommendation 3**
HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.



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**HSCB, Trust and GPs**
**Recommendation 4**
GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

**TRUST**
**Recommendation 5**
Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

**Recommendation 6**
The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

**Recommendation 7**
The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.

**Recommendation 8**
The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

**Recommendation 9**
Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

**Recommendation 10**
The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

**CONSULTANT 1**
**Recommendation 11**
Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

**Recommendation 12**
Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation.



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**17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:**

**18. FURTHER REVIEW REQUIRED? NO**

Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

**SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)**

**19.** PLEASE INDICATE LEVEL OF REVIEW:
LEVEL 2 / LEVEL 3
**Please select as appropriate**

**20.** PROPOSED TIMESCALE FOR COMPLETION:
DD / MM / YYYY

**21.** REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:

**22.** TERMS OF REFERENCE *(If known or submit asap)*:

**SECTION 5**

**APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR**

**23.** NAME:

**24.** DATE APPROVED:

**25.** DESIGANTION:

**SECTION 6**

**26.** DISTRIBUTION LIST:

In addition to the Review Team, the following.
Patient [redacted]
Mr S Devlin, Chief Executive SHSCT.
Dr Maria O'Kane, Medical Director, SHSCT.
Mrs Melanie McClements Director of Acute Services.



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Health & Social Care Board (HSCB).
Chairs of Morbidity & Mortality Groups SHSCT.



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## Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

| | | | |
|---|---|---|---|
| **Reporting Organisation SAI Ref Number:** | Patient 13 | **HSCB Ref Number:** | |

| **SECTION 1** | | | | | |
|---|---|---|---|---|---|
| **INFORMING THE SERVICE USER[1] / FAMILY / CARER** | | | | | |
| 1) Please indicate if the SAI relates to a single service user, or a number of service users.<br>**Please select as appropriate (✓)** | **Single Service User** | | **Multiple Service Users*** | **X** | |
| | **Comment:**<br>***If multiple service users are involved please indicate the number involved*** | | | | |
| 2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI?<br>**Please select as appropriate (✓)** | **YES** | **X** | **NO** | | |
| | If **YES**, insert **date informed**: | | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI | | | | |
| | a) No contact or Next of Kin details or Unable to contact | | | | |
| | b) Not applicable as this SAI is not 'patient/service user' related | | | | |
| | c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | | | |
| | d) Case involved suspected or actual abuse by family | | | | |
| | e) Case identified as a result of review exercise | | | | |
| | f) Case is environmental or infrastructure related with no harm to patient/service user | | | | |
| | g) Other rationale | | | | |
| | **If you selected c), d), e), f) or g) above please provide further details:** | | | | |
| 3) Was this SAI also a Never Event?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | **X** | |
| 4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event?<br>**Please select as appropriate (✓)** | **YES** | If **YES**, insert **date informed**: DD/MM.YY | | | |
| | **NO** | If **NO**, provide details: | | | |
| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)**) | | | | | |
| **Content with rationale?** | **YES** | | **NO** | | |

| **SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER**<br>***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*** | | | | |
|---|---|---|---|---|
| 5) Has the Final Review report been shared with the Service User[1] / Family / Carer?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert date informed: | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer: | | | |
| | a) Draft review report has been shared and further engagement planned to share final report | | | |



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| SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER<br>*(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)* | | |
|---|---|---|
| | b) Plan to share final review report at a later date and further engagement planned | X |
| | c) Report not shared but contents discussed<br>(***if you select this option please also complete 'l' below***) | |
| | d) No contact or Next of Kin or Unable to contact | |
| | e) No response to correspondence | |
| | f) Withdrew fully from the SAI process | |
| | g) Participated in SAI process but declined review report | |
| | ***(if you select any of the options below please also complete 'l' below)*** | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer | |
| | i) case involved suspected or actual abuse by family | |
| | j) identified as a result of review exercise | |
| | k) other rationale | |
| | l) If you have selected **c), h), i), j), or k)** above please provide further details: | |

| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)**) | | | | |
|---|---|---|---|---|
| **Content with rationale?** | **YES** | | **NO** | |

| SECTION 2 | | | | |
|---|---|---|---|---|
| **INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)** ***(complete this section for all death related SAIs)*** | | | | |
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | X |
| | If **YES**, insert **date informed**: | | | |
| | If **NO**, please provide details: | | | |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert **date report shared**: | | | |
| | If **NO**, please provide details: | | | |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert **date informed**: | | | |
| | If **NO**, please provide details: | | | |

| **DATE CHECKLIST COMPLETED** | **20/01/2019** |
|---|---|

[1] *Service User or their nominated representative*



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## LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

### SECTION 1

| | |
|---|---|
| **1. ORGANISATION:** SHSCT | **2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Patient 11 |
| **3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:** | **4. DATE OF INCIDENT/ EVENT: 30/08/2019** |
| **5. PLEASE INDICATE IF THIS SAI IS**<br>**6. INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS:** No | **7. IF 'YES' TO 5. PLEASE PROVDE DETAILS:** |
| **8. DATE OF SEA MEETING / INCIDENT DEBRIEF:** | |

**9.** SUMMARY OF EVENT:

During an internal review in 2016, following an Index Case, the Trust identified a number of GP Urology referrals who were not triaged by one particular Consultant Urologist; 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient Patient 15, discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed.

Patient 11 a Personal Inform-year-old male was referred to Urology Outpatients on 28 July 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of an internal review the referral was upgraded to Red Flag and seen in clinic on day 217. On day 258, Patient 11 was diagnosed with a confirmed cancer; a resultant 9-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Causal Factors

- Referral letters did not have their clinical priority accurately assigned by the GP.
- Referral letters were not triaged following receipt by the Hospital.

### SECTION 2

| | |
|---|---|
| **10. SEA FACILITATOR / LEAD OFFICER:**<br><br>Dr J R Johnston- Consultant Medical Advisor | **11. TEAM MEMBERS PRESENT:**<br><br>Mr M Haynes - Consultant Urologist<br>Mrs K Robinson - Booking & Contact Centre Manager<br>Mrs T Reid - Acute Clinical & Social Care Governance Coordinator |

**12. SERVICE USER DETAILS**:

Patient 11 H&C: Personal Information redacted by the USI



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**13. WHAT HAPPENED?**

5.1 Triage of GP referrals - background

The general public expect that, when they engage with their GP complaining of symptoms that are potentially due to a cancer, they will be referred to the appropriate secondary care services promptly and that they will respond, also promptly, to confirm or exclude the diagnosis of cancer.

The DHSSPSNI Service Framework for cancer prevention, treatment and care (Standard 13) of 2011 indicates, “All people with signs and symptoms that might suggest cancer should be appropriately assessed by their GP and referred promptly on to hospital for further tests if needed”.

Cancer specialists, working in networks, have formulated lists of symptom and sign triggers which can signify the development of a cancer. Using these lists, primary care doctors can refer patients into secondary care; triaging a large number of patients by assigning them to different degrees of urgency (Routine, Urgent and Red-flag). If these are used as designed, this can provide an efficient referral system.

NICE have been instrumental in ensuring uniformity and the validity of these cancer recognition and referral lists of symptoms and signs. They have also formulated guidance regarding how safety nets should be setup to ensure patients are not missed. Local programmes, using this type of guidance, have been established, under the auspices of NICaN and the HSCB, to set up these triage pathways and safety nets.

5.2 Triage of GP referrals – Northern Ireland

NI Referral Guidance for Suspected Cancer (2012)

The Northern Ireland Referral Guidance for Suspected Cancer 2012 is based on the NICE clinical guideline, CG 27 - Referral guidelines for suspected cancer, published in June 2005. This has a section on Urological Cancer. It was introduced to GPs by HSCB correspondence (30/12/2012), revealing the new red-flag process and indicating in appendix A that, “triaging will take place in a timely manner, within 72 hours of receipt of referral or the referral should continue with the GP Prioritisation”.

This is still the only set of referral guidance for suspected urological cancer available online on the NICaN website (last accessed 18/11/2018).

However, the 2005 CG27 guidance has been replaced by NICE Guideline NG12 Suspected cancer: recognition and referral published in June 2015. This was endorsed by the Department of Health (NI) with HSC (SQSD) (NICE NG12) 29/15 on the 19th August 2015 which instructed the HSCB / PHA to send out the guidance to the appropriate Family Practitioners. This particular kind of guidance requires the HSCB to circulate regionally endorsed NICE guidelines to Trusts and GPs for implementation. Trusts are expected to review guidance against a base line assessment and provide HSCB with an assurance that the guidance has been implemented. If a Trust is unable to fully implement the guidance within the one-year period without regional co-ordination and/or additional resources, they should provide a formal assurance to HSCB, and this is to be managed as part of the risk management process. This assurance process does not however apply to primary care and GP’s.

NICaN Urology Cancer Clinical Guideline (2016)

The NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016), was produced regionally to support the diagnosis, treatment and management of urological cancer.

This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.



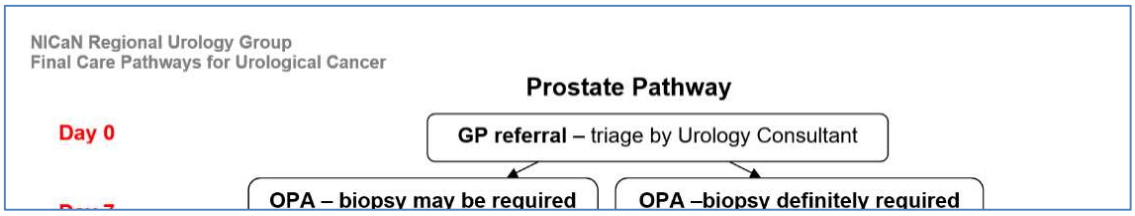
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The Review Team's evaluation of the advantages of NICE NG12 (2015) over the CG27 (2005) guidelines reveals fewer cases would be red-flagged for Urology, as a result of,

- a reduction in number of non-visible haematuria patients; and
- increases in age criteria of 45 years and over.

However, rollout of NG12 by the HSCB does not appear to have happened. The Review Team understands that the reason NG12 has not been implemented lies with ongoing discussions between the HSCB and GPs.

Appendix 2 of the NICaN Urology Cancer Clinical Guideline guidelines highlights the Urology Care pathways. Cons1 was present at the workshop discussing those on 02/10/2008. It clearly indicates that, for the Prostate pathway, the GP referral would be triaged by the Urology Consultant.




**5.3 Triage of GP referrals – SHSCT**

The process of Urology triage in CAH, is based upon the NI Referral Guidance for Suspected Cancer of 2012 as described above i.e. it is based on the 2005 NICE CG27 guidelines and not the more up to date 2012 NG12 . In CAH, triage of referrals is performed by the Consultant Urologist of the week.

The SHSCT Urological Cancer multi-disciplinary team (MDT) was led at the time by Consultant 1 (Cons1), who was also a joint chair.

Over a period of decades, within the SHSCT and Craigavon AH, there were occasions when triage was not performed; certain specialities and individual Consultants were repeat offenders. Acute Services had a particular problem with this issue. Preliminary discussions by the Review Team revealed that triaging within Acute Services was a, "*very haphazard process going back for approximately 25 years. There were many Consultants who would not triage but Consultant 1 was the most persistent and there were multiple attempts to tackle this issue*".

<u>Interview with Associate Medical Director (AMD1)</u>

AMD1 first became aware of waiting list problems with Cons1 in 1996–8 when AMD1 was the lead clinician in outpatients. Cons1's OPD letters were being kept in a ring binder and were not on any waiting list. Once challenged, Cons1 would stop this practice and improve but would then slip back. There were further non-triage meetings with Cons1 when AMD1 was the Clinical Director of Surgery.

<u>Interview with Director of Acute Services (DAS2)</u>

In 2007, DAS2 (while in previous post in CAH) found a waiting list which was 10 years long. They worked on this with the Consultant, Cons1, and cleaned it up; they found no serious patient related issues.



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Interview with Director of Acute Services (DAS1)
DAS1 indicated that the Urology Services were under various kinds of pressure during her time as Director. There was a regional transformation project in place for Regional Urology Services under Mr M. Fordham; this generated an element of pressure to modernise and change. Along with this and other issues, including the triage problem, Consultant 1 struggled to adapt to these changes and to comply with the other issues and triaging. DAS1 paints a picture of many issues with Cons1, triaging being only one of many issues but, in her opinion, not the most important issue.

Nevertheless, in April 2010, Consultant 1 (Cons1) was put under pressure to complete his triage list. The surgical Associate Medical Director (AMD1) brought concerns to DAS1. The other Urologists had been 'covering' triaging for Cons1; the Head of Service Surgery had informed AMD1 of this. They met Cons1 the next day. The European Association of Urology meeting was in Spain the following day and Cons1 wished to attend. DAS1 and AMD1 informed Cons1 he would not be attending the meeting unless he triaged all his referrals immediately. Cons1 duly addressed the triage backlog, completing them that evening. From that time on, AMD1 and the Head of Service (HoS1) monitored that Mr O'Brien was triaging the GP referral letters. However, DAS1 commented that the HoS1 had a difficult job managing Cons1.

Following interview with Head of Service (HoS1)
The Head of Service for Urology (HoS1) indicated that she inherited the problem upon appointment although she was aware that it was a long running issue, going back perhaps 25 years. She highlighted this was an ongoing issue with Cons1. He was the commonest offender and took longest to triage. There were issues with other Consultants who, on occasion, did not triage but Cons1 was the only one, when asked to triage, didn't do it. This came to head in 2010 (referred to above) and again in 2014.

Informal Default Triage (IDT) process
In May 2014, after escalation to HoS1, an Informal Default Triage (IDT) process was put in place by the Trust's booking centre. This process allowed the booking office to allocate patients, who had not been triaged in time, to be allocated to a 'waiting list' using the GP triage category. Therefore, this IDT process of putting patients on the waiting list without triage meant that they did not get missed. However, some patients, who should have been triaged as a red flag, waited on the waiting list with their 'incorrect' GP triage category. After much discussion, this detailed process was formally circulated to all specialties on the 6th November 2015 by the Assistant Director of Support Services (ADSS1).

When questioned about this IDT process, the DAS2 was not aware of it even though it started during her time in post i.e. May '14. When asked about its potential problem of leaving incorrectly triaged (by their GP) patients on a waiting list she stated, "*Completely ridiculous, because would allow a cancer patient who should have been red flagged by their GP to go unchallenged by a Consultant triage process i.e. could have to wait for 11 months*".

**5.4 Index case**
In 2016, the SHSC Trust investigated (RCA ID 52720), in what subsequently became an 'Index case' for the cases in this RCA, the treatment and care of Patient 10. Patient 10 was a patient who had had Ca Colon



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(2010), breast carcinoma (2013) and then developed renal carcinoma. During review for her Breast Ca in June 2014, a CT Scan revealed that, previously noted, renal cysts had increased in size. Further investigation by a MRI scan was reported in a limited and incomplete fashion; resulting in a 'routine' referral GP letter on 29/10/2014.

During the investigation, the Review Team identified that Patient 10's GP referral letter had not been triaged; the Consultant Urologist with responsibility that week for triage duties was Cons1. This referral therefore waited as a 'new routine' referral till January 2016 to be seen by a Consultant Urologist.

The index case Review Panel agreed 3 main contributing factors led directly to Patient 10's delay in diagnosis. Firstly, the content of the MRI report; secondly a letter following a CT scan did not mention important information and thirdly, the opportunity to upgrade the referral to red flag was lost by the omission of triage; this resulted in a 64-week delay to diagnosis of a suspicious renal mass.

The index case Review Panel concluded in March 2017 that, ".... *a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process (*vide infra*) continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team*".

Of the 2 lessons learnt, one indicated that,

> "*Triage of GP referral letters remains a key element in validating appropriate utilisation of specialist services and ensuring patient safety. Triage also serves as an opportunity for early intervention for patients at risk of malignant disease or clinical deterioration*."

This led to a recommendation that,

> "*This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with the Integrated Elective Access Protocol (IEAP).*
>
> *In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The Urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP.*"

The findings of this investigation, chaired by Consultant Urologist 2 (Cons2), were made available in December 2016 and formally signed off on the 15th March 2017. A letter highlighting a number of concerns was sent to the (then) lead for Acute Governance for Acute Services (AGAS1), on the 15th December 2016.

The letter pointed out that the IDT process implied that triage non-compliance was to be expected but that this process did not have a clear escalation plan to include the individual Consultant and, indeed, had not been effective in addressing triage non-compliance. Furthermore, the letter pointed out that, from July 2015 till October 2016, there were 318 non-triaged letters which the Trust could not provide



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assurance that patients were not being exposed to harm by waiting as a routine or urgent appointment i.e. when they should have been red-flagged.

It is not absolutely clear who wrote this letter as it has no signature, but it appears to have been written by, or on behalf of, Cons2. On the 10th January 2017, Cons2 was requested by the Medical Director (MD3) to share the report with the 2 key Consultants involved in the SAI. One of these was Cons1. Cons2 refused, stating that he was Cons1's colleague and not his manager.

This letter was escalated to the Director of Acute Services (DAS3) and the Assistant Director of Anaesthetics & Surgery. This was further escalated to the Chief Executive of the SHSCT.

Cons1 was written to by AMD1 on the 23rd March 2016, acknowledging his hard work as a Consultant Urologist but pointing out that there were governance and patient safety concerns with regard to untriaged letters dating back over 2 years, and other important issues. Cons1 was asked to respond with a commitment and immediate plan to address these issues.

The Review Panel also determined that there were 7 other patients who were not triaged that week along with Patient 10. They subsequently performed a 'look-back' exercise (number 1) of these referrals. Of the seven referrals, six charts were available and each patient had an appropriate management plan. One set of notes were missing and efforts were made to find them.

Cons1 provided his personal review, dated 25/01/2017, of the Index Case to the Chairman of this Review Team. It provides an argued retrospective rationale that a timely triage by himself would not have altered the referral grading. However, it does not provide a sound reason for his actual lack of triage. His report is consistent in arguing his view that he does not have time to perform both Consultant of the Week (CoW) duties and triaging of non-red flag referrals.

**5.5 Look back exercise #2**

Upon realisation that the 'look-back' exercise #1 had resulted from non-triage over the week beginning the 30/10/2014, further efforts were made to investigate the size of this non-triage issue and to find missing referral letters. Cons1 was contacted and the Head of Service for Urology (HoS1) obtained permission to look for missing GP referral letters in his filing cabinet. Cons1 stated that there were referral letters in a filing cabinet in his office. During interview, he stated that he kept the referrals to ensure they would not be missed or overlooked. The Head of Service for Urology retrieved these referral letters, which numbered over 700 along with the triage lists from the booking centre.

These referrals were then reviewed by the Urology Consultant Team revealing 30 patient referrals should have been red-flagged and four of these patients, following review, were diagnosed with cancer, becoming the subject of this review.

At a later date, towards the end of 2018, another patient came to the attention of the Review Team – Patient 15. This patient could also have been one of those found in Cons1 filing cabinet but appeared at an outpatient clinic before the outworking of the look back exercise #2. A Consultant Urologist realised in the clinic that this was also a Cons1 non-triaged patient who was incorrectly referred by their GP.

On 28/07/2016 Patient 11 a Personal Inform-year-old male was referred to Urology Outpatients by GP for assessment



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and advice, concerning an elevated PSA.
The referral was marked Urgent by the GP.
The referral was not triaged on receipt.
On 30/09/2016 Patient 11 was added to W/L Urgent.
On 18/01/2017 as part of an internal review #2,PF was upgraded to R/F. Therefore, this was an incorrect GP referral.
On 20/02/2017 (Day 207) Patient 11 was seen at Red Flag appointment. Patient 11 was sent for MRI and prostate biopsy.
On 11/04/2017 (Day 258) Patient 11 diagnosed with a confirmed low risk prostate cancer and there was a recommendation for treatment of a prostate cancer by surveillance protocol.

**Conclusions**
Resultant 9-month delay in obtaining diagnosis.
Following Review Team consideration, deemed not to be a clinically significant delay.

## SECTION 3 - LEARNING SUMMARY

**14.** WHAT HAS BEEN LEARNED:

The Review Team interviewed a number of Trust staff including Directors (past and present), an Assistant Director, Head of Service and an Associate Medical Director as part of the review process. These interviews, along with clinical documents and health records systems, have helped inform the conclusions by providing the evidence and also corroboration where there appeared to be differences of opinion.

The Review Team and everybody interviewed, including Cons1, provided affirmation that a timely, efficient triage system which checked the initial GP referral was very important to patients. Comments made when interviewees were asked about the importance of triage and where the process of triaging a potential cancer patient ranked alongside other issues such as probity, patient experience and performance, were consistent,

*"Very significant". Very high up the list in terms of importance".*
*"It is fundamental people are seen in the appropriate time".*
*"Very important" ... "Important for the patient".*
*"Vital" ... "Very significant .. patients are often anxious and depend on the system to work".*

Cons1 replied,

*"It is a serious issue, very important"..... "Number one ranking in overall scheme of things"*

The Review Team established that there were factors in HSC service delivery to the 5 patients under examination that resulted in an unnecessary delay in treatment and care. In 4 patients the delay was thought not to be clinically significant but in 1 Patient 13 there probably was a significant delay.



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Consideration of the causative factors to the patients' delays reveal,

- Referral letters did not have the clinical priority accurately assigned by the GP; and
- Referral letters were not triaged following receipt by the Hospital.

**7.1 Referral letters did not have the clinical priority accurately assigned by the GP.**

Contributory factors

*Task Factors (policy and guidelines)*
The Review Team reviewed the GP referrals regarding the five patients listed above. They concluded, as judged from the Northern Ireland Cancer Network (NICaN) Referral Guidance for Suspected Cancer (December 2012), that all five patients should have been referred to Urology by the GP's as red flag referrals (suspected cancer) i.e. incorrect triage.

*Task Factors (decision aids)*
The current decision aid for GPs is the NI Referral Guidance for Suspected Cancer 2012 based on NICE CG 27 *Referral guidelines for suspected cancer* published in June 2005. It is clear that Secondary care, in the form of Consultant Urologists, should triage these GP referrals; by doing so, 11% of GP referrals are changed (from Review Team member). It is also clear that Cons1 would have been in no doubt as to his responsibilities; he was intimately involved in setting this standard and signed off the NICaN clinical guidelines.

However, it is clear this very important and critical triage safety net work can be considered onerous and other electronic methods which GPs can use might be more efficient and help to reduce that load.

According the HoS1, most patient referrals by GPs to Trusts for outpatient appointments are now made through the electronic Clinical Communication Gateway (CCG). However, some paper referrals are still received. CCG is a digital referral system for Primary care which can contain referral criteria that meet NICE and NICaN guidance. This would enable appropriate clinical triaging of referrals to be performed as part of the selection of referral reasons and/or symptom description.

Using the electronic CCG pathway, some clinical specialties, such as gynaecology, have worked closely with the Public Health Authority to develop a better GP referral tool e.g. using 'banner guidance' (a specialty specific banner, listing symptoms and signs) which complies with NICE/NICaN guidance. This 'banner guidance' helps by directing clinicians to use the NICE/NICaN referral criteria which allow for timely and appropriate triage of patients to clinically appropriate appointment types. It is possible when red flag symptoms are chosen that an immediate alert could go to the Red Flag booking team, to allow the appointment booking process to begin immediately. However, currently, the referral criteria fields are optional i.e. not mandatory, so opening up the possibility that fields are not completed, leading to error and delay.

***NICE NG12***
The reference CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* but, despite being endorsed by the DHSSPSNI and accepted by the Regional Urologists, it has yet to be implemented. Its use as a triage standard should result in fewer red-flagged cases which should ease some of the pressure on waiting lists. Its adoption would take place



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in primary care and should form the basis of the electronic CCG referral tool.

There was a consistent medical staff view from the Review Team, the AMD1, and indeed Cons1, that GP's have a crucial and important responsibility in getting the referral criteria/urgency category correct. If the GP does not provide enough, or the correct information, the NI Electronic Care Record (NIECR) needs to be checked and that slows the whole triage process down. It was clear that the triage system works best when the initial GP referral is usually correct and the Secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

**7.2 Referral letters were not triaged following receipt by the hospital.**

**Contributory factor**

***Task Factors (policy and guidelines)***

The Integrated Elective Access Protocol (IEAP) (DHSSPS, April 2008) defines the roles and responsibilities of staff (in both primary and secondary care) when patients enter an elective care pathway. It states,

> '…*an Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to…. Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first'*.

The Principles for booking Cancer Pathway patients states,

> "clinical *teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients*".

and,

> "*Referrals will be received, registered within one working day and forwarded to Consultants for prioritisation*".

However, the IEAP states,

> *"…if clinical priority is not received from Consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency".*

Following on from the IEAP of 2008, national and regional policies and guidelines, already referred to above, have been introduced which have outlined the detailed role of the Urology Consultant in triaging referrals that have come in from Primary care e.g.,

- Service Framework for cancer prevention, treatment and care (Standard 13) 2011;
- NI Referral Guidance for Suspected Cancer 2012; and
- NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016).

These have provided agreed lists of the critical symptomatology of Urological cancers and the roles and responsibilities of Primary and Secondary care staff in ensuring patients receive prompt recognition and treatment of their cancer.



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***Review of Adult Urology Services in Northern Ireland***
In March 2009, a *Review of Adult Urology Services in Northern Ireland - A modernisation and investment plan* was published. Its External Advisor was Mr Mark Fordham. SHSCT Consultant Urologists were represented on the committee.

Recommendation 4 states, "*Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system".* Consultants indicated that they would routinely upgrade a significant number of routine and urgent referrals (GP) to urgent or red flag. It was noted that the development of agreed referral guidelines/criteria for suspected Urological cancers was a priority piece of work for the recently formed NICaN Group. That work was led by Cons1; see page 6.

Section 3.31 of the report indicates that, "*Consultant Urologists unanimously consider that referral triage should be led by Consultants. With over 40% of referrals being cancer related (and with many not red flagged or marked urgent) they believe that they are best placed and skilled to undertake the triage process. They also believe that despite the volume of referrals, this is not a particularly time consuming process*."

**<u>Contributory factor</u>**

***Staff factor***
It is obvious from reading the documents referred to above that Cons1 has been aware of developments in this field and, indeed has been party to the discussions and signed some of them off. Cons1 was chair of NICaN (Urology) and was involved in drafting the NICaN regional Urology guidance, and therefore was very familiar with the requirement to triage GP referrals.

Despite all of this, and even though Cons1 agreed that this triaging role was, "*very important*", …. it was, "*a very serious matter not to be minimised, very serious"* he stated he would not triage non-red flag referrals.

When asked, *"Does triage still need done?"* Cons1 answered*, "a procedure is needed to highlight when it needs done and who does it".* When further asked, *"Who was involved in SHSCT Urology service in setting up triage"?* Cons1 answered for urological cancer, "*I was the Lead"*.

He felt triage of referral letters was too time consuming and the amount of time spent on triage, in his opinion, rendered inpatient care unsafe. He highlighted that he had previously escalated his concerns about work load to management teams and medical directors.

In relation to triage, Cons1 stated, '*I would love if we had a Trust Urology agreement on the type of triage to be conducted*'. When it was pointed out that, "*Consultant colleagues did triage for you. How did they do it?"* He stated, "*It depends on how you do it"* ..... "*Not all do advanced / enhanced triage, they compromise. It is a spectrum"... "They have not done it in the detail I felt it needed for routine/urgent non-red flag case".*

When questioned further, regarding his way of organising his own work load, Cons1 stated, '....*yes I did it my way – I wasn't cognisant of being unbending, I am very particular*'.



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Cons1 highlighted to the Review Team that he currently takes annual leave each Friday and spends the weekend triaging. He stated that it is impossible to be Urologist of the Week and triage referrals appropriately. He stated he still can't do triage and everything else. He stated,
'*I do triage entirely in my own time to allow me to do it properly'*.

When asked about using the NIECR - Electronic Referral using the Clinical Communication Gateway (CCG) method, Cons1 stated found the new CCG triage system*, "Very, very good, I wish all information was available on ECR. It is less time consuming. ECR makes it easier to check information".*

The Review Team concluded that there was a serious inconsistency between the guideline standard that a Consultant should triage GP referrals (which Cons1 helped to construct) along with his stated view of the crucial importance of triage and Cons1's actual practice.

Cons1's chosen method of triage was beyond what is required. His triage is the equivalent of a virtual clinic where he reviews NIECR and books investigations for patients. While the Review Team recognised this was a detailed triage process, they concluded that his prioritisation of work and attention to detail meant that some patients got a higher standard of triage/care, while, crucially, others were not triaged, leading to a potentially critical delay in assessment and treatment for those patients. Cons1 is aware of this.

The Review Team concluded that Cons1's prioritisation of work and attention to detail led to some patients receiving a high standard of care, while others ran the real risk of having a cancer diagnosis delayed till it was dangerously late.

**Contributory factor**

***Work load/scheduling***

In 2008, when the IEAP was published, there was a maximum waiting time of 9 weeks for a first Outpatient appointment. On 30th September 2016, there were 2012 patients on the routine Urology outpatient waiting list, with 597 patients showing as waiting 52 weeks and over. The longest waiting time was 554 days (80 weeks). Therefore, if patient referrals are incorrectly referred, or not triaged and continue to use the GP's classification of urgency, there will be a significant wait. Cons1 is aware of this reality.

The Review Team considered the Consultant of the Week (CoW) work load, including ward rounds, clinics, emergency theatre sessions as a contributory factor. Cons1 has consistently argued that he cannot triage non-red flag referrals and carry out the duties of the CoW. He has not indicated who else should carry out the triage duties. However, the Review Team note that the other Consultant Urologists were able to manage this work load and triage referral letters in a timely fashion, with other members of the consultant team also ordering investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to outcomes achieved from Cons1's 'advanced triage'.



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**Contributory factor**

***Organisational***

The Review Team concluded that the non-triage of Urology referrals by Cons1 has been an ongoing problem in the Trust for many years, possibly decades. While there were pockets of non-compliance by other Consultants, when escalated, compliance improved. However, the Review Team note that Cons1 consistently did not return triage information on referrals thus not allowing the appropriate prioritisation of appointments by clinical need.

Interviews with 2 previous and the current Director of Acute Services, AMD1 and the Head of Surgery Service have highlighted that on many occasions, over a prolonged period, attempts had been made by the Trust's officers to address Cons1's non-compliance with triage. These attempts encompassed both direct face to face conversations which were often heated, correspondence and, as in 2010, study leave refusal until there was compliance. These interventions all resulted in a familiar pattern of response; temporary improvement in compliance with triage, followed by a return to non-compliance.

In 2014, due to continuing non-compliance, the Trust implemented an 'Informal' Default Triage Process to manage the referrals which were not being triaged and returned to the Booking Centre. The Review Team considered the intention of this process was to prevent any delay in patients being added to the waiting list. However, this meant the 'non-return of triage' was not individually addressed with the non-compliant clinicians. Furthermore, and most importantly, it allowed patients, who should have been red-flagged, to remain on a waiting list until review.

In 2014, the Director of Acute Service 2 (DAS2) discussed non-compliance with Cons1 and agreed that Cons1 would no longer triage referral letters. Cons1 was heavily involved with formulating the NICaN Urology guidelines at the time and was grateful to the extent that he thanked DAS2.This task was delegated to other Urology Consultants for a time. However, Cons1 does not recollect having to formally stop triage. At interview, DAS2 was not aware that he had resumed those duties; she remembered that their Cancer performance figures improved when Cons1 was not triaging.

***Escalation within Organisation***

At every interview, questions were asked whether Cons1's consistent and prolonged non-compliance with triaging was referred upwards to executive level i.e. the Medical Director and Chief Executive.

Director DAS1 considered that the problem was being managed at Service level, although as it was only one of a series of issues and considered to be a 'minor' one, it did not predominate at higher level meetings with the Medical Director (MD1); to the extent that he may not have been aware of it.

Director DAS2 considered that the problem was dealt with by agreeing with Cons1 to stop triaging. There were other issues that were flagged up to MD2, but she was not able to remember whether MD2 was made aware of the triage problem.

During DAS3's current tenure Executive members certainly knew; at CAH Oversight meeting level and at the time of the look back exercise #2 which ultimately led onto this SAI and RCA process. The Medical Director (MD3) was directly involved in the RCA process and the CEO was aware. At Trust Board level, it is thought that a non-Executive member was asked to examine the situation which



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would indicate that it had also reached that level.

Overall, the Review Team in considering whether there was a satisfactory escalation of this 'non-triage' issue have concluded that there was no evidence of consistent and proactive escalation of 'non-return of triage' either to the Medical Director or the Chief Executive until the look back exercise #2 basically forced the seriousness of the issue out into the open. Indeed, they do not appear to have appreciated the importance of triage, certainly from the patient's perspective. The Trust's officers made efforts to address Cons1's non-triage over time but were consistently thwarted by Cons1's refusal to comply. The Trust failed to put systems, processes and fail safes in place to ensure Cons1's consistently triaged patient referrals until 2017.

Systems and processes have now been put in place so that the Head of Service for Urology reviews Cons1's compliance with triage. HoS1 will check all Urology triage on an adhoc basis but, with Cons1, she will check daily when he is the Consultant of the Week. Any non-compliance with returning referrals without triage is addressed immediately. However, this process is heavily dependent on HoS1 who, when she is on leave, often has to recover non-triaged cases upon her return.

## 15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

1. The clinical urgency category allocated by GPs to 30 patients referred to Urology were incorrect. The referrals using NICaN guidance should have been referred as a Red Flag. Four (plus 1) of these patients were subsequently shown to have cancer.

2. The process of triaging Urology cancer referrals from Primary Care to Secondary Care, under the direction of the HSCB, appears to be less efficient than it could be, bearing in mind that NICE NG12 guidance has not been adopted and electronic referral using CCG is not being used as efficiently as it could.

3. GP's are not mandated to provide HSCB with an assurance that they comply with the most up to date NICE or other guidelines. Therefore, HSCB are unaware of any risks consequent upon the non-compliance with NICE and other guidance within GP practices.

4. GP's are not mandated to refer patients using CCG clinical criteria banners; this can lead to error and delay.

5. There is no Regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters. Triage of patient referrals is obviously viewed as extremely important but does not seem to be at an equivalent level of importance when ranked alongside other clinical governance issues. Despite being an evident problem for decades and requiring considerable time and effort to find a solution, it only really surfaced within the Trust after an Index case forced the situation out into the open.

6. Despite it being absolutely clear to Consultant 1 (based upon his close proximity to the



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development and signing off of regional guidance) of the consequences of non-triage, he did not routinely triage referral letters. The Review Team consider that Cons1's refusal to triage to a level similar to other clinicians, led to patients not being triaged, and this resulted in delays in assessment and treatment. This may have harmed one patient.

7. Cons1 confirmed that despite the Trust reminding him of the requirement to triage, he did not consistently triage referrals. He argued that, due to time pressures, he felt he was unable to perform the duties of the Consultant of the Week and his triaging duties. He has highlighted those views to Trust operational and management teams over a number of years.

8. The Trust made efforts to address Cons1's non-triage over time. However, the Trust failed to put systems, processes and fail safes in place to ensure Cons1 consistently triaged patient referrals until 2017. However, this safeguarding process is heavily dependent on the Head of Service checking triage is completed when Cons1 is Consultant of the Week.

9. The Informal Default Triage process allows patients who should be red flagged to remain on a waiting list of routine or urgent cases.

From examining the triaging issue over the length of time it has existed, it is obvious that there is an unwillingness or inability within the medical hierarchy to tackle its 'difficult colleague' problem. The reasons behind this probably include not taking ownership of its own problems and poor support from senior medical management perhaps resulting in issues not being referred upwards.

**16. RECOMMENDATIONS (please state by whom and timescale)**

**Recommendation 1**
HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

**Recommendation 2**
HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

**Recommendation 3**
HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

**HSCB, Trust and GPs**
**Recommendation 4**
GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

**TRUST**
**Recommendation 5**
Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence



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the norm.

**Recommendation 6**
The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

**Recommendation 7**
The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.

**Recommendation 8**
The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

**Recommendation 9**
Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

**Recommendation 10**
The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

**CONSULTANT 1**
**Recommendation 11**
Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

**Recommendation 12**
Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation

**17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:**

**18. FURTHER REVIEW REQUIRED? NO**
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

**SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)**



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| | |
|---|---|
| **19.** PLEASE INDICATE LEVEL OF REVIEW:<br>LEVEL 2 / LEVEL 3<br>**Please select as appropriate** | **20.** PROPOSED TIMESCALE FOR COMPLETION:<br>DD / MM / YYYY |
| **21.** REVIEW TEAM MEMBERSHIP *(If known or submit asap)*: | |
| **22.** TERMS OF REFERENCE *(If known or submit asap)*: | |

| **SECTION 5** | |
|---|---|
| **APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR** | |
| **23.** NAME: | **24.** DATE APPROVED: |
| **25.** DESIGANTION: | |

**SECTION 6**

**26.** DISTRIBUTION LIST:

In addition to the Review Team, the following.
Patient [redacted]
Mr S Devlin, Chief Executive SHSCT.
Dr Maria O'Kane, Medical Director, SHSCT.
Mrs Melanie McClements Director of Acute Services.
Health & Social Care Board (HSCB).
Chairs of Morbidity & Mortality Groups SHSCT.



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## Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

| | | | |
|---|---|---|---|
| **Reporting Organisation SAI Ref Number:** | [redacted] | **HSCB Ref Number:** | |

| **SECTION 1** | | | | | |
|---|---|---|---|---|---|
| **INFORMING THE SERVICE USER[1] / FAMILY / CARER** | | | | | |
| 1) Please indicate if the SAI relates to a single service user, or a number of service users.<br>**Please select as appropriate (✓)** | **Single Service User** | | **Multiple Service Users*** | **X** | |
| | **Comment:**<br>***If multiple service users are involved please indicate the number involved*** | | | | |
| 2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI?<br>**Please select as appropriate (✓)** | **YES** | **X** | **NO** | | |
| | If **YES**, insert **date informed**: | | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI | | | | |
| | a) No contact or Next of Kin details or Unable to contact | | | | |
| | b) Not applicable as this SAI is not 'patient/service user' related | | | | |
| | c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | | | |
| | d) Case involved suspected or actual abuse by family | | | | |
| | e) Case identified as a result of review exercise | | | | |
| | f) Case is environmental or infrastructure related with no harm to patient/service user | | | | |
| | g) Other rationale | | | | |
| | **If you selected c), d), e), f) or g) above please provide further details:** | | | | |
| 3) Was this SAI also a Never Event?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | **X** | |
| 4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event?<br>**Please select as appropriate (✓)** | **YES** | If **YES**, insert **date informed**: DD/MM.YY | | | |
| | **NO** | If **NO**, provide details: | | | |
| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)**) | | | | | |
| **Content with rationale?** | **YES** | | **NO** | | |

| **SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER**<br>***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*** | | | | |
|---|---|---|---|---|
| 5) Has the Final Review report been shared with the Service User[1] / Family / Carer?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert date informed: | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer: | | | |
| | a) Draft review report has been shared and further engagement planned to share final report | | | |



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| SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER<br>*(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)* | | |
|---|---|---|
| | b) Plan to share final review report at a later date and further engagement planned | X |
| | c) Report not shared but contents discussed<br>(***if you select this option please also complete 'l' below***) | |
| | d) No contact or Next of Kin or Unable to contact | |
| | e) No response to correspondence | |
| | f) Withdrew fully from the SAI process | |
| | g) Participated in SAI process but declined review report | |
| | ***(if you select any of the options below please also complete 'l' below)*** | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer | |
| | i) case involved suspected or actual abuse by family | |
| | j) identified as a result of review exercise | |
| | k) other rationale | |
| | l) If you have selected **c), h), i), j), or k)** above please provide further details: | |

| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)**) | | | | |
|---|---|---|---|---|
| **Content with rationale?** | **YES** | | **NO** | |

| SECTION 2 | | | | |
|---|---|---|---|---|
| **INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)** ***(complete this section for all death related SAIs)*** | | | | |
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | X |
| | If **YES**, insert **date informed**: | | | |
| | If **NO**, please provide details: | | | |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert **date report shared**: | | | |
| | If **NO**, please provide details: | | | |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert **date informed**: | | | |
| | If **NO**, please provide details: | | | |

| **DATE CHECKLIST COMPLETED** | **20/01/2019** |
|---|---|

[1] *Service User or their nominated representative*



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Southern Health and Social Care Trust

**APPENDIX 6**

**Revised November 2016 (Version 1.1)**

# Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier: Personal Information redacted by USI

Date of Incident/Event: January 2016 – September 2016

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer: Dr J R Johnston

Designation: Consultant Medical Advisor

Report Author: The Review Team

Date report signed off:



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Southern Health and Social Care Trust

## 1.0 EXECUTIVE SUMMARY

During an internal review in 2016, following an Index Case, the Trust identified a number of GP Urology referrals who were not triaged by one particular Consultant Urologist; 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient Patient 15, discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed.

Patient 15 – a Personal-year-old male was referred to Urology Outpatients on 30 August 2015 for assessment and advice for an elevated Prostate specific antigen (PSA) (The blood level of PSA is often elevated in men with prostate cancer). The referral was marked Routine by the GP. The referral was not triaged on receipt. However, a second GP referral was received on 29 January 2016 marked Suspected Cancer Red Flag and had received a red flag appointment. Following this referral, he was seen in clinic on 8 February 2016 (D153). On day 166, Patient 15 was diagnosed with a confirmed cancer; a resultant 6-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Patient 14 – a Personal-year-old male was referred to Urology Outpatients on 3 June 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review the referral was upgraded to Red Flag and was seen in clinic on day 246. On day 304, the patient had a confirmed cancer diagnosis. There has been a resultant 10-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Patient 11 – a Personal-year-old male was referred to Urology Outpatients on 28 July 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of an internal review the referral was upgraded to Red Flag and seen in clinic on day 217. On day 258, Patient 11 was diagnosed with a confirmed cancer; a resultant 9-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Patient 13 – a Personal-year-old male referred to Urology following an episode of haematuria on 28 July 2016. The referral was marked Routine by the GP. The letter was not triaged and Patient 13 was placed on a routine waiting list on 30 September 2016. As part of an internal review this patient's referral letter was upgraded to a Red Flag referral. Patient 13 was reviewed at OPD on 31January 2017. Subsequent investigations diagnosed with bladder and prostate cancer. Patient 13 has locally advanced bladder cancer. There has been a resultant 6-month significant delay in obtaining a diagnosis and a recommendation of treatment for his bladder cancer.

Patient 12 – a Personal-year-old male was referred to Urology Outpatients on 8 Sept 2016 for assessment and advice on lower tract symptoms and elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review the referral was upgraded to Red Flag and was seen in clinic on day 152. On day 215, Patient 12 had a confirmed cancer diagnosis T3a with no nodal metastases. There has been a resultant 8-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.



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**Causal Factors**

1. Referral letters did not have their clinical priority accurately assigned by the GP.
2. Referral letters were not triaged following receipt by the Hospital.

**Recommendation 1**

HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

**Recommendation 2**

HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

**Recommendation 3**

GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards.

**Recommendation 4**

Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

**Recommendation 5**

The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

**Recommendation 6**

The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.

**Recommendation 7**

The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

**Recommendation 8**

Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated in Annual Consultant Appraisal programmes.



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**Recommendation 9**
The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

## 2.0 THE REVIEW TEAM

Dr J R Johnston - Consultant Medical Adviser

Mr M Haynes - Consultant Urologist

Mrs K Robinson - Booking & Contact Centre Manager

Mrs T Reid - Acute Clinical & Social Care Governance Coordinator

## 3.0 SAI REVIEW TERMS OF REFERENCE

1. To undertake an initial investigation/review of the care and treatment of patients Patient 15 ", Patient 13 ", Patient 12 ", Patient 14 and Patient 11, in the period after referral to the SHSCT Urology service using National Patient Safety Agency root cause analysis methodology.
2. To determine whether there were any factors in the health & social care services interventions delivered or omitted to Patient 15, Patient 13, Patient 12, Patient 14 and Patient 11 that resulted in an unnecessary delay in treatment and care.
3. The investigation / Review Team will provide a draft report for the Director of Acute Services. This report will include the outcome of the Team's investigation/review, identifying any lessons learned and setting out their agreed recommendations and actions to be considered by the Trust and others.
4. The Trust will share or disseminate the outcomes of the investigation/review with all relevant parties internally and externally including the service user and relevant family member(s) (where appropriate).

## 4.0 REVIEW METHODOLOGY

The Review Team will undertake an analysis of the information gathered using RCA tools and may make recommendations in order that sustainable solutions can minimise any recurrence of this type of incident. The Review Team will request, collate, analyse and make recommendations on such information as is relevant under its Terms of Reference in respect of the incident outlined above.

**Gather and review all relevant information**

- Inpatient notes Craigavon Hospital.
- Information from the Northern Ireland Emergency Care Record (NIECR) and Patient Administration System.



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- Information from laboratory systems.
- Information obtained from relevant medical, nursing and management staff.
- Review of Relevant Reports, Procedures, Guidelines.

**Information mapping**

- Timeline analysis
- Change analysis for problem identification and prioritisation of care delivery problems and service delivery problems as well as identifying contributory factors.

## 5.0 DESCRIPTION OF INCIDENT/CASE

**5.1 Triage of GP referrals - background**

The general public expect that, when they engage with their GP complaining of symptoms that are potentially due to a cancer, they will be referred to the appropriate secondary care services promptly and that they will respond, also promptly, to confirm or exclude the diagnosis of cancer.

The DHSSPSNI **Service Framework for cancer prevention, treatment and care** (Standard 13) of 2011 indicates, "*All people with signs and symptoms that might suggest cancer should be appropriately assessed by their GP and referred promptly on to hospital for further tests if needed*".

Cancer specialists working in networks have formulated lists of symptom and sign triggers which can signify the development of a cancer. Using these lists, primary care doctors can refer patients into secondary care; triaging a large number of patients by assigning them to different degrees of urgency (Routine, Urgent and Red-flag). If these are used as designed, this can provide an efficient referral system.

NICE have been instrumental in ensuring uniformity and the validity of these cancer recognition and referral lists of symptoms and signs. They have also formulated guidance regarding how safety nets should be setup to ensure patients are not missed. Local programmes, using this type of guidance, have been established, under the auspices of NICaN and the HSCB, to set up these triage pathways and safety nets.

**5.2 Triage of GP referrals – Northern Ireland**

The NI Referral Guidance for Suspected Cancer 2012 is based on the NICE clinical guideline, CG 27 - *Referral guidelines for suspected cancer* published in June 2005. This has a section on Urological Cancer. It was introduced to GPs by HSCB correspondence (30/12/2012), revealing the new red-flag process and indicating in appendix A that, "*triaging will take place in a timely manner, within 72 hours of receipt of referral or the referral should continue with the GP Prioritisation".*



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This is still the only set of referral guidance for suspected urological cancer available online on the NICaN website (last accessed 18/11/2018).

However, the 2005 CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* published in June 2015. This was endorsed by the Department of Health (NI) with HSC(SQSD) (NICE NG12) 29/15 on the 19th August 2015 which instructed the HSCB / PHA to send out the guidance to the appropriate Family Practitioners. This particular kind of guidance requires the HSCB to circulate regionally endorsed NICE guidelines to Trusts and GPs for implementation. Trusts are expected to review guidance against a base line assessment and provide HSCB with an assurance that the guidance has been implemented. If a Trust is unable to fully implement the guidance within the one-year period without regional co-ordination and/or additional resources, they should provide a formal assurance to HSCB, and this is to be managed as part of the risk management process. This assurance process does not however apply to primary care and GP's.

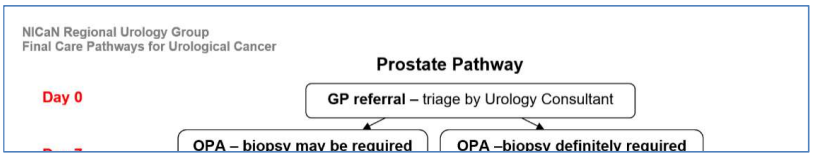
The NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016), was produced regionally to support the diagnosis, treatment and management of urological cancer. This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.

The Review Team's evaluation of the advantages of NICE NG12 over the CG27 guidelines reveals fewer cases would be red-flagged for Urology, as a result of,

- a reduction in number of non-visible haematuria patients; and
- increases in age criteria of 45 years and over.

However, rollout of NG12 by the HSCB does not appear to have happened. The Review Team understands that the reason NG12 has not been implemented lies with ongoing discussions between the HSCB and GPs.

Appendix 2 of the NICaN Urology Cancer Clinical Guideline guidelines highlights the Urology Care pathways. Cons1 was present at the workshop discussing those on 02/10/2008. It clearly indicates that, for the Prostate pathway, the GP referral would be triaged by the Urology Consultant.






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**5.3 Triage of GP referrals – SHSCT**

The process of Urology triage in CAH, is based upon the NI Referral Guidance for Suspected Cancer of 2012 as described above i.e. it is based on the 2005 NICE CG27 guidelines. In CAH, triage of referrals is performed by the Consultant Urologist of the week.

The SHSCT Urological Cancer multi-disciplinary team (MDT) was led at the time by Consultant 1 (Cons1), who was also a joint chair.

Over a period of decades, within the SHSCT and Craigavon AH, there were occasions when triage was not performed; certain specialities and individual Consultants were repeat offenders. Acute Services had a particular problem with this issue. Preliminary discussions by the Review Team revealed that triaging within Acute Services was a, "*very haphazard process going back for approximately 25 years. There were many Consultants who would not triage but Consultant 1 was the most persistent and there were multiple attempts to tackle this issue*".

Interview with Associate Medical Director (AMD1)

AMD1 first became aware of waiting list problems with Cons1 in 1996–8 when AMD1 was the lead clinician in outpatients. OPD letters were being kept in a ring binder and were not on any waiting list. Once challenged, Cons1 would stop this practice and improve but would then slip back. There were further non-triage meetings with Cons1 when AMD1 was the Clinical Director of Surgery.

Interview with Director of Acute Services (DAS2)

In 2007, DAS2 (while in previous post in CAH) found a waiting list which was 10 years long. They worked on this with the Consultant, Cons1, and cleaned it up; they found no serious patient related issues.

Interview with Director of Acute Services (DAS1)

DAS1 indicated that the Urology Services were under various kinds of pressure during her time as Director. There was a regional transformation project in place for Regional Urology Services under Mr M. Fordham; this generated an element of pressure to modernise and change. Along with this and other issues, including the triage problem, Consultant 1 struggled to adapt to these changes and to comply with the other issues and triaging. DAS1 paints a picture of many issues with Cons1, triaging being only one of many issues but, in her opinion, not the most important issue.

Nevertheless, in April 2010, Consultant 1 (Cons1) was put under pressure to complete his triage list. The surgical Associate Medical Director (AMD1) brought concerns to DAS1. The other Urologists had been 'covering' triaging for Cons1; the Head of Service Surgery had informed AMD1 of this. They met Cons1 the next day. The European Association of Urology meeting was in Spain the following day and Cons1 wished to attend. DAS1 and AMD1 informed Cons1 he would not be attending the meeting unless he triaged all his referrals



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immediately. Cons1 duly addressed the triage backlog, completing them that evening. From that time on, AMD1 and the Head of Service (HoS1) monitored that Mr O'Brien was triaging the GP referral letters. However, DAS1 commented that the HoS1 had a difficult job managing Cons1.

Following interview with Head of Service (HoS1)

The Head of Service for Urology (HoS1) indicated that she inherited the problem upon appointment although she was aware that it was a long running issue going back perhaps 25 years. She highlighted this was an ongoing issue with Cons1. He was the commonest offender and took longest to triage. There were issues with other Consultants who, on occasion, did not triage but Cons1 was the only one, when asked to triage, didn't do it. This came to head in 2010 (referred to above) and again in 2014.

Informal Default Triage (IDT) process

In May 2014, after escalation to HoS1, an Informal Default Triage (IDT) process was put in place by the Trust's booking centre. This process allowed the booking office to allocate patients, who had not been triaged in time, to be allocated to a 'waiting list' using the GP triage category. Therefore, this IDT process of putting patients on the waiting list without triage meant that they did not get missed. However, some patients, who should have been triaged as a red flag, waited on the waiting list with their 'incorrect' GP triage category. After much discussion, this detailed process was formally circulated to all specialties on the 6th November 2015 by the Assistant Director of Support Services (ADSS1).

When questioned about this IDT process, the DAS2 was not aware of it even though it started during her time in post i.e. May '14. When asked about its potential problem of leaving incorrectly triaged (by their GP) patients on a waiting list she stated, "*Completely ridiculous, because would allow a cancer patient who should have been red flagged by their GP to go unchallenged by a Consultant triage process i.e. could have to wait for 11/12*".

**5.4 Index case**

In 2016, the SHSC Trust investigated (RCA ID 52720), in what subsequently became an 'Index case' for the cases in this RCA, the treatment and care of Patient 10. Patient 10 was a patient who had had Ca Colon (2010), breast carcinoma (2013) and then developed renal carcinoma. During review for her Breast Ca in June 2014, a CT Scan revealed that, previously noted, renal cysts had increased in size. Further investigation by a MRI scan was reported in a limited and incomplete fashion; resulting in a 'routine' referral GP letter on 29/10/2014.

During the investigation, the Review Team identified that Patient 10's GP referral letter had not been triaged; the Consultant Urologist with responsibility that week for triage duties was Cons1. This referral therefore waited as a 'new routine' referral till January 2016 to be seen by a Consultant Urologist.

The Review Panel agreed 3 main contributing factors led directly to Patient 10's delay in diagnosis.



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Firstly, the content of the MRI report; secondly a letter following a CT scan did not mention important information and thirdly, the opportunity to upgrade the referral to red flag was lost by the omission of triage; this resulted in a 64-week delay to diagnosis of a suspicious renal mass.

This Review Panel concluded in March 2017 that, "…. *a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process (*vide infra*) continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team*".

Of the 2 lessons learnt, one indicated that,

> "*Triage of GP referral letters remains a key element in validating appropriate utilisation of specialist services and ensuring patient safety. Triage also serves as an opportunity for early intervention for patients at risk of malignant disease or clinical deterioration*."

This led to a recommendation that,

> "*This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with the Integrated Elective Access Protocol (IEAP).*
>
> *In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The Urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP.*"

The findings of this investigation, chaired by Consultant Urologist 2 (Cons2), were made available in December 2016 and formally signed off on the 15th March 2017. A letter highlighting a number of concerns was sent to the (then) lead for Acute Governance for Acute Services (AGAS1), on the 15th December 2016.

The letter pointed out that the IDT process implied that triage non-compliance was to be expected but that this process did not have a clear escalation plan to include the individual Consultant and, indeed, had not been effective in addressing triage non-compliance. Furthermore, the letter pointed out that, from July 2015 till October 2016, there were 318 non-triaged letters which the Trust could not provide assurance that patients were not being exposed to harm by waiting as a routine or urgent appointment i.e. when they should have been red-flagged.

It is not absolutely clear who wrote this letter as it has no signature, but it appears to have been written by, or on behalf of, Cons2. On the 10th January 2017, Cons2 was requested by



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the Medical Director (MD3) to share the report with the 2 key Consultants involved in the SAI. One of these was Cons1. Cons2 refused, stating that he was Cons1's colleague and not his manager.

This letter was escalated to the Director of Acute Services (DAS3) and the Assistant Director of Anaesthetics & Surgery. This was further escalated to the Chief Executive of the SHSCT.

Cons1 was written to by AMD1 on the 23rd March 2016, acknowledging his hard work as a Consultant Urologist but pointing out that there were governance and patient safety concerns with regard to untriaged letters dating back over 2 years, and other important issues. Cons1 was asked to respond with a commitment and immediate plan to address these issues.

The Review Panel also determined that there were 7 other patients who were not triaged that week along with Patient 10. They subsequently performed a 'look-back' exercise (number 1) of these referrals. Of the seven referrals, six charts were available and each patient had an appropriate management plan. One set of notes were missing and efforts were made to find them.

Cons1 provided his personal review, dated 25/01/2017, of the Index Case to the Chairman of this Review Team. It provides an argued retrospective rationale that a timely triage by himself would not have altered the referral grading. However, it does not provide a sound reason for the actual lack of triage. His report is consistent in arguing his view that he does not have time to perform both Consultant of the Week (CoW) duties and triaging of non-red flag referrals.

**5.5 Look back exercise #2**

Upon realisation that the 'look-back' exercise #1 had resulted from non-triage over the week beginning the 30/10/2014, further efforts were made to investigate the size of this non-triage issue and to find missing referral letters. Cons1 was contacted and the Head of Service for Urology (HoS1) obtained permission to look for missing GP referral letters in his filing cabinet. Cons1 stated that there were referral letters in a filing cabinet in his office. During interview, he stated that he kept the referrals to ensure they would not be missed or overlooked. The Head of Service for Urology retrieved these referral letters, which numbered over 700 along with the triage lists from the booking centre.

These referrals were then reviewed by the Urology Consultant Team revealing 30 patient referrals should have been red-flagged and four of these patients, following review, were diagnosed with cancer, becoming the subject of this review.

The Review Team reviewed the clinical notes from these 4 patients and following discussion, under the Urological guidance of Mr M Haynes, detailed the clinical course and made the following conclusions.

Patient 14 03/06/2016 - Personal-year-old male referred to Urology Outpatients by GP for assessment and advice with a raised PSA.



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The referral was marked Urgent by the GP.
The referral was not triaged on receipt.
09/08/2016 - added to W/L Urgent.
27/01/2017, as part of the internal review #2, the referral was upgraded to R/F and was seen in clinic on day 246. Therefore, this was an incorrect GP referral.
05/04/2017 (D304), following U/S guided biopsy, the patient obtained a confirmed cancer diagnosis and there was a recommendation for treatment of a prostate cancer by surveillance protocol.
**Conclusions**
Resultant 10-month delay in obtaining diagnosis.
Following Review Team consideration, deemed not to be a clinically significant delay.

Patient 11 28/07/2016 - Personal-year-old male referred to Urology Outpatients by GP for assessment and advice, concerning elevated PSA.
The referral was marked Urgent by the GP.
The referral was not triaged on receipt.
30/09/2016 - added to W/L Urgent.
18/01/2017 - as part of an internal review #2, upgraded to R/F. Therefore, this was an incorrect GP referral.
20/02/2017 (D207) seen at R/F appointment. Sent for MRI and prostate biopsy.
11/04/2017 (D258) - diagnosed with a confirmed low risk prostate cancer and there was a recommendation for treatment of a prostate cancer by surveillance protocol.
**Conclusions**
Resultant 9-month delay in obtaining diagnosis.
Following Review Team consideration, deemed not to be a clinically significant delay.

Patient 13 28/07/2016 - Personal-year-old male referred to Urology by GP following an episode of haematuria.
The referral was marked Routine by the GP.
The letter was not triaged.
30/09/2016 - Patient 13 was placed on a Routine waiting list.
19/01/2017 - As part of an internal review #2, upgraded to a R/F referral. Therefore, this was an incorrect GP referral.
31/01/2017 (188d) - reviewed at OPD and flexible cystoscopy.
22/02/2017 TURBT/TURP - diagnosed with bladder (locally advanced) and prostate cancer and there was a recommendation of treatment for his bladder cancer.
**Conclusions**
Resultant 6-month delay in obtaining diagnosis.
Following Review Team consideration, it is probable that the delay is clinically significant; time will tell*.

* The Review Team referred to an expert for advice.
*Delay in definitive surgical treatment beyond 12 weeks conferred an increased risk of disease-specific and all-cause mortality among subjects with stage II bladder cancer. He remains*



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*disease free as of September 2018.*


1. John L. Gore, Julie Lai, Claude M. Setodji, Mark S. Litwin, Christopher S. Saigal, and the Urologic Diseases in America Project. Mortality increases when radical cystectomy is delayed more than 12 weeks. Results from a surveillance, epidemiology, and end results–Medicare analysis. Cancer March 1, 2009.
2. Nader M. Fahmy, Salaheddin Mahmud, Armen G. Aprikian. Delay in the surgical treatment of bladder cancer and survival: Systematic Review of the Literature. *European Urology 50 (2006) 1176–1182.*


Patient 12 08/09/2016 - Personal-year-old male was referred to Urology Outpatients on for assessment and advice on lower tract symptoms and elevated PSA.
The referral was marked Urgent by the GP.
The referral was not triaged on receipt.
27/01/2017 – further GP letter – please upgrade to R/F.
30/01/2017 - as part of the internal review #2, upgraded to R/F.
06/02/2017 - seen in clinic on day 152.
11/04/2017 (D215) - confirmed cancer diagnosis T3a with no nodal metastases – high risk and there was a recommendation of treatment for a locally advanced non-metastatic prostate cancer.

**Conclusions**

Resultant 8-month delay in obtaining diagnosis.
Following Review Team consideration, it is probable that the delay is not clinically significant.

At a later date, towards the end of 2018, another patient came to the attention of the Review Team – Patient. This patient could also have been one of those found in Cons1 filing cabinet but appeared at an outpatient clinic before the outworking of the look back exercise #2. A Consultant Urologist realised in the clinic that this was also a Cons1 non-triaged patient who was incorrectly referred by their GP.

Patient 15 30/08/2015 - Personal-year-old male referred to Urology Outpatients by GP for assessment and advice with a raised PSA.
The referral was marked Routine by the GP.
The referral was not triaged on receipt.
29/01/2016 2nd GP referral marked as Suspected Cancer – Red flag; Patient was added to W/L R/F following this referral.
As part of the internal look back #2, the referral was noted.
Patient had already received an appointment and was seen in clinic on day 153. Therefore, 1st GP referral was incorrect; the 2nd was a correct GP referral.
11/02/2016 (D166), following a prostate biopsy, the patient obtained a confirmed cancer diagnosis T3a and there was a recommendation for treatment of a prostate cancer.

**Conclusions**

Resultant 6-month delay in obtaining diagnosis.
Following Review Team consideration, it is felt that the delay is unlikely to be clinically



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significant.

**7.0 CONCLUSIONS**

The Review Team interviewed a number of Trust staff including Directors (past and present), an Assistant Director, Head of Service and an Associate Medical Director as part of the review process. These interviews, along with clinical documents and health records systems, have helped inform the conclusions by providing the evidence and also corroboration where there appeared to be differences of opinion.

The Review Team and everybody interviewed, including Cons1, provided affirmation that a timely, efficient triage system which checked the initial GP referral was very important to patients. Comments made when interviewees were asked about the importance of triage and where the process of triaging a potential cancer patient ranked alongside other issues such as probity, patient experience and performance, were consistent,

*"Very significant". Very high up the list in terms of importance".*
*"It is fundamental people are seen in the appropriate time".*
*"Very important" ... "Important for the patient".*
*"Vital" ... "Very significant .. patients are often anxious and depend on the system to work".*

Cons1 replied,

*"It is a serious issue, very important"..... "Number one ranking in overall scheme of things"*

The Review Team established that there were factors in HSC service delivery to the 5 patients under examination that resulted in an unnecessary delay in treatment and care. In 4 patients the delay was thought not to be clinically significant but in 1 Patient 13 there probably was a significant delay.

Consideration of the causative factors to the patients' delays reveal,

- Referral letters did not have the clinical priority accurately assigned by the GP; and
- Referral letters were not triaged following receipt by the Hospital.

**7.1 Referral letters did not have the clinical priority accurately assigned by the GP.**

Contributory factors

*Task Factors (policy and guidelines)*
The Review Team reviewed the GP referrals regarding the five patients listed above. They concluded, as judged from the Northern Ireland Cancer Network (NICaN) Referral Guidance for Suspected Cancer (December 2012), that all five patients should have been referred to Urology by the GP's as red flag referrals (suspected cancer).



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*Task Factors (decision aids)*
The current decision aid for GPs is the NI Referral Guidance for Suspected Cancer 2012 based on NICE CG 27 *Referral guidelines for suspected cancer* published in June 2005. It is clear that Secondary care, in the form of Consultant Urologists, should triage these GP referrals; by doing so, 11% of GP referrals are changed (from Review Team member). It is also clear that Cons1 would have been in no doubt as to his responsibilities; he was intimately involved in setting this standard and signed off the NICaN clinical guidelines.

However, it is clear this very important and critical triage safety net work can be considered onerous and other electronic methods which GPs can use might be more efficient and help to reduce that load.

According the HoS1, most patient referrals by GPs to Trusts for outpatient appointments are now made through the electronic Clinical Communication Gateway (CCG). However, some paper referrals are still received. CCG is a digital referral system for Primary care which can contain referral criteria that meet NICE and NICaN guidance. This would enable appropriate clinical triaging of referrals to be performed as part of the selection of referral reasons and/or symptom description.

Using the electronic CCG pathway, some clinical specialties, such as gynaecology, have worked closely with the Public Health Authority to develop a better GP referral tool e.g. using 'banner guidance' (a specialty specific banner, listing symptoms and signs) which complies with NICE/NICaN guidance. This 'banner guidance' helps by directing clinicians to use the NICE/NICaN referral criteria which allow for timely and appropriate triage of patients to clinically appropriate appointment types. It is possible when red flag symptoms are chosen that an immediate alert could go to the Red Flag booking team, to allow the appointment booking process to begin immediately. However, currently, the referral criteria fields are optional i.e. not mandatory, so opening up the possibility that fields are not completed, leading to error and delay.

*NICE NG12*
The reference CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* but, despite, being endorsed by the DHSSPSNI and accepted by the Regional Urologists, it has yet to be implemented. Its use as a triage standard should result in fewer red-flagged cases which should ease some of the pressure on waiting lists. Its adoption would take place in primary care and should form the basis of the electronic CCG referral tool.

There was a consistent medical staff view from the Review Team, the AMD1, and indeed Cons1, that GP's have a crucial and important responsibility in getting the referral criteria/urgency category correct. If the GP does not provide enough, or the correct information, the NI Electronic Care Record (NIECR) needs to be checked and that slows the whole triage process down. It was clear that the triage system works best when the initial GP referral is usually correct and the Secondary care 'safety-net' is only required in a minority of



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cases. Systems should be designed that make that particular sequence the norm.

**7.2 Referral letters were not triaged following receipt by the hospital.**

Contributory factor

*Task Factors (policy and guidelines)*
The Integrated Elective Access Protocol (IEAP) (DHSSPS, April 2008) defines the roles and responsibilities of staff (in both primary and secondary care) when patients enter an elective care pathway. It states,

> '*…an Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to…. Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first'*.

The Principles for booking Cancer Pathway patients states,

> "clinical *teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients*".

and,

> "*Referrals will be received, registered within one working day and forwarded to Consultants for prioritisation*".

However, the IEAP states,

> *"…if clinical priority is not received from Consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency".*

Following on from the IEAP of 2008, national and regional policies and guidelines, already referred to above, have been introduced which have outlined the detailed role of the Urology Consultant in triaging referrals that have come in from Primary care e.g.,

- Service Framework for cancer prevention, treatment and care (Standard 13) 2011;
- NI Referral Guidance for Suspected Cancer 2012; and
- NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016).

These have provided agreed lists of the critical symptomatology of Urological cancers and the roles and responsibilities of Primary and Secondary care staff in ensuring patients receive prompt recognition and treatment of their cancer.

*Review of Adult Urology Services in Northern Ireland*
In March 2009, a *Review of Adult Urology Services in Northern Ireland - A modernisation and investment plan* was published. Its External Advisor was Mr Mark Fordham. SHSCT Consultant Urologists were represented on the committee.

Recommendation 4 states, "*Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system".* Consultants indicated that they would routinely upgrade a significant number of routine and



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urgent referrals (GP) to urgent or red flag. It was noted that the development of agreed referral guidelines/criteria for suspected Urological cancers was a priority piece of work for the recently formed NICaN Group. That work was led by Cons1; see page 6.

Section 3.31 of the report indicates that, "*Consultant Urologists unanimously consider that referral triage should be led by Consultants. With over 40% of referrals being cancer related (and with many not red flagged or marked urgent) they believe that they are best placed and skilled to undertake the triage process. They also believe that despite the volume of referrals, this is not a particularly time consuming process.*"

Contributory factor

*Staff factor*
It is obvious from reading the documents referred to above that Cons1 has been aware of developments in this field and, indeed has been party to the discussions and signed some of them off. Cons1 was chair of NICaN (Urology) and was involved in drafting the NICaN regional Urology guidance, and therefore was very familiar with the requirement to triage GP referrals.

Despite all of this, and even though Cons1 agreed that this triaging role was, "*very important*", …. it was, "*a very serious matter not to be minimised, very serious"* he stated he would not triage non-red flag referrals.

When asked, *"Does triage still need done?"* Cons1 answered*, "a procedure is needed to highlight when it needs done and who does it".* When further asked, *"Who was involved in SHSCT Urology service in setting up triage"?* Cons1 answered for urological cancer, "*I was the Lead".*

He felt triage of referral letters was too time consuming and the amount of time spent on triage, in his opinion, rendered inpatient care unsafe. He highlighted that he had previously escalated his concerns about work load to management teams and medical directors.

In relation to triage, Cons1 stated, '*I would love if we had a Trust Urology agreement on the type of triage to be conducted*'. When it was pointed out that, "*Consultant colleagues did triage for you. How did they do it?"* He stated, "*It depends on how you do it"* ..... "*Not all do advanced / enhanced triage, they compromise. It is a spectrum"... "They have not done it in the detail I felt it needed for routine/urgent non-red flag case".*

When questioned further, regarding his way of organising his own work load, Cons1 stated, '*....yes I did it my way – I wasn't cognisant of being unbending, I am very particular*'.

Cons1 highlighted to the Review Team that he currently takes annual leave each Friday and spends the weekend triaging. He stated that it is impossible to be Urologist of the Week and triage referrals appropriately. He stated he still can't do triage and everything else. He stated, '*I do triage entirely in my own time to allow me to do it properly*'.



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When asked about using the NIECR - Electronic Referral using the Clinical Communication Gateway (CCG) method, Cons1 stated found the new CCG triage system, *"Very, very good, I wish all information was available on ECR. It is less time consuming. ECR makes it easier to check information".*

The Review Team concluded that there was a serious inconsistency between the guideline standard that a Consultant should triage GP referrals (which Cons1 helped to construct) along with his stated view of the crucial importance of triage and Cons1's actual practice.

Cons1's chosen method of triage was beyond what is required. His triage is the equivalent of a virtual clinic where he reviews NIECR and books investigations for patients. While the Review Team recognised this was a detailed triage process, they concluded that his prioritisation of work and attention to detail meant that some patients got a higher standard of triage/care, while, crucially, others were not triaged, leading to a potentially critical delay in assessment and treatment for those patients. Cons1 is aware of this.

The Review Team concluded that Cons1's prioritisation of work and attention to detail led to some patients receiving a high standard of care, while others ran the real risk of having a cancer diagnosis delayed till it was dangerously late.

Contributory factor

*Work load/scheduling*

In 2008, when the IEAP was published, there was a maximum waiting time of 9 weeks for a first Outpatient appointment. On 30th September 2016, there were 2012 patients on the routine Urology outpatient waiting list, with 597 patients showing as waiting 52 weeks and over. The longest waiting time was 554 days (80 weeks). Therefore, if patient referrals are incorrectly referred, or not triaged and continue to use the GP's classification of urgency, there will be a significant wait. Cons1 is aware of this reality.

The Review Team considered the Consultant of the Week (CoW) work load, including ward rounds, clinics, emergency theatre sessions as a contributory factor. Cons1 has consistently argued that he cannot triage non-red flag referrals and carry out the duties of the CoW. He has not indicated who else should carry out the triage duties. However, the Review Team note that the other Consultant Urologists were able to manage this work load and triage referral letters in a timely fashion, with other members of the consultant team also ordering investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to outcomes achieved from Cons1's 'advanced triage'.

Contributory factor

*Organisational*

The Review Team concluded that the non-triage of Urology referrals by Cons1 has been an ongoing problem in the Trust for many years, possibly decades. While there were pockets of non-compliance by other Consultants, when escalated, compliance improved. However, the



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Review Team note that Cons1 consistently did not return triage information on referrals thus not allowing the appropriate prioritisation of appointments by clinical need.

Interviews with 2 previous and the current Director of Acute Services, AMD1 and the Head of Surgery Service have highlighted that on many occasions, over a prolonged period, attempts had been made by the Trust's officers to address Cons1's non-compliance with triage. These attempts encompassed both direct face to face conversations which were often heated, correspondence and, as in 2011, study leave refusal until there was compliance. These interventions all resulted in a familiar pattern of response; temporary improvement in compliance with triage, followed by a return to non-compliance.

In 2014, due to continuing non-compliance, the Trust implemented an 'Informal' Default Triage Process to manage the referrals which were not being triaged and returned to the Booking Centre. The Review Team considered the intention of this process was to prevent any delay in patients being added to the waiting list. However, this meant the 'non-return of triage' was not individually addressed with the non-compliant clinicians. Furthermore, and most importantly, it allowed patients, who should have been red-flagged, to remain on a waiting list until review.

In 2014, the Director of Acute Service 2 (DAS2) discussed non-compliance with Cons1 and agreed that Cons1 would no longer triage referral letters. Cons1 was heavily involved with formulating the NICaN Urology guidelines at the time and was grateful to the extent that he thanked DAS2.This task was delegated to other Urology Consultants for a time. However, Cons1 does not recollect having to formally stop triage. At interview, DAS2 was not aware that he had resumed those duties; she remembered that their Cancer performance figures improved when Cons1 was not triaging.

*Escalation within Organisation*
At every interview, questions were asked whether Cons1's consistent and prolonged non-compliance with triaging was referred upwards to executive level i.e. the Medical Director and Chief Executive.

Director DAS1 considered that the problem was being managed at Service level, although as it was only one of a series of issues and considered to be a 'minor' one, it did not predominate at higher level meetings with the Medical Director (MD1); to the extent that he may not have been aware of it.

Director DAS2 considered that the problem was dealt with by agreeing with Cons1 to stop triaging. There were other issues that were flagged up to MD2, but she was not able to remember whether MD2 was made aware of the triage problem.

During DAS3's current tenure Executive members certainly knew; at CAH Oversight meeting level and at the time of the look back exercise #2 which ultimately led onto this SAI and RCA process. The Medical Director (MD3) was directly involved in the RCA process and the CEO was aware. At Trust Board level, it is thought that a non-Executive member was asked to



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examine the situation which would indicate that it had also reached that level.

Overall, the Review Team in considering whether there was a satisfactory escalation of this 'non-triage' issue have concluded that there was no evidence of consistent and proactive escalation of 'non-return of triage' either to the Medical Director or the Chief Executive until the look back exercise #2 basically forced the seriousness of the issue out into the open. Indeed, they do not appear to have appreciated the importance of triage, certainly from the patient's perspective. The Trust's officers made efforts to address Cons1's non-triage over time but were consistently thwarted by Cons1's refusal to comply. The Trust failed to put systems, processes and fail safes in place to ensure Cons1's consistently triaged patient referrals until 2017.

Systems and processes have now been put in place so that the Head of Service for Urology reviews Cons1's compliance with triage. HoS1 will check all Urology triage on an adhoc basis but, with Cons1, she will check daily when he is the Consultant of the Week. Any non-compliance with returning referrals without triage is addressed immediately. However, this process is heavily dependent on HoS1 who, when she is on leave, often has to recover non-triaged cases upon her return.

## 8.0 LESSONS LEARNED

1. The clinical urgency category allocated by GPs to 30 patients referred to Urology were incorrect. The referrals using NICaN guidance should have been referred as a Red Flag. Four (plus 1) of these patients were subsequently shown to have cancer.

2. The process of triaging Urology cancer referrals from Primary Care to Secondary Care, under the direction of the HSCB, appears to be less efficient than it could be, bearing in mind that NICE NG12 guidance has not been adopted and electronic referral using CCG is not being used as efficiently as it could.

3. GP's are not mandated to provide HSCB with an assurance that they comply with the most up to date NICE or other guidelines. Therefore, HSCB are unaware of any risks consequent upon the non-compliance with NICE and other guidance within GP practices.

4. GP's are not mandated to refer patients using CCG clinical criteria banners; this can lead to error and delay.

5. There is no Regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters. Triage of patient referrals is obviously viewed as extremely important but does not seem to be at an equivalent level of importance when ranked alongside other clinical governance issues. Despite being an evident problem for decades and requiring considerable time and effort to find a solution, it only really surfaced within the Trust after an Index case forced the situation out into



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the open.

6. Despite it being absolutely clear to Consultant 1 (based upon his close proximity to the development and signing off of regional guidance) of the consequences of non-triage, he did not routinely triage referral letters. The Review Team consider that Cons1's refusal to triage to a level similar to other clinicians, led to patients not being triaged, and this resulted in delays in assessment and treatment. This may have harmed one patient.

7. Cons1 confirmed that despite the Trust reminding him of the requirement to triage, he did not consistently triage referrals. He argued that, due to time pressures, he felt he was unable to perform the duties of the Consultant of the Week and his triaging duties. He has highlighted those views to Trust operational and management teams over a number of years.

8. The Trust made efforts to address Cons1's non-triage over time. However, the Trust failed to put systems, processes and fail safes in place to ensure Cons1 consistently triaged patient referrals until 2017. However, this safeguarding process is heavily dependent on the Head of Service checking triage is completed when Cons1 is Consultant of the Week.

9. The Informal Default Triage process allows patients who should be red flagged to remain on a waiting list of routine or urgent cases.

10. From examining the triaging issue over the length of time it has existed, it is obvious that there is an unwillingness or inability within the medical hierarchy to tackle its 'difficult colleague' problem. The reasons behind this probably include not taking ownership of its own problems and poor support from senior medical management perhaps resulting in issues not being referred upwards.



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## 9.0 RECOMMENDATIONS AND ACTION PLANNING

**Recommendation 1**
HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

**Recommendation 2**
HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

**Recommendation 3**
GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards.

**Recommendation 4**
Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

**Commented [KP1]:** Already does happen, needs to speed up process to go straight to test.

**Recommendation 5**
The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

**Commented [KP2]:**

**Recommendation 6**
The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.

**Recommendation 7**
The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

**Recommendation 8**
Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes.

**Recommendation 9**
The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation

**Commented [KP3]:** Concerns



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## 9.0 RECOMMENDATIONS AND ACTION PLANNING

and influence.

## 10.0 DISTRIBUTION LIST

In addition to the Review Team, the following.

Mr S Devlin, Chief Executive SHSCT.

Dr Maria O'Kane, Medical Director, SHSCT.

Esther Gishkori, Director of Acute Services.

Health & Social Care Board (HSCB).

Chairs of Morbidity & Mortality Groups SHSCT.

Patient 159, Patient 13, Patient 12, Patient 14 and Patient 11.



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**Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident**

| **Reporting Organisation SAI Ref Number:** | | **HSCB Ref Number:** | |
|---|---|---|---|

## SECTION 1

## INFORMING THE SERVICE USER[1] / FAMILY / CARER

| | | | | | |
|---|---|---|---|---|---|
| 1) Please indicate if the SAI relates to a single service user, or a number of service users.<br>**Please select as appropriate (✓)** | **Single Service User** | | **Multiple Service Users*** | | |
| | **Comment:**<br>***If multiple service users are involved please indicate the number involved*** | | | | |
| 2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| | If **YES**, insert **date informed**: | | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI | | | | |
| | a) No contact or Next of Kin details or Unable to contact | | | | |
| | b) Not applicable as this SAI is not 'patient/service user' related | | | | |
| | c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user | | | | |
| | d) Case involved suspected or actual abuse by family | | | | |
| | e) Case identified as a result of review exercise | | | | |
| | f) Case is environmental or infrastructure related with no harm to patient/service user | | | | |
| | g) Other rationale | | | | |
| | **If you selected c), d), e), f) or g) above please provide further details:** | | | | |
| 3) Was this SAI also a Never Event?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | | |
| 4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event?<br>**Please select as appropriate (✓)** | **YES** | If **YES**, insert **date informed**: DD/MM.YY | | | |
| | **NO** | If **NO**, provide details: | | | |
| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate (✓)** | | | | | |
| **Content with rationale?** | **YES** | | **NO** | | |

## SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)***

| | | | | |
|---|---|---|---|---|
| 5) Has the Final Review report been shared with the Service User[1] / Family / Carer?<br>**Please select as appropriate (✓)** | **YES** | | **NO** | |
| | If **YES**, insert date informed: | | | |
| | If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer: | | | |
| | a) Draft review report has been shared and further engagement planned to share final report | | | |
| | b) Plan to share final review report at a later date and further engagement planned | | | |



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| SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER<br>*(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)* | | |
|---|---|---|
| | c) Report not shared but contents discussed<br>***(if you select this option please also complete 'l' below)*** | |
| | d) No contact or Next of Kin or Unable to contact | |
| | e) No response to correspondence | |
| | f) Withdrew fully from the SAI process | |
| | g) Participated in SAI process but declined review report | |
| | ***(if you select any of the options below please also complete 'l' below)*** | |
| | h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer | |
| | i) case involved suspected or actual abuse by family | |
| | j) identified as a result of review exercise | |
| | k) other rationale | |
| | l) If you have selected **c), h), i), j), or k)** above please provide further details: | |

| **For completion by HSCB/PHA Personnel Only** (**Please select as appropriate** (✓) | | | | |
|---|---|---|---|---|
| **Content with rationale?** | **YES** | | **NO** | |

| SECTION 2<br>INFORMING THE CORONERS OFFICE<br>(under section 7 of the Coroners Act (Northern Ireland) 1959)<br>*(complete this section for all death related SAIs)* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death?<br>**Please select as appropriate** (✓) | **YES** | | | | **NO** | | | |
| | If **YES**, insert **date informed**: | | | | | | | |
| | If **NO**, please provide details: | | | | | | | |
| 2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner?<br>**Please select as appropriate** (✓) | **YES** | | | | **NO** | | | |
| | If **YES**, insert **date report shared**: | | | | | | | |
| | If **NO**, please provide details: | | | | | | | |
| 3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed?<br>**Please select as appropriate** (✓) | **YES** | | **NO** | | **N/A** | | **Not Known** | |
| | If **YES**, insert **date informed**: | | | | | | | |
| | If **NO**, please provide details: | | | | | | | |

| **DATE CHECKLIST COMPLETED** | |
|---|---|

[1] *Service User or their nominated representative*



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# Clinical Audit Summary Report to Acute Directorate Clinical Governance Meeting, 7th January 2020

| | Audit topic | Directorate contact | Clinical audit lead | Deadline | Proposed areas for discussion and action within Acute Directorate |
|---|---|---|---|---|---|
| 1 | IV Fluids in children and Young People: | ADs | Mrs Davidson | Continuous<br><br>January 2019 | Cases have been reviewed as below.<br>1) Hyponatraemia audit action plans for<br>Reminder that all wards to forward data or advise nil return is applicable for each week.<br>Internal audit are undertaking an audit of children in adult wards including management of IV fluids. |
| 2 | Clinical Audit work programme 2018/2019, Acute Directorate | All | Operational teams | | Directorate's clinical audit work programme 2018/19, 2019/20 attached.<br>Database Clinical Audit Acute 2018 201 |
| 3 | HQIP 2019/2020 list for consideration | All | Operational teams | | HQIP Quality Accounts list 2019-20 for validation by clinical teams. Awaiting feedback on outstanding audits regarding SHSCT participation.<br>HQIP Quality Accounts list 2019-20 |
| 4 | NCEPOD Dysphagia in people with Parkinson's Disease study | C McGoldrick | R Haffey | 13/01/20<br><br>18/1/20 | NCEPOD are undertaking a study to look at the care of patients with Parkinson's Disease (PD) who are admitted to hospital when acutely unwell. Patient identification spreadsheet submitted to NCEPOD following approval. Case note extract and12 clinical questionnaires selected by NCEPOD. 4 clinical questionnaires outstanding and reminders have been sent to the relevant Consultants to complete these.<br>Organisational questionnaire to be completed for Craigavon, Daisy Hill, Lurgan and South Tyrone Hospitals.<br>Dysphagia in people with PD_Organisation |



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| | Audit topic | Directorate contact | Clinical audit lead | Deadline | Proposed areas for discussion and action within Acute Directorate |
|---|---|---|---|---|---|
| 5 | NCEPOD hospital management of out of hospital cardiac arrests | All | R Haffey<br><br>Mrs M Burke | Data submitted<br><br>Data submitted | Case identification stage spreadsheet submitted to NCEPOD following approval. NCEPOD had selected cases requesting copies of case notes. These have been forwarded to NCEPOD.<br>Cases requiring completion of clinical questionnaires have been requested by NCEPOD. All clinical questionnaires have been submitted.<br><br>Organisational questionnaires for Craigavon and Daisy Hill Hospitals submitted. |
| 6 | NCEPOD Acute Heart Failure Audit | Mrs K Carroll | Dr P Campbell / nominee | To be advised | Report has been disseminated November 2018. Recommendation in the report: Hospitals should audit against the standards contained in the final reports annually. Information request submitted. |
| 7 | NCEPOD: Physical Healthcare of Inpatients in a Mental Health Hospital - Scoping information | All | R Haffey | Data submitted | Final Information signed off by Directors of Acute Services and Mental Health and Learning Disability and submitted on 27/8/19. This study is currently in the design stage. |
| 8 | NCEPOD KNOW THE SCORE - a new report released by NCEPOD reviewing the quality of care received patients with a new diagnosis of pulmonary embolism | Mrs McVey | | Report | Reports for this study have been disseminated to the Director, Associate Medical Director, Assistant Director and Mrs Leeman on 10/10/19 to ensure that recommendations are communicated for both learning and improvement planning purposes. |
| 9 | National Audit of Community Acquired Pneumonia (CAP) from British Thoracic Society (BTS) | Mrs McVey | Dr R Convery , Dr L Polley | Data submitted | The aim of the BTS audit programme is to drive improvements in the quality of care and services provided for patients with respiratory conditions across the UK.<br><br>Audit period: 1 December 2018 – 31 January 2019. Data entry period: 1 December 2018 – 31 May 2019.<br>The 2018/19 audit had two parts:<br><br>**Part 1: Main adult CAP audit –** one record per patient.<br>**Part 2: Organisational audit –** one record to be submitted by each participating site to provide information on the audit process for the Trust.<br><br>Data has been submitted by Dr Polley. |



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| | Audit topic | Directorate contact | Clinical audit lead | Deadline | Proposed areas for discussion and action within Acute Directorate |
|---|---|---|---|---|---|
| 10 | Adult Non Invasive Ventilation (NIV) Audit from British Thoracic Society (BTS) | Mrs McVey | Dr R Convery , Dr L Polley | Data submitted | Clinical audit - Data collection period is 1 February 2019 – 31 March 2019.<br><br>Organisational audit. Data submitted by Dr Convery. |
| 11 | Adult Smoking Cessation Audit from British Thoracic Society (BTS) | Mrs McVey | Dr R Convery | Data submitted | Audit period is 1 Jul 2019 – 31 Aug 2019. Data entry completed. |
| 12 | National End of Life Audit (NACEL) – Round 1<br>- Northern Ireland Summary Report | | | Completed | The National Audit of Care at the End of Life (NACEL), was commissioned by HQIP.<br><br>The key recommendations were:<br>1. Ensure that all resources which have been/are available by the Regional Palliative Care in Partnership Programme are being utilised locally in Health and Social Care Trusts.<br>2. Promote the use of practices and methodologies such as Schwartz Rounds to ensure staff involved in the care of the dying feel emotionally supported.<br>3. Ensure that HSCTs consider the allocation of side rooms for people who are dying, if this is their wish, wherever possible.<br>4. Explore the options to ensure access to specialist palliative care teams during out of hours periods.<br>5. Palliative Care Locality Boards should ensure engagement, inclusion and implementation of regional and locality activities within Mental Health sites within each HSCT's organisational remit.<br>6. Ensure that all HSCTs have guidelines in place which indicate clearly the time taken to notify the patient's GP of the patient's death**.**<br><br>The next round of the audit (Round 2) is underway as detailed below. |



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| | Audit topic | Directorate contact | Clinical audit lead | Deadline | Proposed areas for discussion and action within Acute Directorate |
|---|---|---|---|---|---|
| 13 | National End of Life Audit (NACEL) – Round 2 | Mr B Conway | Mr D Calvin, Dr G Nicholson | Data submitted | Audit methodology: All adult deaths (18 plus).<br>• 20 consecutive deaths audited from first 2 weeks in April and 20 consecutive deaths from first 2 weeks in May (DHH and CAH).<br>• 40 deaths from whole of April and May (STH and LGH)<br>All sudden deaths and all deaths that occurred within 4 hrs of admission are excluded.<br>Data collection now completed.<br>Organisational template also completed.<br><br>NACEL Northern Ireland Feedback Event. This will report back on findings and recommendations from the second round of the audit. The NACEL Northern Ireland Feedback Event is to be held on:- Wednesday 4th March 2020, at The Linen Suite, Mossley Mill, Carnmoney Rd North, Newtownabbey BT36 5QA From 9.30 am – 3.00 pm. |
| 14 | NHS Benchmarking Audit Managing Frailty in Acute Settings | K McGoldrick | P Fearon (User Audit) | 27/9/19 (User Audit)<br><br>5/12/19 | Two elements Submissions from Craigavon and Daisy Hill Hospitals required.<br>a) Service User Audit – 50 cases from CAH and DHH. Data collection complete and signed off for submission.<br>b) Organisational Benchmarking data - Managing Frailty and Delayed Transfers of Care in the Acute Setting - final deadline to submit is 5/12/19. Data submitted.<br><br>Service User Audit 2019 FINAL - BLANK (<br>Managing Frailty spec 2019 - FINAL.xls |
| 15 | IBD UK – IBD Benchmarking Tool | Ms L Devlin | Dr Bhat | 22/11/19 (Survey)<br><br>15/1/20 (Benchmarking) | Benchmarking audit with the quality markers being drawn from the recent standards review. 3 reports will be generated – The patient survey for the site, the site specific assessment and a national report. |
| 16 | Royal College of Emergency Medicine audits 2018-19.<br><br>➢ Feverish Children | Mrs A McVey, Mrs M Burke | Dr Patton, Dr Mawhinney | Report | Reports for Craigavon and Daisy Hill Hospitals circulated. |



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| | Audit topic | Directorate contact | Clinical audit lead | Deadline | Proposed areas for discussion and action within Acute Directorate |
|---|---|---|---|---|---|
| 17 | Royal College of Emergency Medicine audits 2018-19.<br>➢ Vital Signs in Adults report | Mrs A McVey, Mrs M Burke | Dr Patton, Dr Mawhinney | Report | Reports for Craigavon and Daisy Hill Hospitals circulated. |
| 18 | Royal College of Emergency Medicine audits 2018-19.<br>➢ VTE risk in lower limb immobilisation | Mrs A McVey, Mrs M Burke | Dr Patton, Dr Mawhinney | Report | Reports for Craigavon and Daisy Hill Hospitals circulated. |
| 19 | Royal College of Emergency Medicine audits 2019-20.<br>➢ Mental Health | Mrs A McVey, Mrs M Burke | Dr Patton, Dr Mawhinney | 14/2/20 | **Methodology / Inclusion criteria**<br>Data should be collected on patients attending from 1 August 2019 – 31 January 2020.<br>**Inclusion criteria**<br>Patients must meet the following criteria for inclusion:<br>➢ Patients **aged 18 years and older**<br>➢ Who presented at a type 1 ED having intentionally **self-harmed** (either self-injury or self-poisoning)<br>➢ **AND** required an emergency mental health assessment by your organisation's specified acute psychiatric service<br><br>**Exclusion criteria**<br>Do not include:<br>• Any patient 17 years of age or under<br>• Any patient who was unable to undergo a mental health examination or risk assessment in the ED due to their physical condition (e.g. unconscious)<br>• Any patient who was **admitted** to an in-hospital ward or ITU for **medical** treatment<br>• Any patient who had previously attended due to self-harm within the audit period (first attendance only to be included)<br>• Any patient who left the ED before **any** of the assessments outlined in the RCEM standards could be done (i.e. if some assessments were completed before patient left please include in the audit – if no assessments were done before patient left do not include) |



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| | Audit topic | Directorate contact | Clinical audit lead | Deadline | Proposed areas for discussion and action within Acute Directorate |
|---|---|---|---|---|---|
| 20 | Royal College of Emergency Medicine audits 2019-20.<br><br>➢ Assessing for Cognitive Impairment in Older People | Mrs A McVey, Mrs M Burke | Dr Patton, Dr Mawhinney | 14/2/20 | **Methodology / Inclusion criteria**<br>Data should be collected on patients attending from 1 August 2019 – 31 January 2020.<br>Patients must meet the following criteria for inclusion:<br>• Patients **aged 65 years and older**<br>• Presenting to a type 1 ED<br>• **NEWS2 score of 4 or under** (or your department's equivalent for a low or low-medium clinical response if NEWS2 is not used)<br><br>**Exclusion criteria**<br>Do not include patients:<br>• Any patient 64 years of age or under<br>• Patient's with have a **Glasgow Coma Scale (GCS) less than 13**<br>• **NEWS2 score greater than 5** (or your department's equivalent for a medium/high clinical response if NEWS2 is not used) |
| 21 | Royal College of Emergency Medicine audits 2019-20.<br><br>➢ Care of Children in the ED | Mrs A McVey, Mrs M Burke | Dr Patton, Dr Mawhinney | 14/2/20 | **Methodology / Inclusion criteria**<br>Data should be collected on patients attending from 1 August 2019 – 31 January 2020.<br><br>Patients must meet the following criteria for inclusion:<br>• Presenting to a type 1 ED<br>• Children aged 18 years old and under.<br><br>Sub-samples:<br>• Children aged 12 months and under **AND** presenting with an injury (e.g. fracture, bruising, burns or triaged as an injury)<br>• OR Children aged 18 years old or under **AND** who left without being seen.<br><br>**Exclusion criteria**<br>Do not include patients aged 19 years or older. |



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| | Audit topic | Directorate contact | Clinical audit lead | Deadline | Proposed areas for discussion and action within Acute Directorate |
|---|---|---|---|---|---|
| 22 | SSNAP 2019 Acute Organisational Audit: Site-level results available | Mrs A McVey | N Lambe Dr McCaffrey Dr McGleenon | Report | The results of the acute organisational audit will not appear in the public domain until it has been signed off by NHSE and SSNAP will notify when the embargo has been lifted. For now, please do not share any of these outputs outside the NHS. To share these reports with the Chief Executive and Non-Executive Board Chair, helping to initiative discussions arounds areas of good practice and those where remediation is needed.<br><br>This is also referenced in item 33 below. |
| 23 | Healthcare Quality Improvement Partnership (HQIP) MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2017 | | Dr Hogan Mr Conway | Report | Report has been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. |
| 24 | NCEPOD - Healthcare Quality Improvement Partnership (HQIP) National Pregnancy in Diabetes (NPID) Audit Report 2018 | | Dr Hogan Mr Conway | Report | Report has been emailed to Director, Associate Medical Director, Assistant Directors and Mrs Leeman. |
| 25 | Healthcare Quality Improvement Partnership (HQIP) National Perinatal Mortality Review Tool First Annual Report | | Dr Hogan Mr Conway | Report | Report has been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. |
| 26 | Healthcare Quality Improvement Partnership (HQIP) National Child Mortality Database First Annual Report 2019 | | | Report | Report has been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. |
| 27 | Healthcare Quality Improvement Partnership (HQIP) National Early Inflammatory Arthritis Audit (NEIAA) 1st Annual Report | All | All | Report | Reports have been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. |
| 28 | Healthcare Quality Improvement Partnership (HQIP) National Clinical Audit of Anxiety and Depression | | | Report | Reports have been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. |



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| | Audit topic | Directorate contact | Clinical audit lead | Deadline | Proposed areas for discussion and action within Acute Directorate |
|---|---|---|---|---|---|
| 29 | Healthcare Quality Improvement Partnership (HQIP) National Neonatal Audit Programme 2019 Annual Report | | | Report | Reports have been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. |
| 30 | Healthcare Quality Improvement Partnership (HQIP) National Vascular Registry 2019 Annual Report | | | Report | Reports have been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. |
| 31 | Healthcare Quality Improvement Partnership (HQIP) National Prostate Cancer Audit Short Report – Prostate Biopsy | | | Report | Reports have been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. |
| 32 | Healthcare Quality Improvement Partnership (HQIP) National Emergency Laparotomy Audit – Fifth Patient Report | | | Report | Reports have been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. |
| 33 | Healthcare Quality Improvement Partnership (HQIP) Sentinel Stroke National Audit Programme – Organisational Audit report | | | Report | Reports have been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. |
| 34 | Healthcare Quality Improvement Partnership (HQIP) National Diabetes Audit – Report 2: Complications and Mortality | | | Report | Reports have been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. |
| 35 | Healthcare Quality Improvement Partnership (HQIP) Paediatric Intensive Care Audit Network: Annual Report 2019 | | | Report | Reports have been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. |
| 36 | Healthcare Quality Improvement Partnership (HQIP) National Hip Fracture Database – 2019 Annual Report | | | Report | Reports have been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. |
| 37 | Healthcare Quality Improvement Partnership (HQIP) National Confidential Inquiry into Suicide and Safety in Mental Health – Annual Report 2019 | | | Report | Reports have been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. |



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| | Audit topic | Directorate contact | Clinical audit lead | Deadline | Proposed areas for discussion and action within Acute Directorate |
|---|---|---|---|---|---|
| 38 | Healthcare Quality Improvement Partnership (HQIP) Maternal, Newborn and Infant Programme: Saving Lives, Improving Mothers' Care 2019 | | Dr Scullion, Mr Conway | Report | Reports have been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. |
| 39 | Healthcare Quality Improvement Partnership (HQIP) Adult Asthma Audit Report 2019 | | Dr P Murphy, Mrs McVey | Report | Reports have been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. |
| 40 | Healthcare Quality Improvement Partnership (HQIP) National Oesophago-Gastric Cancer Audit 2019 | | Mr Haynes, Dr Scullion, Mr R Carroll | Report | Reports have been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. |
| 41 | Invitation to apply for funding 2020-21 to support clinical audit and/or quality improvement projects/prototypes across the health and social care community. | All | Mrs F Davidson | Submission | RQIA had uploaded an Invitation to apply for funding 2020-21 to support clinical audit and/or quality improvement projects/prototypes across the health and social care community onto our website. Details are found via the following link https://www.rqia.org.uk/what-we-do/rqia-s-funding-programme/<br><br>RQIA Letter to Service applications 2<br><br>A submission regarding the Innovative NG 29 Annual Surveillance audit has been forwarded to RQIA for their consideration. Rationale for the audit: The DHSSPSNI endorsed the NICE guidance (NG 29) for intravenous fluid therapy in children and young persons. As part of the SHSCT's accountability responsibilities for Standards and Guidelines (S&G), all of the guideline's 32 recommendations have been reviewed. The outcome has provided a scoping specification of the evidence that would demonstrate that effective systems and processes are in place to ensure the NG 29 Guidance is met.<br><br>RQIA have requested that the audit and co-project lead attend a meeting on 20/1/20 with members of the funding allocation panel to discuss the application. |
| 42 | Annual Audit Assurance Report 2018/19 | | | | Final report has been shared with SMT 26/11/19 and has been presented at Governance committee on 5/12/19. |



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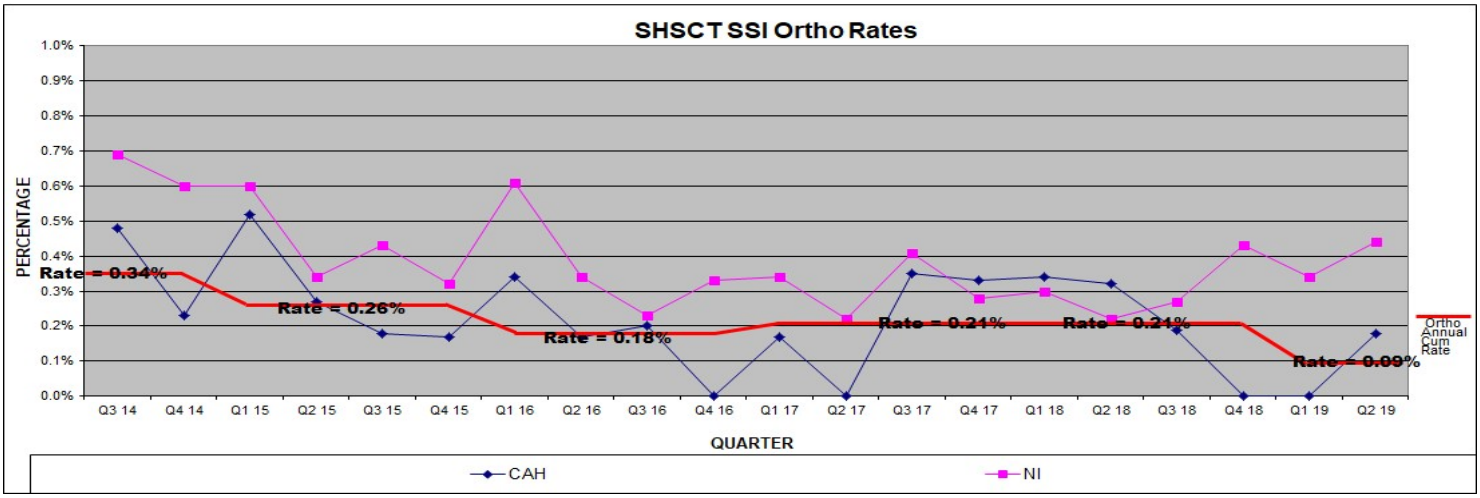
| | Audit topic | Directorate contact | Clinical audit lead | Deadline | Proposed areas for discussion and action within Acute Directorate |
|---|---|---|---|---|---|
| 43 | Internal audit review of Morbidity and Mortality (M&M) 2018-2019 | | | | The action plan to address the internal audit recommendations has been drafted for SMT and Trust Board Governance Committee. |
| 44 | MCCD book - contingency arrangements for death certification when RM&MRS is down | All | Operational teams | | The MCCD booklets are now stored on the Patient flow office, in both CAH &DHH and Sister office Ward 1, Lurgan Hospital. These booklets are for only for use in as a contingency when the NIECR system is down. A communication from the Medical Director's office has been shared regarding this matter. |
| 45 | Morbidity and Mortality meetings | All | | | • Issues around videoconferencing have arisen. Meeting undertaken with IT to discuss.<br>• Difficulty for new Locum appointments completing death certificate on NIECR. These new appointments require to be added to their respective M&M team on NIECR. M&M facilitators to be advised of new starts. |



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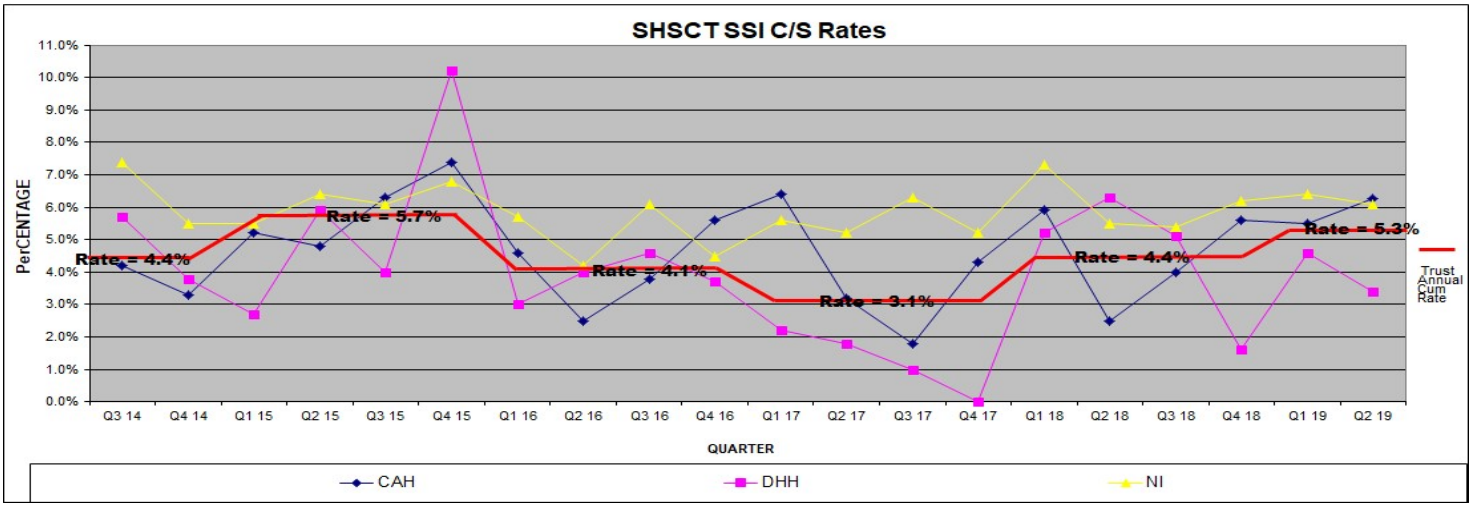
# Patient Safety Report for Acute Governance Meeting Jan 2020

## Surgical Site Infection (SSI) Ortho:



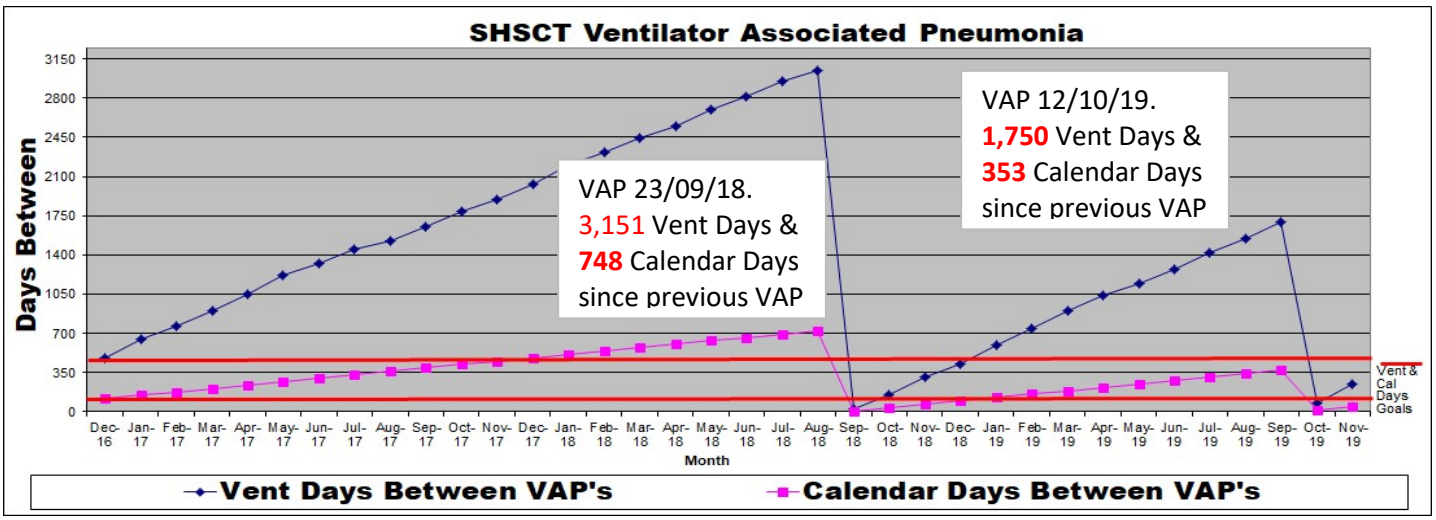

- Next update when Q3 2019 SSI Rates are released by the PHA

## Surgical Site Infection (SSI) C/Section:




- Next update when Q3 2019 SSI Rates are released by the PHA
- The quarterly SSI C/Section Audits take place in Dec 19, with results reported on in Feb 20

## Ventilator Associated Pneumonia (VAP):

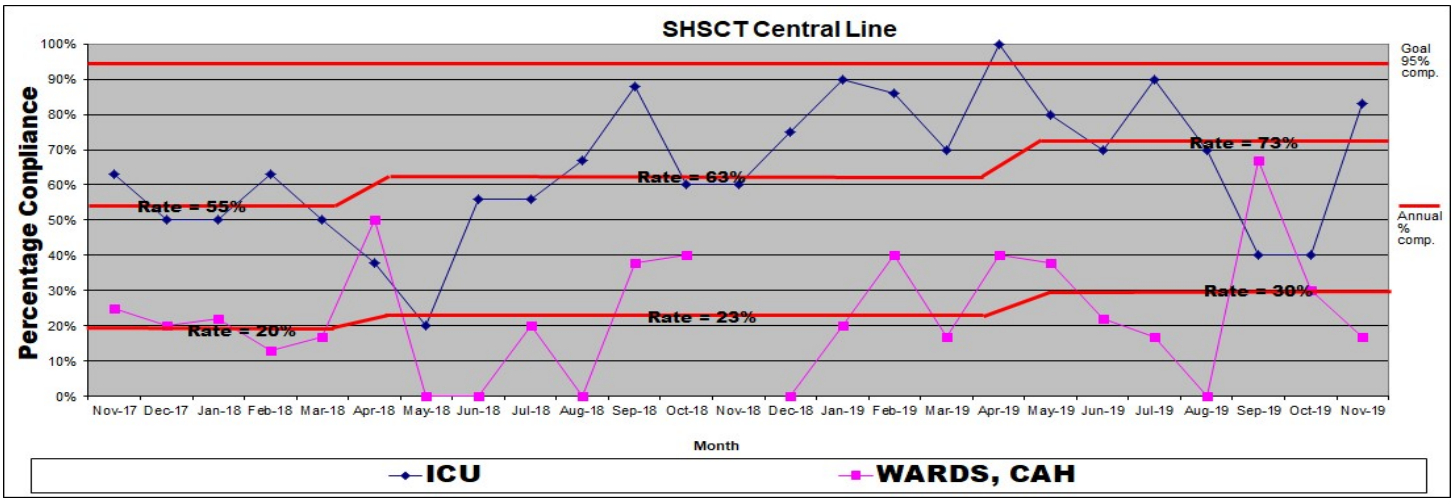





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- Vent Days Between VAP's **246** (13th October 19 → 30th November 19)
- Calendar Days Between VAP's **49** (13th October 19 → 30th November 19)

**Central Line:**




Overall Bundle Compliance Nov 19, ICU **83%** (5/6 cases audited) & Wards, CAH **17%** (1/6 cases audited)

Non-Compliant elements ICU:

- In 1 of 10 cases audited the method of Hand Hygiene was inapproprite

Non-Compliant elements Wards, CAH:

- In 1 of 6 cases audited the Central Line Insertion Record was not completed therefore there was no evidence of the method of Hand Hygiene, Skin Prep or type of Drape used
- In 1 of 6 cases audited the jugular was used with no contrindication documented
- In 3 of 6 cases audited the Daily Review of the Line was not carried out every day the line was in situ (2 days missed in 1 case & 1 day missed in 2 cases)

- Results shared with Lead Clinician & Lead Nurse for this QI work to address areas of non-compliance

**NEWS:**

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

| Quarter | Q2 19/20 | Q1 19/20 | Q4 18/19 | Q3 18/19 |
|---|---|---|---|---|
| ACUTE | 87% (498/573) | 82% (360/439) | 80% (430/532) | 81% (430/532) |
| TRUST | 89% (657/741) | 85% (501/588) | 83% (517/620) | 84% (589/704) |

- Next update when Q3 19/20 data is available

**MUST (Malnutrition Universal Screening Tool):**

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

| Quarter | Q2 19/20 | Q1 19/20 | Q4 18/19 | Q3 18/19 |
|---|---|---|---|---|
| ACUTE | 87% (498/573) | 88% (386/439) | 91% (425/469) | 86% (460/532) |
| TRUST | 89% (662/741) | 90% (531/588) | 93% (575/620) | 89% (626/704) |

- Next update when Q3 19/20 data is available



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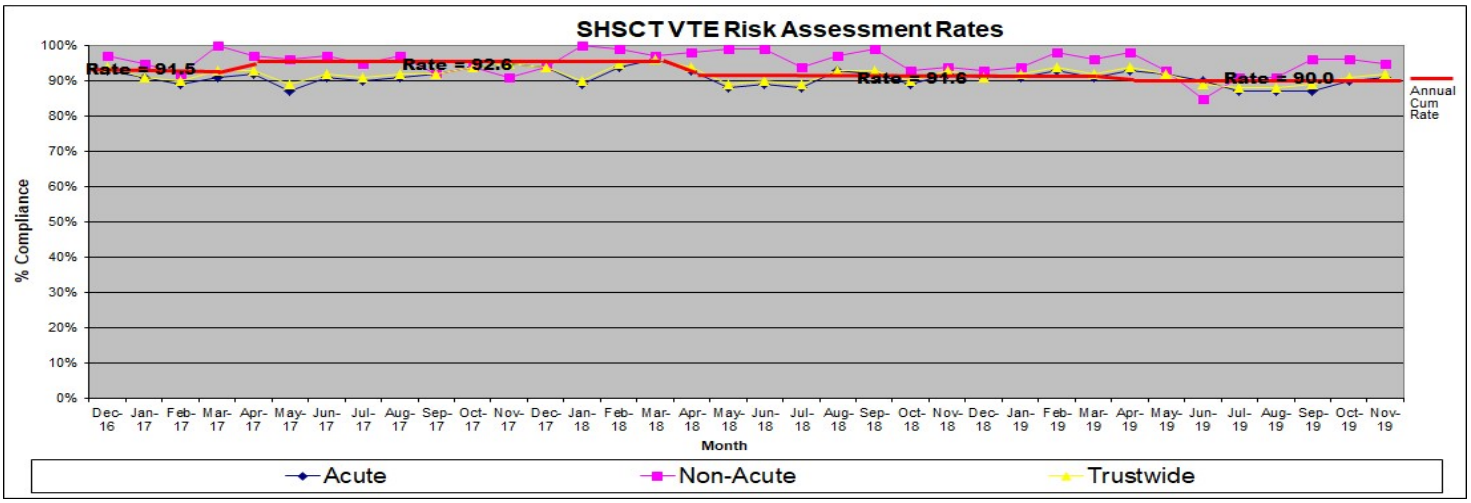
## Nov 19 (Week Commencing 04/11/19 → Week Commencing 25/11/19)

| Division | Site | Ward | Number of Weekly Audits not done | Charts with Fully Completed VTE Risk Assessment | Number of Charts Audited | Monthly Percentage Compliance | Quarter 2 19/20 Percentage Compliance |
|---|---|---|---|---|---|---|---|
| S&EC | CAH | 3 South | 0 | 15 | 19 | 79% ↓ | 77% ↓ |
| | | 4 North CESW | 1 | 14 | 15 | 93% ↓ | 92% ↔ |
| | | 4 South | 0 | 15 | 17 | 88% ↑ | 89% ↓ |
| | | Elective Adm. | 0 | 12 | 19 | 63% ↓ | 32% ↓ |
| | | Orthopaedic | 1 | 14 | 14 | 100% ↔ | 100% ↔ |
| | | Trauma | 0 | 20 | 20 | 100% ↔ | 95% ↓ |
| | DHH | F/male Surg. | 0 | 24 | 24 | 100% ↔ | 96% ↑ |
| | | MSW/HDU | 0 | 17 | 18 | 94% ↓ | 96% ↔ |
| M&UC | CAH | 1 South | 1 | 13 | 15 | 87% ↓ | 97% ↑ |
| | | 1 North | 0 | 17 | 20 | 85% ↑ | 91% ↑ |
| | | 2 North Resp. | 0 | 19 | 20 | 95% ↑ | 88% ↓ |
| | | Haematology | 0 | 14 | 14 | 100% ↔ | 93% ↔ |
| | | 2 South | 0 | 19 | 19 | 100% ↔ | 97% ↑ |
| | | 2 North Med. | 0 | 19 | 20 | 95% ↑ | 86% ↓ |
| | | AMU | 0 | 17 | 20 | 85% ↓ | 94% ↑ |
| | DHH | F/male Med. | 0 | 17 | 19 | 89% ↑ | 74% ↓ |
| | | CCC/MMW | 0 | 19 | 20 | 95% ↑ | 81% ↓ |
| | | Stroke/Rehab | 0 | 17 | 19 | 89% ↓ | 86% ↓ |
| IMWH | CAH | Gynae | 0 | 17 | 17 | 100% ↔ | 95% ↓ |
| TOTAL | | | 3 ↑ (2) | 319 | 349 | 91.4% ↑ | 87.2% ↓ |

Key: Red – Under 85% compliance, Amber – Compliance between 85% & 94%, Green – Above 95% (Reg. target)

- In summary Overall Compliance with fully completed Risk Assessment on the Acute Wards was **91.4%** (319/349 charts audited) up from **90.0%** (307/341 charts audited) in Oct 19.
- Total number of weekly audits not completed in Nov 19 was **3** up from **2** in Oct 19

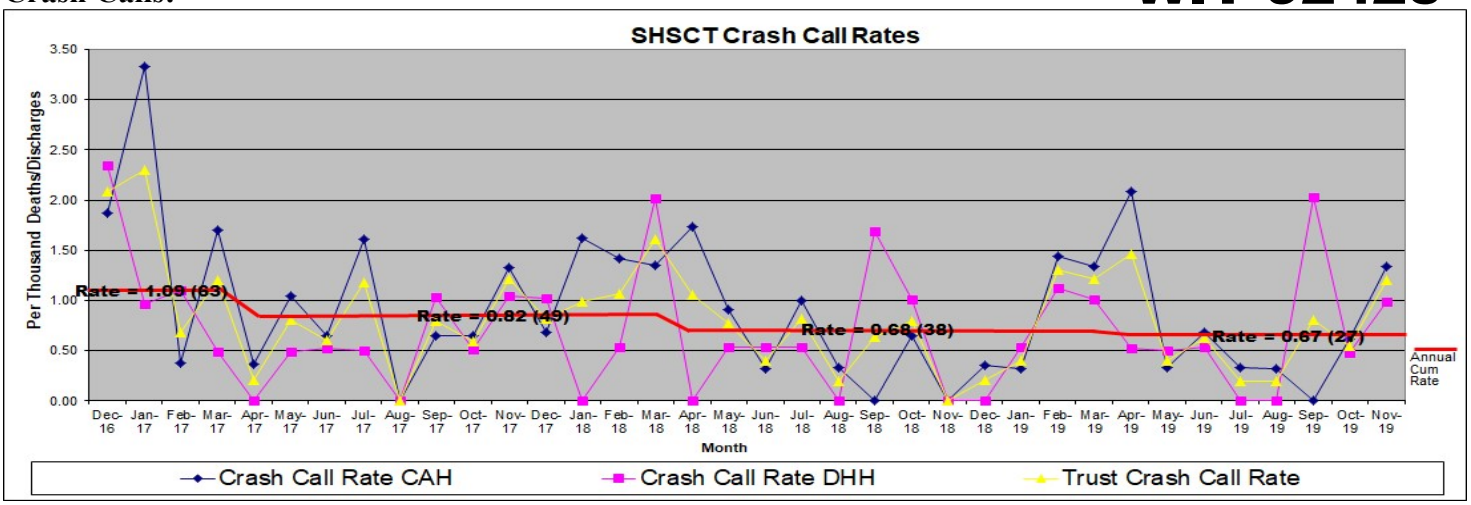
- The Run Chart below shows compliance against the Commissioning Plan target of **95%** compliance. The Trust Compliance includes the Non-Acute Wards & therefore their compliance has been included also for comparison. Trust Overall Compliance in Nov 19 was **92%** (407/442), up from **91%** in Oct 19





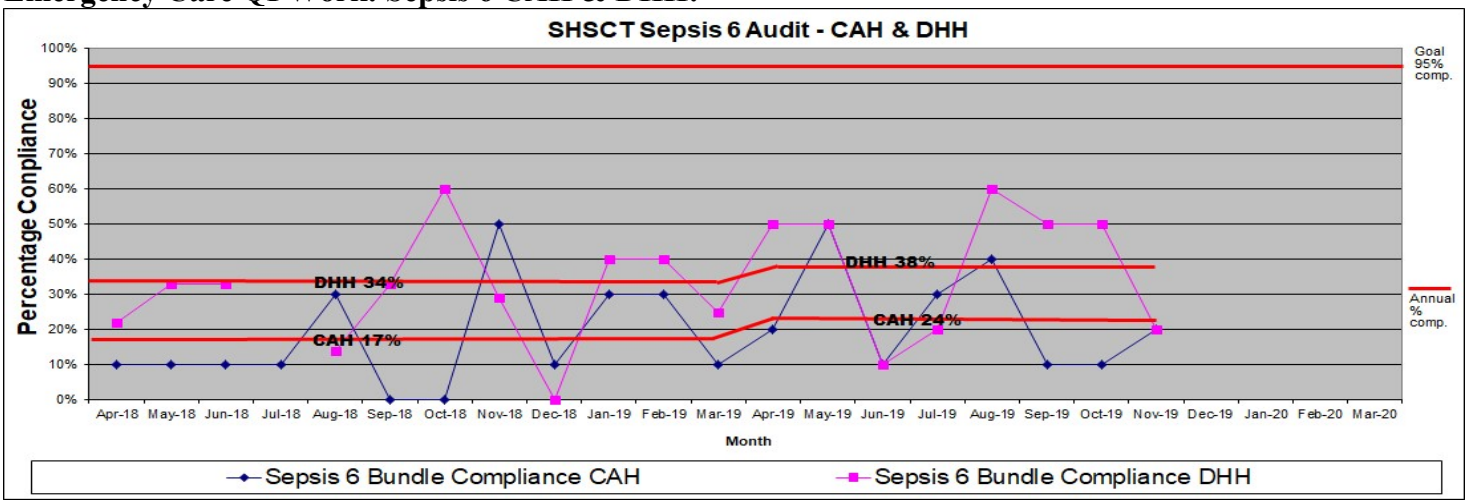

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**Crash Calls:**




- CAH Rate **1.34** per 1,000 deaths/discharges (**4** Crash Calls) up from **0.61** (**2** Crash Calls) in Oct 19
- DHH Rate **0.99** per 1,000 deaths/discharges (**2** Crash Calls) up from **0.48** (**1** Crash Call) in Oct 19
- Trust Rate **1.20** per 1,000 deaths/discharges (**6** Crash Calls) up from **0.56** (**3** Crash Calls) in Oct 19
- Trust cumulative Crash Call Rate for 19/20 stands at **0.67 (27)** per 1,000 deaths/discharges, down from **0.68 (38)** in 18/19

**Emergency Care QI Work: Sepsis 6 CAH & DHH:**




- Summary of Nov 19 Audit CAH – Overall Compliance with the Sepsis 6 Bundle was **20%** up from **10%** in Oct19. The time dependent elements of the Bundle i.e. IV Fluids & IV Antibiotics administered within 1 hour of arrival remain a challenge.
- Summary of Nov 19 Audit DHH – Overall Compliance with the Sepsis 6 Bundle was **20%** down from **50%** in Oct 19. As with CAH, the Time Dependent elements of the Bundle remain a challenge.

- Results shared with Lead Clinician & Lead Nurse for this QI work to address areas of non-compliance

**Critical Medicines Omitted:**

The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

| Quarter | Q2 19/20 | Q1 19/20 | Q4 18/19 | Q3 18/19 |
|---|---|---|---|---|
| ACUTE | 5 (573) | 2 (439) | 5 (469) | 3 (532) |
| TRUST | 6 (741) | 3 (588) | 6 (620) | 5 (704) |

- Next update in when Q3 19/20 data is available

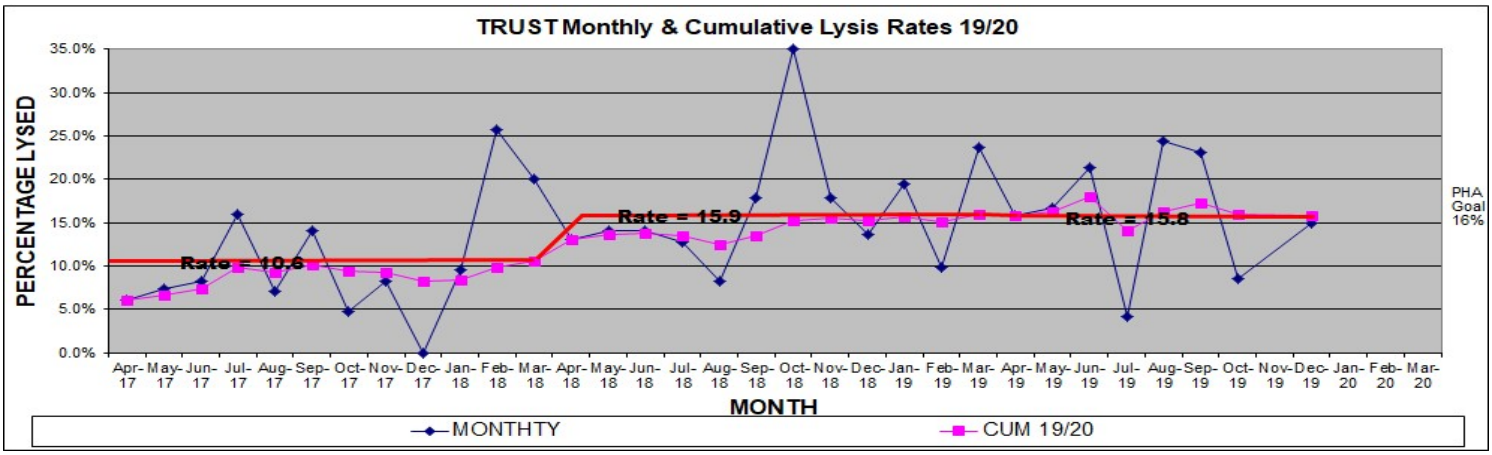


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**Stroke Collaborative:**

- Regional agreement to collect data on the following, however only Lysis Data will be reported to the PHA/DHSSPS on a quarterly basis:

| | CAH | | DHH | | TRUST | | |
|---|---|---|---|---|---|---|---|
| Measure | | Nov 19 | | Nov 19 | | Nov 19 | Commentary Nov 19 |
| Patients who are potentially eligible for thrombolysis are assessed by Acute Stroke Team within 30 minutes of arrival | 17/18 98%<br>18/19 99% | 100% (47/47) | 17/18 99%<br>18/19 99% | 97% (31/32) | 17/18 99%<br>18/19 99% | 99% (78/79) | DHH: Case presented out-of-hours. IR1 & Root Cause Analysis completed in respect of this case |
| Patients who are potentially eligible for thrombolysis receive CT scan within 45 minutes | 17/18 96%<br>18/19 99% | 100% (17/17) | 17/18 95%<br>18/19 98% | 89% (16/18) | 17/18 96%<br>18/19 99% | 94% (33/35) | DHH: Case 1 as above. Case 2 presented out-of-hours. Outside target timescale by 5 Mins. Patient in ED 28 mins before Stroke Bleep was initiated |
| Patients deemed suitable for thrombolysis receive first bolus within 60 minutes | 17/18 59%<br>18/19 90% | 50% (2/4) | 17/18 88%<br>18/19 75% | 33% (1/3) | 17/18 68%<br>18/19 86% | 43% (3/7) | DHH: Cases 1 & 2 as above CAH: Both cases out-of-hours. Delay in contacting Consultant in decision making |
| Patients transferred to Hyper Acute Stroke Unit (or appropriate environment) within 90 mins | 17/18 91%<br>18/19 4% | 100% (4/4) | 17/18 100%<br>18/19 89% | 67% (2/3) | 17/18 94%<br>18/19 93% | 86% (6/7) | DHH: Case 1 as above |
| | **CAH** | | **DHH** | | **TRUST** | | **AIM 19/20 (Based on Commissioning Plan) To ensure that the proportion of thrombolysis administration is at least 16%** |
| Outcome Measure | **2018/19** | **Nov 19** | **2018/19** | **Nov 19** | **2018/19** | **Nov 19** | |
| Monthly Thrombolysis Rate | | 16.0% (4/25) | | 13.6% (3/22) | | 14.9% (7/47) | |
| Thrombolysis Rate (Yearly) | 16.3% (49/301) | 17.1% (39/228) | 14.9% (20/134) | 13.3% (16/120) | 15.9% (69/435) | 15.8% (55/348) | |




The above is "Real Time" data, which is subject to change. The Directorate of Performance & Reform is responsible for reporting to the RHSCB. From the above table only the lysis rates are reported. Furthermore their report is 3 months in arrears to allow Clinical Coding to reach an acceptable level.



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**SKIN Care (Pressure Ulcer):**

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

| Quarter | Q2 19/20 | Q1 19/20 | Q4 18/19 | Q3 18/19 |
|---|---|---|---|---|
| ACUTE | 71% (207/293) | 67% (143/212) | 74% (165/222) | 70% (201/288) |
| TRUST | 77% (324/420) | 78% (271/346) | 82% (295/361) | 78% (338/435) |

- Next update in when Q3 19/20 data is available

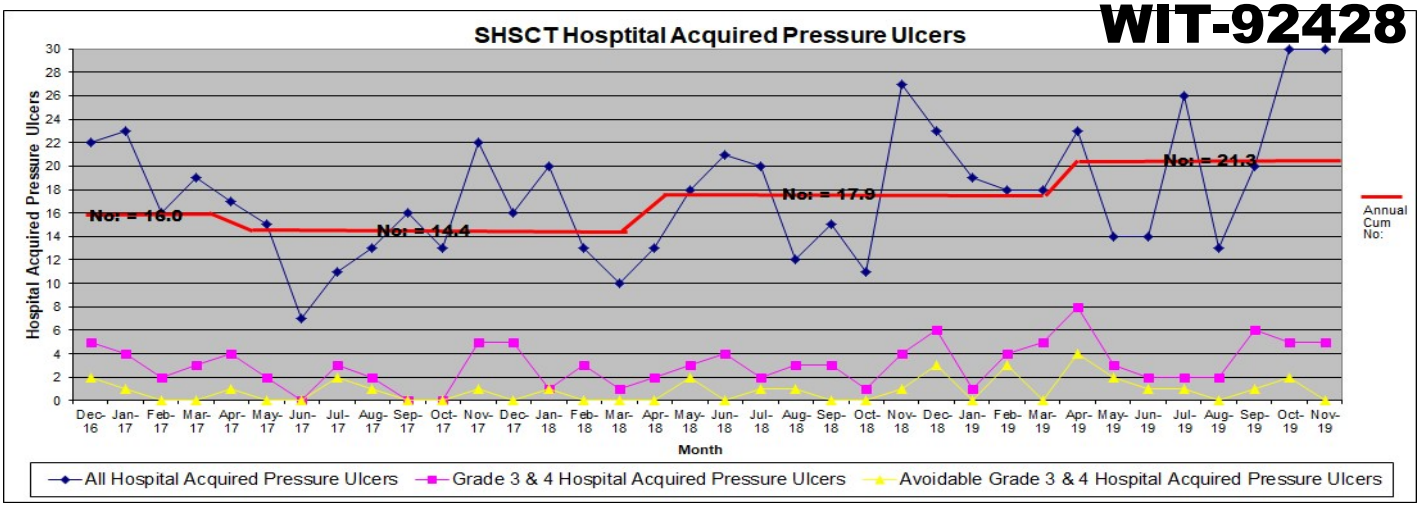
- There were **30** Hospital Acquired Pressures reported in Nov 19. Of these, **5** were Grade 3/4 Ward Acquired Pressure Ulcers, (ICU (2), Recovery, 2 South Medical & Trauma, CAH).
- In 19/20 RCA's have been carried out on **25** cases to date with **11** deemed avoidable. RCA's will be undertaken in the remainder of these cases (**8**) in due course
- In 18/19 RCA's were carried out on **38** cases with **11** deemed to have been avoidable. This represents **5.1%** of all Ward Acquired Pressure Ulcers reported in 18/19

**Ward Acquired Pressure Ulcers & Rate per 1,000 Occupied Bed Days 2019/20:**

| | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | TOTAL | Rate 19/20 | Rate & No 18/19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **CAH** | | | | | | | | | | | | | | | |
| Ward 4 South | 1 | 0 | 0 | 2 | 2 | 0 | 7 | 4 | | | | | 16 | 1.83 | 0.62 (8) ↑ |
| Ward 4 North | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 2 | | | | | 5 | 0.65 | 0.81 (9) ↓ |
| Ward 3 South | 2 | 1 | 1 | 0 | 2 | 2 | 0 | 0 | | | | | 8 | 1.08 | 0.48 (6) ↑ |
| Trauma Ward | 3 | 1 | 1 | 1 | 0 | 5 | 5 | 6 | | | | | 22 | 3.67 | 3.13 (28) ↑ |
| Orthopaedic Ward | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 | 0 | 0 (0) ↔ |
| Gynae Ward | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | | | | | 1 | 0.44 | 0.58 (2) ↓ |
| ICU | 1 | 0 | 0 | 4 | 1 | 5 | 4 | 3 | | | | | 18 | 11.43 | 10.10(24) ↑ |
| Ward 2 South Medicine | 0 | 0 | 3 | 2 | 0 | 0 | 2 | 1 | | | | | 8 | 1.93 | 2.62 (16) ↓ |
| Ward 2 South Stroke | 0 | 1 | 0 | 3 | 1 | 0 | 1 | 0 | | | | | 6 | 1.47 | 1.82 (11) ↓ |
| Ward 2 North | 0 | 2 | 0 | 5 | 0 | 1 | 1 | 0 | | | | | 9 | 1.08 | 0.72 (9) ↑ |
| Ward 5 Haematology | 1 | 1 | 0 | 0 | 1 | 0 | 1 | 1 | | | | | 5 | 1.65 | 1.79 (8) ↓ |
| Ward 1 South | 2 | 4 | 4 | 3 | 0 | 0 | 2 | 3 | | | | | 18 | 2.08 | 1.31 (17) ↑ |
| Ward 1 North | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 2 | | | | | 5 | 0.65 | 0.79 (9) ↓ |
| AMU | 0 | 1 | 1 | 4 | 0 | 1 | 1 | 1 | | | | | 9 | 1.13 | 0.70 (8) ↑ |
| Rec/Renal/2 West/WinterW | 2 | 1 | 2 | 0 | 1 | 2 | 2 | 2 | | | | | 12 | N/A | N/A |
| **DHH** | | | | | | | | | | | | | | | |
| Male Surgical | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 | 0 | 0.17 (1) ↓ |
| Female Surg/Gynae | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | | | | | 3 | 0.49 | 0.79 (7) ↓ |
| HDU | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | | | | | 2 | 0.97 | 1.23 (4) ↓ |
| Stroke/Rehab | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | | | | | 1 | 0.14 | 0.19 (2) ↓ |
| Male Med/CCU | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 | 0 | 0 (0) ↔ |
| Female Medical | 0 | 0 | 0 | 0 | 2 | 0 | 1 | 0 | | | | | 3 | 0.37 | 0.85 (10) ↓ |
| **Lurgan** | | | | | | | | | | | | | | | |
| Ward 1 | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | | | | | 4 | 1.06 | 0.18 (1) ↑ |
| Ward 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 1 | 0.25 | 1.64 (10) ↓ |
| Ward 3 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | | | | | 2 | 0.52 | 0.68 (4) ↓ |
| **STH** | | | | | | | | | | | | | | | |
| Ward 1 STH | 3 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | | | | | 6 | 1.45 | 0.64 (4) ↑ |
| Ward 2 STH | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | | | | | 4 | 0.99 | 0.49 (3) ↑ |
| **MHLD** | | | | | | | | | | | | | | | |
| Gillis | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | | | | | 2 | 0.53 | 0.45 (3) ↑ |
| Willows | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 | 0 | 0.29 (2) ↓ |
| **TOTAL** | 23 | 14 | 14 | 26 | 13 | 20 | 30 | 30 | | | | | 170 | | |
| **RATE** | 1.25 | 0.73 | 0.77 | 1.40 | 0.70 | 1.08 | 1.56 | 1.63 | | | | | | 1.14 | 0.98 (215)↑ |

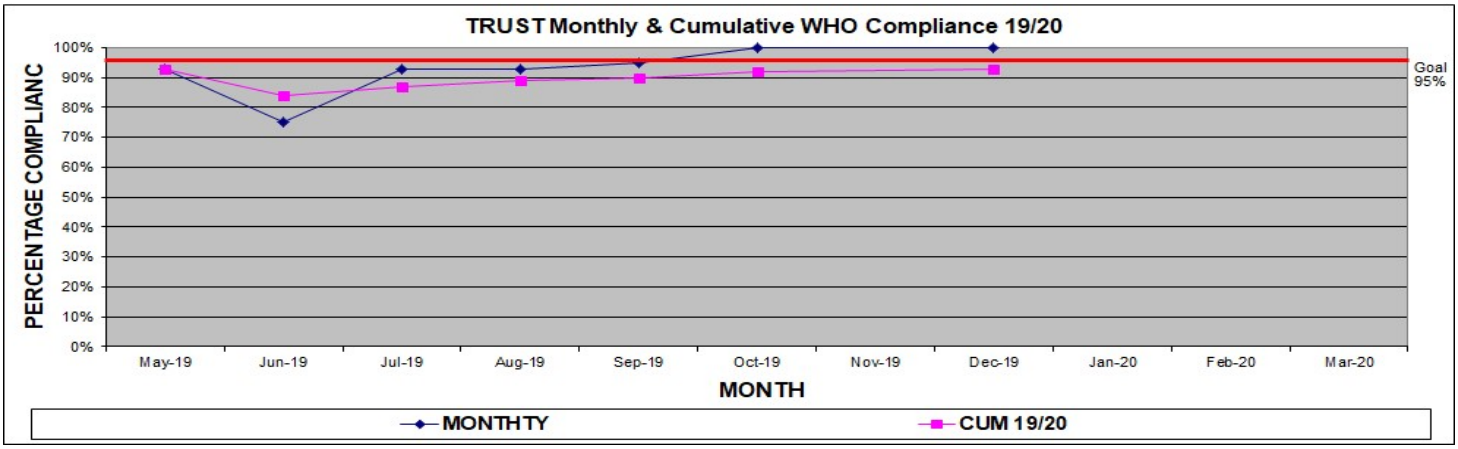


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- The Trust's Monthly Hospital Acquired Pressure Ulcer Rate for Nov 19, based on **29** Wards was **1.63** (**30**/18,395) per 1,000 Occupied Bed Days up from **1.56** (**30**/19,175) per 1,000 Occupied Bed Days in Oct
- The Trust's 2019/20 Hospital Acquired Pressure Ulcer Rate, based on **29** Wards stands at **1.14 (170)** per 1,000 Bed Days, up from **0.98 (215)** in 2018/19.

**WHO Surgical Safety Checklist:**




- The Monthly Audits were reinstated in May 19
- Overall Bundle compliance in Nov 19 was **100%** (60/60), same as Oct 19

**Patient Falls:**

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

| Quarter | Q2 19/20 | Q1 19/20 | Q4 18/19 | Q3 18/19 |
|---|---|---|---|---|
| Acute Bundle A Compliance | 81% (462/573) | 77% (340/439) | 72% (339/469) | 76% (402/532) |
| Trust Bundle A Compliance | 84% (621/741) | 82% (480/588) | 78% (481/620) | 80% (563/704) |

| Quarter | Q2 19/20 | Q1 19/20 | Q4 18/19 | Q3 18/19 |
|---|---|---|---|---|
| Acute Bundle B Compliance | 66% (285/430) | 63% (205/326) | 70% (252/361) | 69% (295/426) |
| Trust Bundle B Compliance | 73% (429/587) | 71% (338/473) | 76% (390/511) | 74% (438/591) |

- Next update when Q3 19/20 data is available

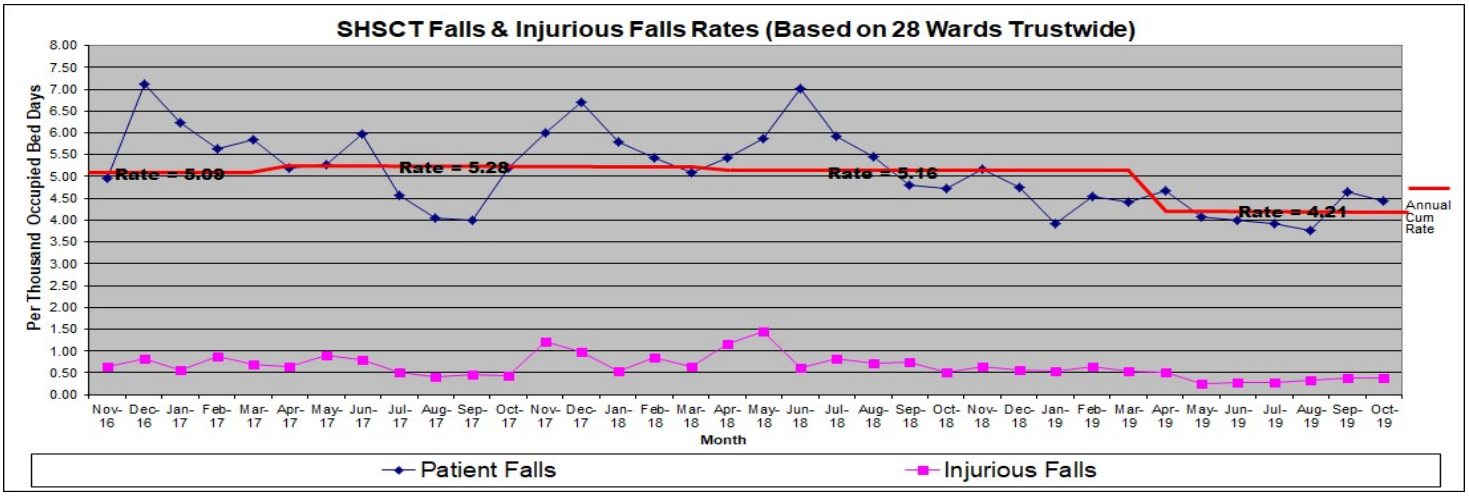


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The table below gives details of individual Ward's Falls Numbers & Falls Rate 19/20

| | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | TOTAL | Rate 19/20 | Rate 18/19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **CAH** | | | | | | | | | | | | | | | |
| Ward 4 South | 5 | 0 | 3 | 0 | 4 | 4 | 9 | 2 | | | | | 27 | 3.09 | 2.72 (35) ↑ |
| Ward 4 North | 1 | 2 | 2 | 1 | 0 | 4 | 2 | 2 | | | | | 14 | 1.82 | 4.33 (48) ↓ |
| Ward 3 South | 1 | 2 | 2 | 3 | 2 | 7 | 3 | 6 | | | | | 26 | 3.50 | 3.30 (41) ↑ |
| Trauma Ward | 3 | 3 | 4 | 3 | 6 | 2 | 4 | 2 | | | | | 27 | 4.50 | 5.26 (47) ↓ |
| Orthopaedic Ward | 1 | 0 | 1 | 3 | 0 | 0 | 1 | 2 | | | | | 8 | 2.99 | 4.55 (21) ↓ |
| Gynae Ward | 0 | 3 | 0 | 1 | 0 | 0 | 1 | 0 | | | | | 5 | 2.19 | 2.60 (9) ↓ |
| Ward 2 South Medicine | 5 | 4 | 4 | 4 | 10 | 6 | 1 | 6 | | | | | 40 | 9.65 | 8.53 (52) ↑ |
| Ward 2 South Stroke | 4 | 3 | 4 | 0 | 0 | 2 | 2 | 7 | | | | | 22 | 5.38 | 6.29 (38) ↓ |
| Ward 2 North | 4 | 4 | 4 | 3 | 2 | 1 | 5 | 3 | | | | | 26 | 3.13 | 4.96 (62) ↓ |
| Haematology Ward | 4 | 3 | 0 | 2 | 2 | 2 | 1 | 2 | | | | | 16 | 5.28 | 2.90 (13) ↑ |
| Ward 1 South | 7 | 4 | 7 | 4 | 3 | 0 | 3 | 3 | | | | | 31 | 3.58 | 5.18 (67) ↑ |
| Ward 1 North | 2 | 3 | 3 | 4 | 1 | 6 | 3 | 6 | | | | | 28 | 3.64 | 3.59 (41) ↑ |
| AMU | 12 | 7 | 12 | 5 | 5 | 11 | 11 | 9 | | | | | 72 | 9.05 | 7.82 (89) ↑ |
| 3 North Winter Ward | 5 | 3 | 2 | 2 | 0 | 3 | 1 | 4 | | | | | 20 | 4.46 | 3.31 (7) ↑ |
| **DHH** | | | | | | | | | | | | | | | |
| Male Surgical | 2 | 3 | 0 | 3 | 1 | 2 | 0 | 2 | | | | | 13 | 3.15 | 4.14 (25) ↓ |
| Female Surg/Gynae | 0 | 1 | 1 | 5 | 2 | 2 | 3 | 0 | | | | | 14 | 2.27 | 3.82 (34) ↓ |
| HDU | 3 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | | | | | 4 | 1.93 | 2.46 (8) ↓ |
| Stroke/Rehab | 4 | 1 | 1 | 4 | 3 | 8 | 3 | 2 | | | | | 26 | 3.68 | 5.22 (55) ↓ |
| Male Med/CCU | 4 | 2 | 3 | 9 | 4 | 2 | 5 | 5 | | | | | 34 | 4.26 | 4.41 (52) ↓ |
| Female Medical | 7 | 6 | 2 | 2 | 6 | 4 | 5 | 2 | | | | | 34 | 4.18 | 5.08 (60) ↓ |
| **Lurgan** | | | | | | | | | | | | | | | |
| Ward 1 | 1 | 2 | 1 | 1 | 2 | 3 | 2 | 2 | | | | | 14 | 3.71 | 5.23 (29) ↓ |
| Ward 2 | 0 | 2 | 1 | 2 | 4 | 1 | 1 | 0 | | | | | 11 | 2.70 | 4.27 (26) ↓ |
| Ward 3 | 1 | 3 | 2 | 2 | 1 | 0 | 1 | 3 | | | | | 13 | 3.35 | 2.57 (15) ↑ |
| **STH** | | | | | | | | | | | | | | | |
| Ward 1 STH | 2 | 1 | 0 | 0 | 0 | 1 | 2 | 2 | | | | | 8 | 1.93 | 1.93 (12) ↔ |
| Ward 2 STH | 1 | 0 | 2 | 1 | 0 | 1 | 4 | 0 | | | | | 9 | 2.23 | 2.44 (15) ↓ |
| **MHLD** | | | | | | | | | | | | | | | |
| Gillis | 3 | 4 | 3 | 3 | 3 | 11 | 5 | 11 | | | | | 43 | 11.32 | 16.32 (108) ↓ |
| Willows | 3 | 11 | 8 | 5 | 8 | 2 | 6 | 3 | | | | | 46 | 9.07 | 15.86 (108) ↓ |
| **TOTAL** | 85 | 77 | 72 | 72 | 70 | 85 | 84 | 86 | | | | | 631 | | |
| **RATE** | 4.68 | 4.07 | 4.00 | 3.91 | 3.77 | 4.66 | 4.42 | 4.73 | | | | | | 4.28 | 5.16 (1117) ↓ |

The Run Chart below shows Patient Falls & Injurious Falls Rates per 1,000 Occupied Bed Days based on 28 Wards, captured by staff using the Falls Walking Stick & Datix.




- Falls Rate **4.73** (**86**/18,189 Occupied Bed Days) up from **4.42** (**84**/19,016) in Oct 19
- Injurious Falls Rate **0.93** (**17**/18,189 Occupied Bed Days) up from **0.37** (**7**/19,016) in Oct 19
- Cumulative Falls Rate for 19/20 stands at **4.28**, compared to **5.16** in 18/19



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- Three measures are in place to demonstrate progress in the use of the Delirium Tool:
  - **Number of at risk patients who have a SQiD (single question in delirium) carried out**
  - **Number of patients with a 4AT completed (tool to assess for delirium)**
  - **Number of patients with an investigations & management plan completed**

The table below shows compliance against each of the 3 Measures for those Acute Wards, for which Audits have been received

| Ward/Measure | At risk patients who have a SQiD carried out (single question in delirium) | Patients with a 4AT completed (tool to assess for delirium) | Patients with an Investigations & Management Plan completed |
|---|---|---|---|
| **Trauma (Nov 19)** | **100% (20/20)** | **100% (2/2)** | **100% (2/2)** |
| **1 South (Sept 19)** | **100% (20/20)** | **100% (6/6)** | **100% (1/1)** |
| **1 North (Oct 19)** | **100% (2/2)** | **100% (2/2)** | **100% (1/1)** |
| **2 South Med (Oct 19)** | **100% (20/20)** | **50% (5/10)** | **100% (4/4)** |
| **4 South (Nov 19)** | **93% (13/14)** | **100% (3/3)** | **100% (2/2)** |
| **Stroke/Rehab (Oct 19)** | **100% (8/8)** | **100% (8/8)** | **N/A (0/0)** |

- Ward 4 North undertook their Baseline Audit in Dec 19
- Auditing is also undertaken in the 5 Non-Acute Wards



Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

# Acute SMT Report on Patient Experience and Adverse Incidents

## Introduction

The attached report looks at complaints, compliments and adverse incidents for the month of December 2019 in Acute Services.

## Key Messages

Complaints

- There has been a decrease in the number of formal complaints received in December 2019 with 29 recorded.
- There are a number of overdue current complaints which require response. There has been an decrease in the number of replied to complainants within the 20 day response time this month due to clinical pressures and delay in approvals of drafts. Assistant Directors are asked to please remind their teams the importance of responding to Governance Team with a draft response within 10 working days and communicate with their HOS about the need for more timely responses being relayed back to Governance Team for them to be processed and sent out.
- The 2 day acknowledgement target has been met at 100% for December complaints.
- We have currently 6 ongoing Ombudsman Cases in Acute (2 of which are ongoing at initial assessment). One case has been closed as final report has been released and a summary is available for SEC by HOS for Acute Governance.
- The top subject of complaint for December is Quality of Treatment and Care with 10 formal complaints with then followed by Quality of Staff Attitude with 6 formal complaints. Overall from January to December the top subject of complaint is quality of treatment and care with 123 formal complaints to date with Staff Attitude sitting at 116 formal complaints.
- Currently there are 5 new re-opened complaints for December 2019. We have 5 re-opened complaints that meetings have been arranged for and there has been a great response in getting this done. We have a further 4 re-opened complaints that require a written response. We would ask for co-operation of clinical staff and HOS to help facilitate these meetings. The Governance Team are happy to organise but we need co-operation of each area to try and move these meetings with families on.

Compliments

- A discussion needs to take place in relation to the recording of compliments and the revised Trust process. There was no available data this month for compliments due to issues with the reports from Corporate and this is due to the new process/system.

Incidents

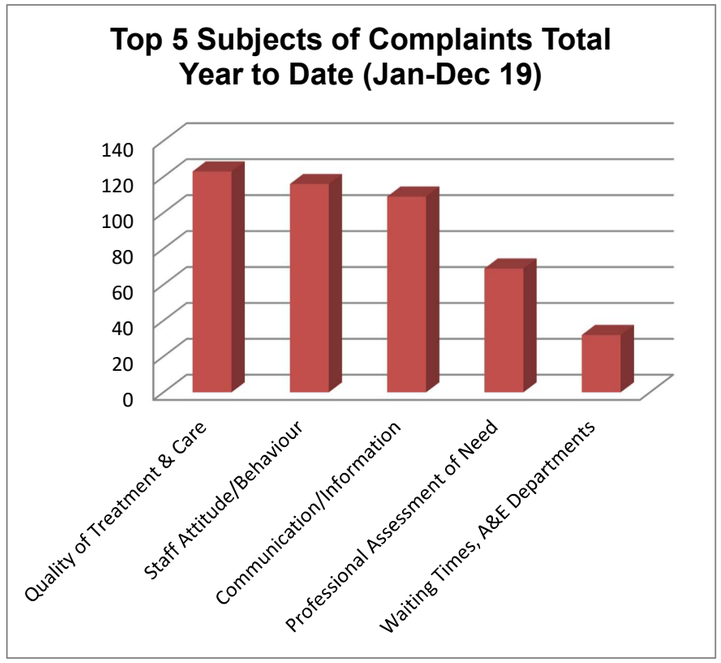
- There were 524 incidents in December 2019 a decrease from November 2019.
- Behaviour (violence and aggression included) is the still the top incident for the period May to December contributing to 781 incidents recorded. Patient accidents and falls is second with 715 incidents recorded followed by medications incidents with 672 for the same period.

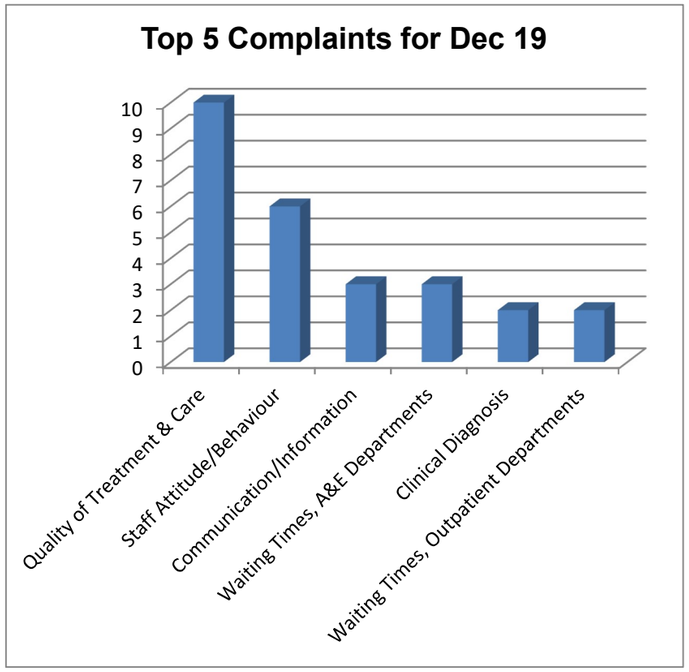
# PATIENT EXPERIENCE (Complaints and Compliments)

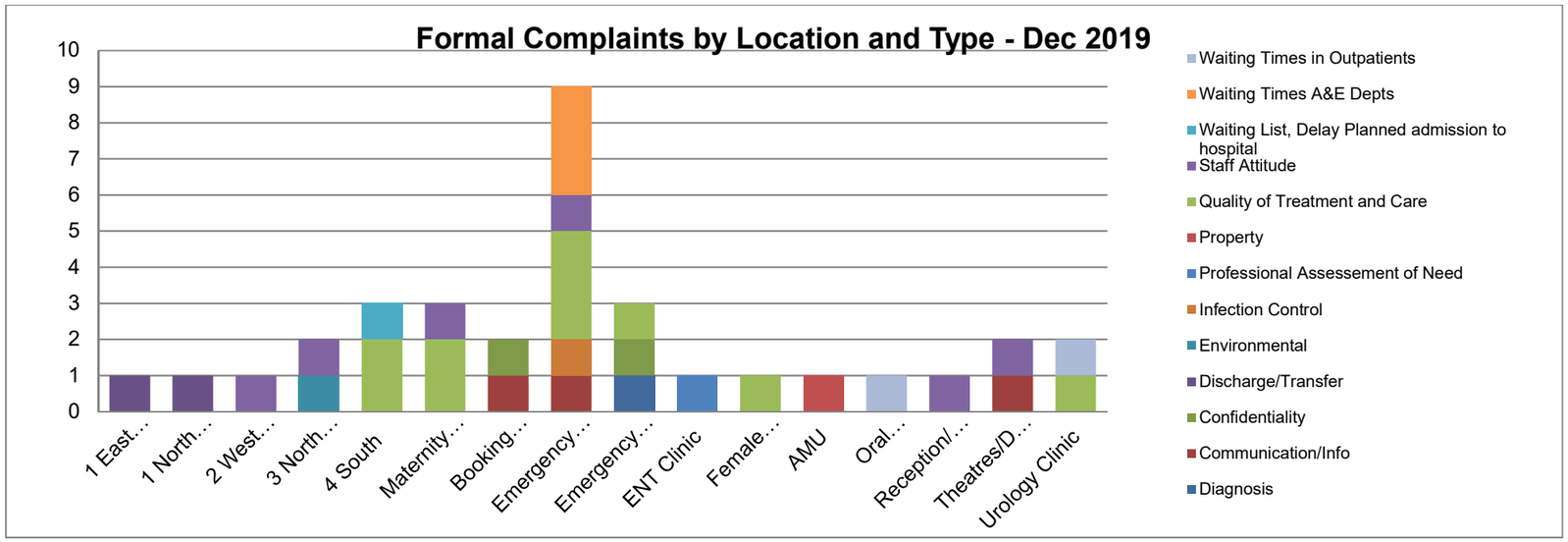
## Complaint Statistics

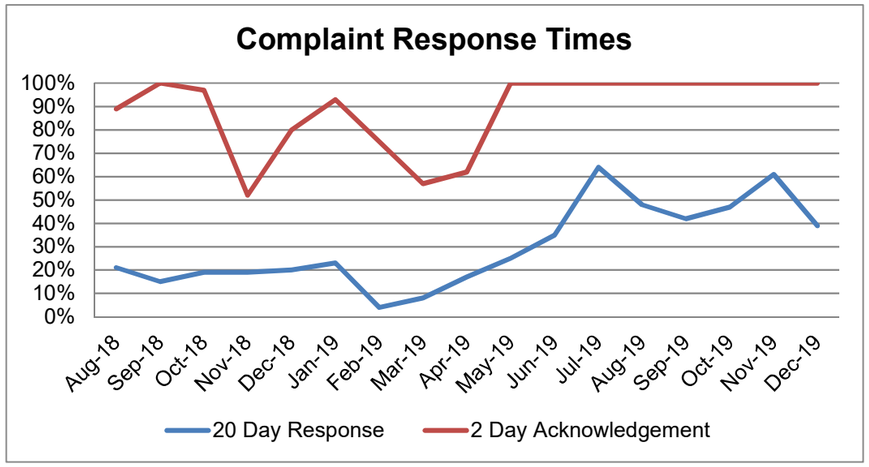
| | Formal Complaints | Informal Complaints | MLA Enquiries | Re-Opened Complaints | Awaiting Consent | Ombudsman* |
|---|---|---|---|---|---|---|
| Jun | 40 | 10 | 12 | 2 | 1 | 1 |
| Jul | 46 | 7 | 8 | 7 | 1 | 0 |
| Aug | 52 | 8 | 10 | 7 | 2 | 0 |
| Sep | 38 | 9 | 15 | 4 | 2 | 1 |
| Oct | 38 | 3 | 9 | 6 | 3 | 0 |
| Nov | 58 | 14 | 7 | 9 | 5 | 1 |
| Dec | 30 | 8 | 11 | 3 | 2 | 1 |
| Jan-19 | 43 | 12 | 11 | 3 | 4 | 1 |
| Feb | 45 | 7 | 21 | 3 | 0 | 0 |
| Mar | 31 | 5 | 14 | 8 | 0 | 1 |
| Apr | 53 | 3 | 15 | 6 | 0 | 0 |
| May | 51 | 5 | 19 | 7 | 0 | 0 |
| June | 31 | 6 | 14 | 9 | 1 | 0 |
| July | 39 | 18 | 6 | 7 | 0 | 0 |
| August | 25 | 7 | 12 | 7 | 4 | 2 |
| Sept | 44 | 8 | 17 | 5 | 6 | 1 |
| October | 35 | 4 | 16 | 7 | 7 | 0 |
| November | 39 | 3 | 13 | 8 | 9 | 0 |
| December | 29 | 2 | 9 | 5 | 8 | 0 |
| **Total** | **767** | **139** | **239** | **113** | **55** | **9** |

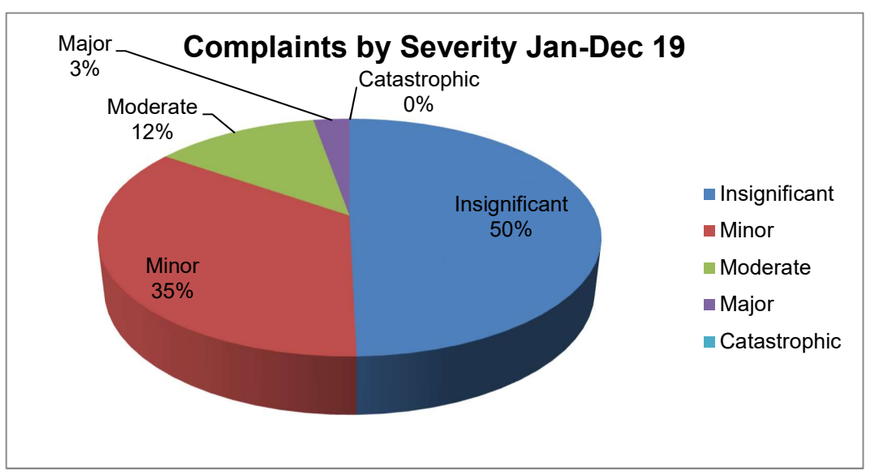
* There are currently 6 cases in total opened with NIPSO.



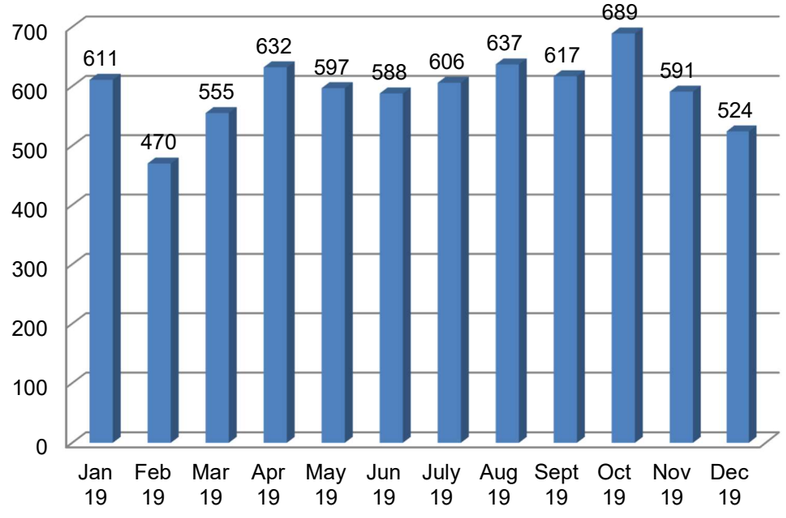

### Complaints by Division and Date Received
### Apr 19 to Dec 19

| | Apr | May | Jun | July | Aug | Sept | Oct | Nov | Dec | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **IMWH / CCS** | 11 | 20 | 11 | 22 | 4 | 10 | 13 | 14 | 7 | 112 |
| **FSS** | 4 | 7 | 4 | 3 | 3 | 2 | 2 | 3 | 3 | 31 |
| **MUC** | 25 | 33 | 14 | 25 | 16 | 32 | 19 | 16 | 17 | 197 |
| **PHARMACY** | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 2 |
| **SEC** | 10 | 27 | 13 | 14 | 15 | 17 | 15 | 14 | 9 | 134 |

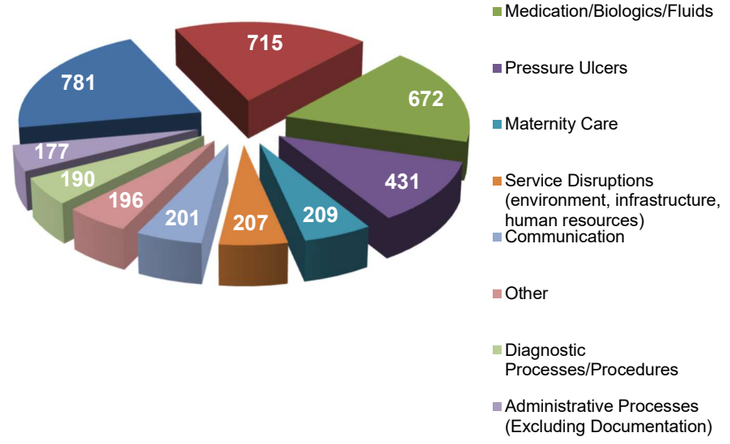
Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

## ADVERSE INCIDENTS

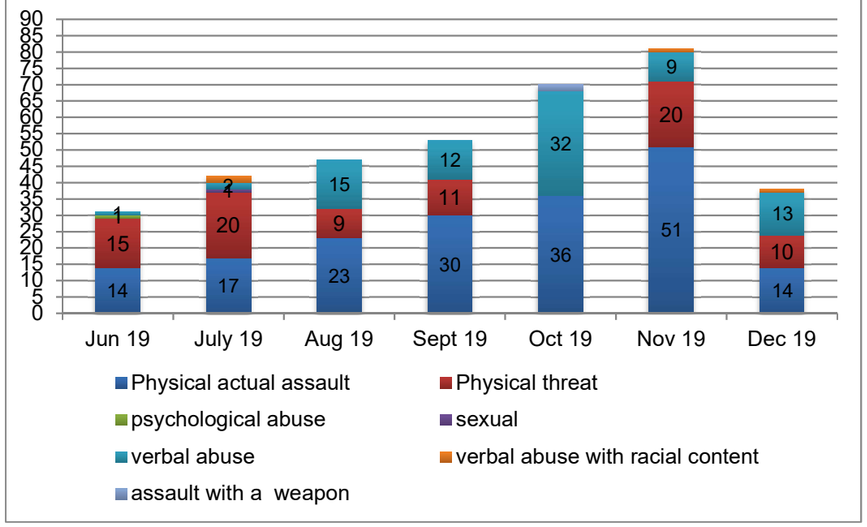
### Adverse Incidents



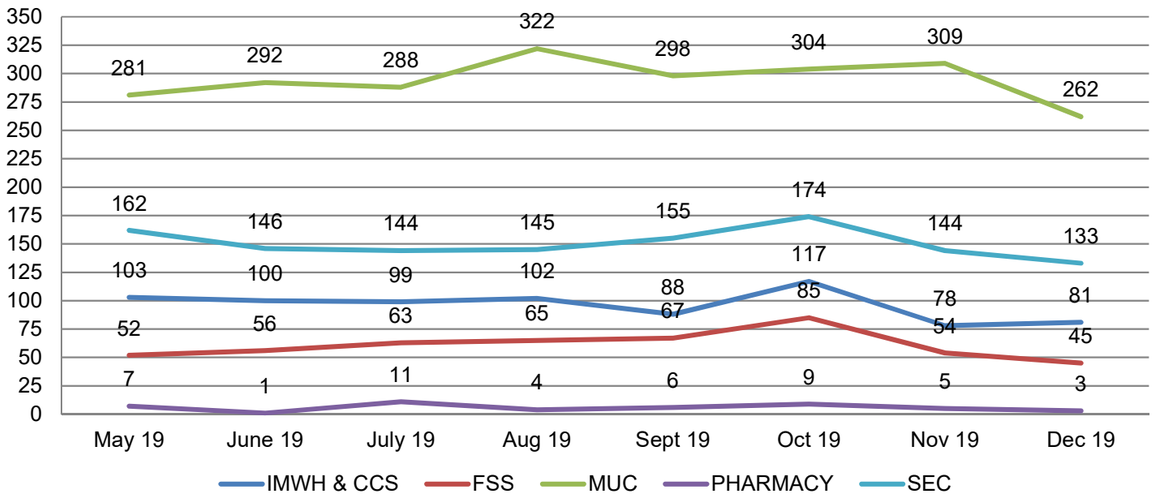

### Top 10 Incidents - May to Dec 2019




### Violence and Aggression Incidents by Month and Type - Acute Services



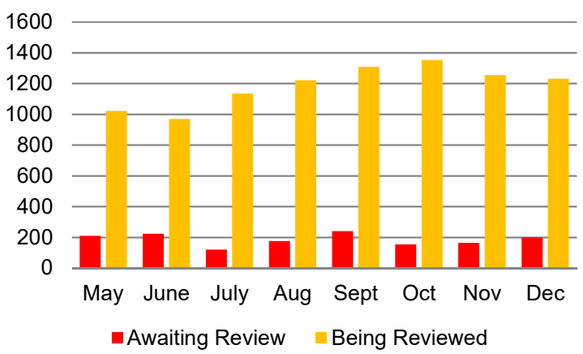

### Adverse Incidents by Division



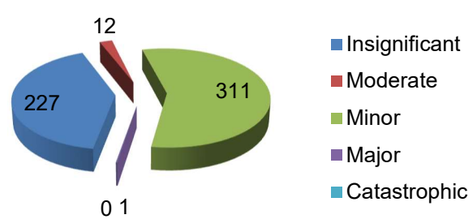

### Staffing Incidents by Quarter and Location



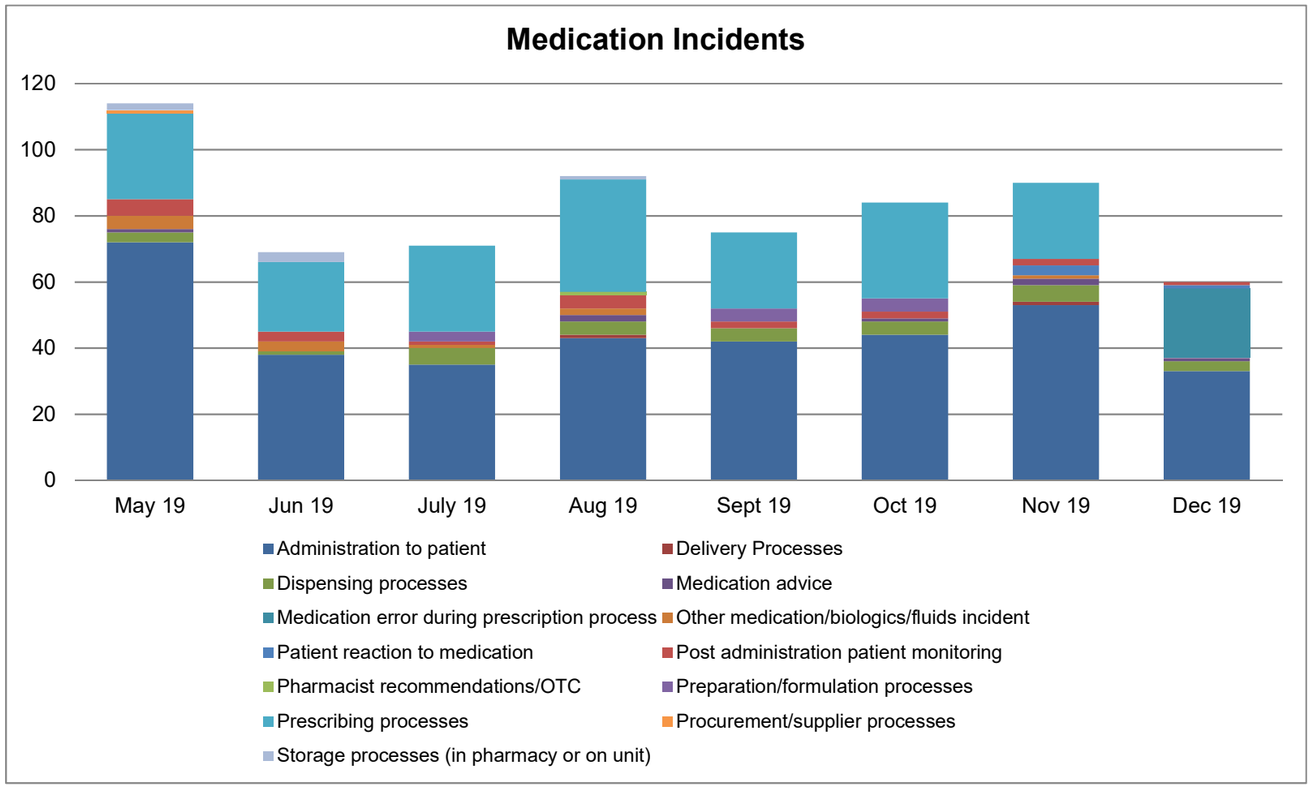

### Stages of Investigation

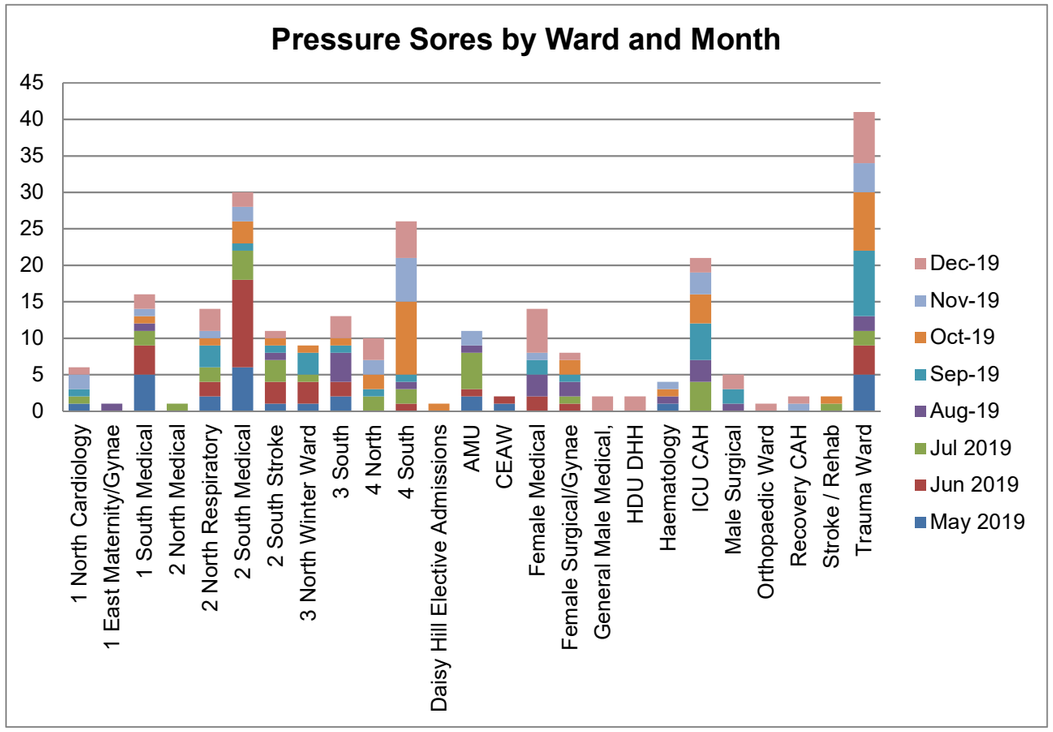


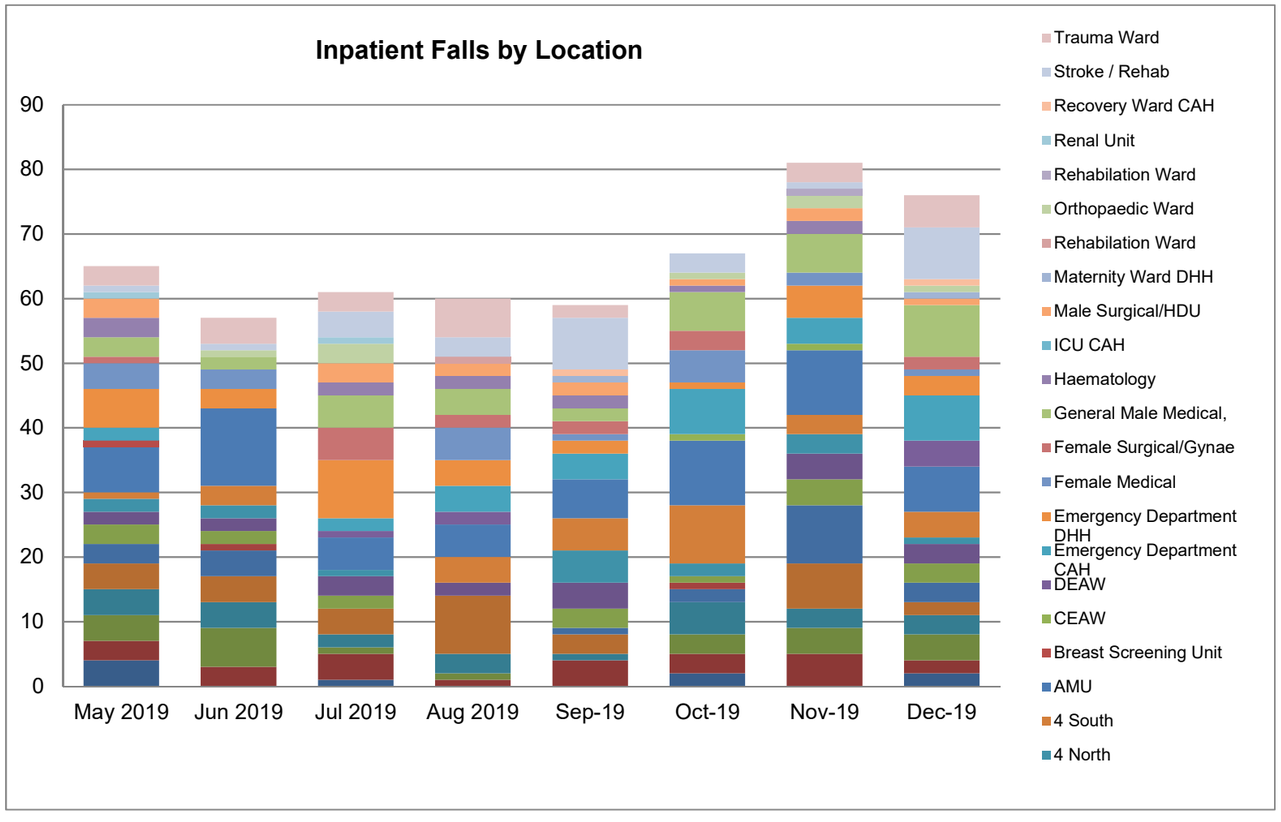

### Severity of Falls May 19- Dec 19




Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.




## Absconding Patients

Absconders from April to Dec 2019

| | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Total |
|---|---|---|---|---|---|---|---|---|---|
| 1 North Cardiology | 0 | 1 | 0 | 0 | 0 | | | | 1 |
| 1 South Medical | 1 | 0 | 0 | 0 | 0 | | | | 1 |
| 2 South Medical | 0 | 0 | 0 | 0 | 0 | | 1 | | 1 |
| 3 North Winter Ward | 0 | 0 | 1 | 1 | 0 | | | | 2 |
| 3 South | 1 | 0 | 0 | | 0 | | | | 1 |
| 4 North | 0 | 1 | 1 | 3 | 0 | | 1 | 1 | 5 |
| 4 South | 0 | 0 | 0 | 1 | 0 | | 1 | | 1 |
| AMU | 0 | 1 | 2 | 5 | 2 | 5 | 1 | 1 | 17 |
| Discharge Lounge | 0 | 0 | 1 | | 1 | | | | 1 |
| Coronary Care | | | | | | 1 | | | |
| Emergency Department CAH | 12 | 19 | 15 | 11 | 7 | 18 | 13 | 10 | 105 |
| Emergency DepartmentDHH | 9 | 10 | 27 | 6 | 16 | 11 | 3 | 8 | 90 |
| Female Medical | 0 | 0 | 0 | 1 | 0 | | | | 2 |
| Female Surgical/Gynae | 0 | 1 | 0 | 0 | 0 | | | | 1 |
| General Male Medical, | 0 | 1 | 0 | 0 | 0 | 3 | 1 | | 1 |
| Male Surgical/HDU | 0 | 0 | 1 | 1 | 2 | | | | 2 |
| Maternity Ward | 0 | 0 | 0 | 1 | 0 | | | | 1 |
| Recovery CAH | | | | | | | | 4 | 4 |
| Total | 23 | 34 | 48 | 30 | 28 | 38 | 21 | 24 | 236 |

**DIRECTORATE OF ACUTE SERVICES**
**Weekly Report on Formal Complaints - 10 February 2020**

| Ref | Record name | Div | Loc (Exact) | Date Received | Current Date | Investigation due | | Reply due | Current Stage | Last Holding |
|---|---|---|---|---|---|---|---|---|---|---|
| AS419.18/19 | Personal Information redacted by the USI | MUC | Male Medical Ward DHH | 29/03/2019 | 04/06/2019 | 12/04/2019 | M | 30/04/2019 | Dr G Ahmed, L McAuliffe, A McVey, C McCaul. Meeting arranged 08/11/19 - FAMILY CANCELLED. 20/11/19 - 2 Jan 2020 dates offered - not suitable. MEETING ARRANGED FOR 27 MARCH 2020 | 08/01/2020 |
| AS239.19/20 | | SEC | General Surgery | 18/09/2019 | | 02/10/2019 | R | 16/10/2019 | Response provided by Mr McKay. Mr McArdle is awaiting DHH notes for additional info. Amie trying to speed up. - *reminders sent 14/10/19, 4/12/19, 12/12/19, 9/1/20, 22/1/20 & 4/2/20* | 09/01/2019 |
| AS272.19/20 | | IMWH | 2 West | 05/11/2019 | | 19/11/2019 | R | 03/12/2019 | Awaiting response from Dr Currie. *Reminders issued 18/12/19, 7/1/20, 21/01/2020, 29/1/20 & 5/2/20* | 05/02/2020 |
| AS276.19/20 | | IMWH | Delivery Suite - CAH | 06/11/2019 | | 20/11/2019 | M | 04/12/2019 | Draft notes to WC for amendment/approval (Vivienne to go through with Wendy Clarke on Mon 10 Feb) | 11/12/2019 |
| AS282.19/20 | | IMWH | Delivery Suite - CAH | 08/11/2019 | | 22/11/2019 | R | 06/12/2019 | Awaiting response from Mary Dawson - *reminder sent 28/1/20* Wendy Clarke to meet with M/W to discuss (30/1/20) - *VK to discuss with WC on Monday 10 Feb)* | 05/02/2020 |
| AS286.19/20 | | SEC | 4 North | 12/11/2019 | | 26/11/2019 | M | 10/12/2019 | **(PCC Cheryl)** D Sharpe, A Nelson and E McCann to attend meeting. Anne McVey suggesting Salman Ahmed to attend? **Check with Pamela 10/02/2020** | 05/02/2020 |
| AS297.19/20 | | SEC | Day Procedure Clinic | 22/11/2019 | | 06/12/2019 | R | 20/12/2019 | *Reminder sent to Amie 22.1.20 (Advised this was discussed with Ronan on 21/1/20) Reminder sent to Helena / Ronan 23/1/20. Helena Murray / Marti McKenna checking section of response with Amie, before sending to Ronan 29/01/20 - further reminder sent 5/2/20* | 05/02/2020 |
| AS308.19/20 | | CCS | 4 South | 02/12/2019 | | 16/12/2019 | R | 02/01/2020 | Amie/Ronan & Charlotte-Anne/Barry E-mailed 16/01/2020 Requesting response from Charlotte-Anne re Physiotherapists. Pt contacted 15/01/2020 *Reminder sent to Charlotte Anne 5/2/20* | 05/02/2020 |
| AS309.19/20 | | MUC | 3 North Winter Ward | 04/12/2019 | | 18/12/2019 | M | 06/01/2020 | Meeting held 07/02/2020. Trudi Kelly & Anne McVey. Notes being drafted by Chrisy 07/02/2020 | 03/01/2020 |
| AS313.19/20 | | SEC | Day Procedure Clinic | 09/12/2019 | | 23/12/2019 | R | 09/01/2020 | To Director for approval 5/2/20 | 08/01/2020 |
| AS317.19/20 | | MUC | ED DHH | 11/12/2019 | | 27/12/2019 | M | 13/01/2019 | **(PCC - Cheryl)** L Small to phone complainant w/c 07/01. Meeting to be organised as per Anne McVey - L Small, M Burke,C McGoldrick 14/01/2020, 20/01/2020 - awaiting responses. | |
| AS323.19/20 | | SEC | Urology | 16/12/2019 | | 02/01/2020 | R | 16/01/2020 | Awaiting response from Martina Corrigan and Mark Haynes. Mr Haynes advised this will take a significant amount of time to investigate - *reminders sent 9/1/20, 22/1/20 & 30/1/20. Collette liaising with Patricia re wording of response 5/2/20* | 13/01/2020 |
| AS328.19/20 | | MUC | ED DHH | 27/12/2019 | | 10/01/2020 | R | 27/01/2020 | *To Director for signature 5/2/2020- not to be posted out Flo to meet patient and give directly* | NO HOLDING |
| AS331.19/20 | | MUC | Female Medical DHH | 02/01/2020 | | 16/01/2020 | R | 30/01/2020 | Response being drafted 10/2/20 | 27/01/2020 |
| AS332.19/20 | | MUC | ED DHH | 23/12/2019 | | 17/01/2020 | R | 31/01/2020 | Meeting offered - complainant in Thailand until February. Will contact us following this. | n/a |
| AS334.19/20 | | MUC | ED DHH | 03/01/2020 | | 17/01/2020 | R | 31/01/2020 | Response received from Dr Spedding - ?? Need further input from medical team | 30/01/2020 |
| AS335.19/20 | | IMWH | Maternity Ward DHH | 06/01/2020 | | 20/01/2020 | R | 03/02/2020 | To Barry Conway for approval 03/02/2020 | 03/02/2020 |
| AS338.19/20 | | ATICS | Intensive Care Unit | 10/01/2020 | | 24/01/2020 | R | 07/02/2020 | To Ronan Carroll for approval 07/02/020 | 05/02/2020 |
| AS343.19/20 | | MUC | ED CAH | 14/01/2020 | | 28/01/2020 | R | 11/02/2020 | Response being drafted 6/2/20 | 12/02/2020 |
| AS340.19/20 | | MUC | Female Medical DHH | 15/01/2020 | | 29/01/2020 | R | 12/02/2020 | Awaiting response from Laura McAuliffe / Kay Carroll - *reminders sent 27/1/20 & 5/2/20* | 12/02/2020 |
| AS345.19/20 | | SEC / MUC | ENT & AMU | 15/01/2020 | | 29/01/2020 | R | 12/02/2020 | Response being drafted 12/2/20 | 12/02/2020 |
| AS346.19/20 | | MUC | ED DHH | 15/01/2020 | | 29/01/2020 | R | 12/02/2020 | Dr Hampton response drafted. Awaiting response from Amie re Surgical Team input 11/02/2020 | |
| AS348.19/20 | | MUC | Clinical Decision Unit | 17/01/2020 | | 31/01/2020 | R | 14/02/2020 | Awaiting response from OPPC - *reminder sent 30/1/20* . Sent to Chris Walmsley and Karen Kelly for investigation 3/2/20 | |
| AS350.19/20 | | IMWH | Delivery Suite DHH | 20/01/2020 | | 03/02/2020 | R | 17/02/2020 | Meeting arranged for 25 February 2020 in DHH - Joanne McGlade, Dr Chinnadurai & VK | 03/02/2020 |
| AS351.19/20 | | MUC | ED CAH | 21/01/2020 | | 04/02/2020 | R | 18/02/2020 | Awaiting response from Dr Eleanor McCormick - *reminder sent 5/2/20* | |
| AS355.19/20 | | IMWH/FSS | 1 East/Gynae Ward | 21/01/2020 | | 04/02/2020 | R | 18/02/2020 | Awaiting response from M Portis / Rachel Donnelly - *reminder sent 4/2/20* | |
| AS354.19/20 | | SEC | ENT clinic | 23/01/2020 | | 06/02/2020 | R | 20/02/2020 | Awaiting response from Martina Corrigan - *reminder sent 5/2/20* | |
| AS356.19/20 | | MUC | Male Medical Ward DHH | 27/01/2020 | | 11/02/2020 | R | 25/02/2020 | Awaiting response from John McAteer, Laura McAuliffe, Mary Haughey, Maria Fegan and Andrew Dines | |
| AS357.19/20 | | FSS | Canteen | 29/01/2020 | | 13/02/2020 | R | 27/02/2020 | To Anita Carroll for approval 10/2/20 | |
| AS358.19/20 | | MUC | ED DHH | 29/01/2020 | | 13/02/2020 | R | 27/02/2020 | Response being drafted 3/2/20 | |
| AS361.19/20 | | MUC | General Surgery | 30/01/2020 | | 14/02/2020 | R | 28/02/2020 | To director for approval 11/2/20 | |
| AS360.19/20 | | SEC | Respiratory Clinic | 31/01/2020 | | 14/02/2020 | R | 28/02/2020 | To Director for approval 11/2/20 | |
| AS362.19/20 | | MUC | ED | 03/02/2020 | | 17/02/2020 | R | 02/03/2020 | Ruth Speddings response drafted. Awaiting further response re specific visit to ED 11/02/2020 | |
| AS368.19/20 | | MUC | 1 North | 03/02/2020 | | 17/02/2020 | R | 02/03/2020 | Awaiting response from Ruth Weir / Patricia Loughan / Kay Carroll | |
| AS364.19/20 | | MUC | ED | 04/02/2020 | | 18/02/2020 | R | 03/03/2020 | Awaiting response from Dr E Holmes, Mary Burke, Paul Smyth and Sharon Holmes | |
| AS366.19/20 | | MUC | ED | 04/02/2020 | | 18/02/2020 | R | 03/03/2020 | Awaiting response from Sharon Holmes, Paul Smyth, Elaine Campbell and Mary Burke | |
| AS367.19/20 | | CCS | X-Ray | 04/02/2020 | | 18/02/2020 | R | 03/03/2020 | Awaiting response from Jeanette Robinson | |
| AS369.19/20 | | SEC | Outpatients | 04/02/2020 | | 18/02/2020 | R | 03/03/2020 | Awaiting response from Amie Nelson and Mr Yousaf | |
| AS370.19/20 | | SEC (ATICS) | Theatres | 06/02/2020 | | 20/02/2020 | R | 05/03/2020 | Awaiting response from Emma Jane Kearney / Helena Murray | |
| AS371.19/20 | | CCS (IMWH) | EPPC | 06/02/2020 | | 20/02/2020 | R | 05/03/2020 | Awaiting response from Michelle Portis / Wendy Clarke | |

| Ref | Record name | Div | Loc (Exact) | Date Received | Current Date | Investigation due | | Reply due | Current Stage | Last Holding |
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| AS372.19/20 | Personal Information redacted by the USI | SEC | Orthopaedic Surgery | 06/02/2020 | | 20/02/2020 | R | 05/03/2020 | Awaiting response from Wendy Clayton / Dr Lynn Wilson | |
| AS373.19/20 | | MUC | 1 North / Pharmacy | 06/02/2020 | | 20/02/2020 | R | 05/03/2020 | Awaiting response from Sr Weir / Kay Carroll / Patricia Loughan & Tracey Boyce | |
| AS374.19/20 | | CCS | X-Ray | 10/02/2020 | | 24/02/2020 | R | 09/03/2020 | Awaiting response from Gillian Reaney | |
| AS375.19/20 | | CCS | X-Ray | 10/02/2020 | | 24/02/2020 | R | 09/03/2020 | Awaiting response from Jeanette Robinson | |
| AS376.19/20 | | SEC | Trauma Ward | 10/02/2020 | | 24/02/2020 | R | 09/03/2020 | Awaiting response from Trudi Kelly, Sarah Ward, Wendy Clayton, Helena Murray and Damien Scullion | |
| 11474 CYP | Personal Information redacted by the USI | MUC | ED Paeds CAH | 04/02/2020 | | 18/02/2020 | | 03/03/2020 | Awaiting response from Sharon Holmes / Paul Smyth | |

Medication incidents CCS2

| ID | Incident date | Directorate | Division | Site | Loc (Exact) | Description | Drug administered | Correct drug | Action taken | Consequence | Incident affecting | Incident type tier one | Incident type tier two | Incident type tier three | DHSSPS impact | DHSSPS potential | DHSSPS likelihood | DHSSPS risk rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information | 22/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | Patient was written up a kardex in A&E for IV and PO antibiotic administration (Amoxicillin & Doxycycline). Allergies were not documented despite the patient having 13 allergies. Antibiotics and enoxaparin, as well as regular medicines, were administered without allergies documented on kardex. Patient was allergic to 'Galenamox' - brand name for amoxicillin which was prescribed and administered twice, and paracetamol which was also prescribed but not administered. | Amoxicillin | | I checked the patient had not experienced an adverse reaction to the two IV doses of amoxicillin which patient denies and no report documented in notes. I documented all allergies on kardex according to GP and confirmed with daughter on front of kardex. I made daughter and patient aware that amoxicillin had been administered. | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Contraindication due to history of allergy | insignifica | catastrop | possible | extreme |
| Redaction Code 4 | 21/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | new presentation of type 2 diabetes. blood sugar of 25. was given a stat dose of 15 units Actrapid. Inappropriate insulin and inappropriately large dose for a stat dose. Assuming a traditional correction ratio of 1 unit reduces blood sugar by 2 could have potentially caused this patient to have a hypo | Insulins | Insulins | ED pharmacist informed | Minor | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Incorrect dose | minor | catastrop | possible | extreme |
| Personal Information | 19/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | Patient had been prescribed Apixaban 5mg at 10am same had not been given and was not noticed until 1600 | apixaban | apixaban | When missed dose was noted a stat doses for both prescribed doses had been charted and given | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect frequency of dose (omitted dose) | insignifica | major | unlikely | high |
| Personal Information | 23/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 2 North Respiratory | PATIENT WAS DUE WARFARIN-DOSE MISSED<br>NO INR COMPLETED FROM 20/12/19 AND PATIENT HAD BEEN REQUESTED TO HAVE DAILY BLOODS +INR COMPLETED. SAME NOT REQUESTED IN BLOOD BOOK. | Warfain | Warfain | MEDICAL REG INFORMED, NURSE IN CHARGE AWARE. CLINICAL COORDINATOR INFORMED<br>URGENT INR SENT<br>ENOXAPARIN PRESCRIBED AND GIVEN AS INR 1.5 | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Failure to administer | minor | major | unlikely | high |
| Personal Information | 12/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | General Male Medical, | Patient had been admitted with erratic BM's, T1DM, and had been commenced on IV insulin infusion, patient had been actively vomiting and BM at bedtime was 5.2. Patient had not been prescribed bedtime insulin, nor was it handed over that patient was to remain on insulin and IV insulin. I was not aware of the guidelines, and as a result, patient did not receive bedtime insulin. | Insulins | Insulins | I contacted patient flow, who were able to confirm that insulin should have been given. Patient was closely monitored following same. Medics were informed. | | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Failure to administer | minor | major | possible | high |

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| Personal Information | 13/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 1 North Cardiology | The above named patient appeared to have missed her 1800hrs Enoxaparin 60mg injection. | Enoxaparin | Enoxaparin | The patient was asked if she remembered getting the injection and she replied 'No'. The nursing documentation had no record of administration. The Clinical Coordinator was informed. She advised that she would liaise with the F1 and that a Datix be completed. Further discussion at approximately 0230hrs with a new Clinical coordinator. Suggested to continue to wait for F1 and 6am dose to be given. | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Failure to administer | insignifica | major | unlikely | high |
| Personal Information | 27/12/2019 | Acute Services | Surgery and Elective Care | Craigavon Area Hospital | ICU CAH | Pt receiving dialysis and handed over this am that no heparin running. Labs contacted ward to say that pt had prolonged coagulation. Dialysis machine checked and heparin running at 0.5mls/hr. | Heparin | | Dr & NIC informed. Heparin stopped. Rpt coags taken throughout the day. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Administered but not prescribed | minor | major | possible | high |
| Personal Information | 30/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | Kardex written - probably based on NIECR GP list instead of recent early December 2019 discharge letter - and no antiplatelets prescribed. Patient's early December 2019 admission was for cardiac stent insertion. | Clopidogrel | | Clopidogrel and aspirin prescribed on Kardex as per early December 2019 discharge letter. Patient therefore did not miss any doses of antiplatelets. | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Not prescribed required medication (reconciliation error) | insignifica | major | possible | high |
| Personal Information | 12/12/2019 | Acute Services | Surgery and Elective Care | Craigavon Area Hospital | Trauma Ward | Patient missed his dose of Rivaroxaban. | rivaroxaban | rivaroxiban | Informed the ward manager during handover, medication ordered from JACS System, Datix and reflections done. | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Failure to administer | insignifica | major | unlikely | high |

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| Personal Information | 13/12/2019 | Acute Services | Surgery and Elective Care | Craigavon Area Hospital | Theatres 1-4 CAH | 13/12/19<br>Theatre 4 Urology patient given Epirubicin, a Mitomycin C chemo substitute intra-operatively. Patient allocated bed space in Recovery in open ward as team leader unaware that a Mitomycin substitute was administered.<br><br>Theatre nurse handed over to Recovery nurse (Recovery nurse pregnant not exposed to any risk at handover), Epirubicin was administered and Consultant Urologist would release from bladder in Recovery. AS. | Epirubicin | Epirubicin | Recovery nurse informed me of above.<br>Patient transferred to sideward.<br>One SN dedicated to care for patient and follow isolation precautions.<br>I spoke with Lead nurse, Theatre Sister and then went to pharmacy to discuss with Pharmacist who would speak with Chemo pharmacist.<br>Pharmacist called back to Recovery: same precautions as Mitomycin.<br><br>On return to Recovery, Consultant Urologist had released drug from bladder. Explained policy and SOP regarding Mitomycin, Consultant said he was aware of this and accepted full responsibility, and that the procedure was carried out safely.<br><br>I explained had Recovery been aware of intentions to give Mitomycin substitute we would have escalated to Patient flow to ensure patient was prioritised for transfer to 3 south Urology for safe administration /disposal of treatment. | | Patient Incidents | Medication/ Biologics/Fluids | Post-administration Patient Monitoring | Incorrect/insufficient handover/transition | insignifica | moderate | possible | medium |
| Personal Information | 23/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | Patient initially incorrectly prescribed Lantus and short-acting insulin. This was incorrect. Then prescribed Humalog MIX50 but at the incorrect dose. (The morning dose that the doctor used was the dose on NIECR printout - 24 units, but this was not the most recent dose as per the diabetic review and which I confirmed with the patient's wife - it should have been 44 units). The patient received 24 units. | Insulins | Insulins | Insulin chart amended to reflect preadmission dose, so that future dosing would be correctly informed. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Incorrect dose | minor | moderate | possible | medium |

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| Personal Information | 30/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | Emergency Department DHH | Person yr old girl presented to ED 10hrs post Paracetamol ingestion. Approx. 8 grams of Paracetamol consumed (167mg/kg). Paracetamol level 43 and was above the treatment line.<br><br>Call made to paeds ward by ED doctor to inform them of her of arrival and to see if the child could be transferred to paeds to commence treatment as reported that Parvolex could not be started in ED.<br>At that stage no beds on the paediatric ward which was also over capacity. SSPAU not currently open. ED doctor then said they would have to transfer the child to Craigavon to commence Parvolex infusion there.<br><br>In accordance with the guidelines, Parvolex infusion should have been commenced on the child's arrival to ED at 6am. Discussion with lead nurse and medical team in paeds and staff sourced from another area to open ambulatory to ensure there was no more further delays in the commencement of treatment for the child caused by waiting for transfer. Treatment was commenced and the child was transferred to ambulatory at 9am. | Acetylcysteine | Acetylcysteine | staff sources to ensure ambulatory unit was open so the child could receive treatment asap | Insignificant | Patient Incidents | Medication/Biologics/Fluids | Administration to Patient | Incorrect timing of dose (delayed) | insignifica | moderate | possible | medium |
| Personal Information | 09/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | AMU | Patient prescribed Ivabradine 20mg twice daily on Kardex. Patient on ivabradine 5mg twice daily pre-admission. Patient's heart rate was reduced <50beats per min. | ivabradine | ivabradine | Prescribing error noted on front of Kardex, patient's notes and ward booklet. Medical staff on lunch but nursing staff aware and follow up required with medical staff prior to next dose. | Minor | Patient Incidents | Medication/Biologics/Fluids | Prescribing Processes | Incorrect dose | minor | moderate | possible | medium |
| Personal Information | 09/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | Female Medical | Patient is on L3 fluids and L4 puree diet as per speech and language therapist. On dietetic review it was noticed that the patient had an empty bottle of oral nutritional supplement different from what was prescribed on the drug Kardex. The supplement prescribed was Fresubin 2kcal crème (level 4 puree) but the supplement on the patients table was Fesubin 2kcal drink (level 1). | Fresubin Creme | Fresubin creme | The dietitian removed the incorrect supplement from the patients table, however the supplement bottle was empty. The patient was unable to clarify whether she had drank the supplement. The dietitian checked the drug Kardex to ensure the correct supplement had been prescribed which it had, she then spoke to SN Vera re: her concerns that the incorrect consistency of supplement may been given | Minor | Patient Incidents | Medication/Biologics/Fluids | Administration to Patient | Formulation of medicine was wrong | insignifica | moderate | possible | medium |

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| Personal Information | 27/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 1 South Medical | Pt was prescribed Teicoplanin (1st loading dose) for 6pm on 27/12/19- dose was not given. Staff nurse handing over to me stated that first dose was due at 6am on 28/12/19. Pt diagnosed with empyema- treatment was therefore delayed. | Teicoplanin | | Co-ordinator contacted. Dose given at 2300 | | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect frequency of dose (omitted dose) | insignifica | moderate | possible | medium |
| Personal Information | 20/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 1 North Cardiology | Patient came up to the ward at 2300. Insulin was not given in A+E or prescribed. Patient did not get his insulin until 01:05. | Insulins | Insulins | Recorded in patients notes. Clinical co-ordinator and F1 informed. | | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Not prescribed required medication (reconciliation error) | minor | moderate | possible | medium |
| Personal Information | 20/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 2 North Respiratory | novomix 30 prescribed on discharge for patient should have been novorapid. | Insulins | Insulins | Changed at clinical check stage. | | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Incorrect medication/fluid | insignifica | moderate | possible | medium |
| Personal Information | 10/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | Emergency Department DHH | Patient arrived from A + E. It was noted on admission to ward that evening insulin (Humalog Mix 25) had been missed. It was noted in ED flimsy that ED staff had attempted to get staff on another ward to check for insulin as same not available in ED. However, same not obtained or followed up. Insulin was not given. | Insulins | | Medics informed. Blood sugar monitored - remained stable. Person in charge at time of incident aware. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect frequency of dose (omitted dose) | minor | moderate | possible | medium |
| Personal Information | 01/12/2019 | Acute Services | Surgery and Elective Care | Craigavon Area Hospital | 3 South | Syringe Driver checks did not appear to have been completed on a patient from 30.11.19 at 19.15hrs until 08:30 hrs on 1/12/19. The label in the syringe had not been signed by two staff nurses, prescription chart had been signed by two staff members | | | Reported to nurse in charge of ward at the time (SN Newell) | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Post-administration Patient Monitoring | Failure/insufficient/incomplete monitoring | insignifica | moderate | possible | medium |

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| Personal Information | 23/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Discharge Lounge | Patient transferred to Discharge Lounge to wait on family coming to collect her. Informed by OPAU nurse on leaving patient off that her clothes had been lost in A&E. OPAU Nurse stated she had looked in A&E for them but they couldn't be found, but that she had told family to bring in clothes. She had long winter coat on over clothes but no shoes. At 3pm daughter and other family members came to collect her, I was on telephone at the time sorting out another issue. I overheard daughter saying that she hadn't brought shoes in. I put call on hold and called daughter over and asked her to go and check in A&E as she could recognize shoes and clothes better, as she couldn't go home without them. She left to do this, my colleague was dealing with her discharge and when I had finished she had been discharged. When filing away notes at 16:45 approx. I found two envelopes relating to patient that had been misled and not sent with patient. I opened them to find highlighted note related to page 6 to hold two medications due to collapse episode. | Atenolol | | I told my colleague who had missed sending theses as family were in a rush to bring mum home. She rang NOK and asked her to stop taking these two medications as stated on medical assessment. She then informed her they had blister pack and couldn't identify them. My colleague stated she would have to try and check with team and get back to her – granddaughter stated she would be at home and contactable. I rang on-call pharmacist and he stated he couldn't identify them over phone or could he dispense other three she needed in am separately as it wasn't safe. We discussed other possibilities but could not come up with a solution on how to get these medications dispensed over holidays. I tried her own community chemist it was closed. I tried bed manager who advised me to contact OPAU team or Med Reg. I obtained OPAU Manager mobile no from a colleague (last port of call), I contacted her and she | Insignificant | Patient Incidents | Medication/Biologics/Fluids | Post-administration Patient Monitoring | Incorrect/insufficient handover/transition | insignifica | moderate | possible | medium |
| Personal Information | 24/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 2 South Medical | Insulin dose omitted | Insulins | | Person informed | Insignificant | Patient Incidents | Medication/Biologics/Fluids | Administration to Patient | Incorrect frequency of dose (omitted dose) | minor | moderate | possible | medium |
| Personal Information | 16/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | Emergency Department DHH | Evening dose of regular insulin not prescribed while in ED. Correctional insulin required at midnight for rebound hyperglycaemia. | Insulins | Insulins | Correctional insulin prescribed and regular insulin prescribed for following morning. | Insignificant | Patient Incidents | Medication/Biologics/Fluids | Prescribing Processes | Not prescribed required medication (reconciliation error) | moderate | moderate | possible | medium |
| Personal Information | 30/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | Ptx received 1x dose of IV abs in Ed and was meant to go home on oral Abs... Ptx did not receive these meds. Returned 3/7 with worsening infection | Amoxicillin | | Ptx informed Sister Stephanie informed | Minor | Patient Incidents | Medication/Biologics/Fluids | Administration to Patient | Failure to administer | moderate | moderate | possible | medium |

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| Personal Information | 30/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | Female | Medical | Nursing home resident admitted with drowsiness on a background of CCF on LTOT. Found to have a pneumonia, required non-invasive ventilation.<br><br>At time of discharge it was found that the medications prescribed in the Kardex were different to that that the patient had previously been on. Errors included, addition of two blood pressure tablets the patient had never taken, addition of an antithyroid medication the patient may have taken previously according to family but hadn't been on for years, and errors in dosage of two medications - one for neuropathic pain and another for agitation (Carbimazole, bisoprolol, pregabalin, ramipril, quetiapine) | Bisoprolol | | This was escalated to consultant as soon as the errors had become apparent. The advice was open disclosure to patient and family which was done on 30/12/2019 at 16:30. Our plan is to keep this patient in for another day to check her thyroid function. She had been due for discharge today. | | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Incorrect medication/fluid | minor | moderate | possible | medium |
| Personal Information | 17/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 1 South | Medical | Patient due to have critical med Keppra at 1800 on the evening of 17/12/19 and 18/12/19 both not given on both dates | Levetiracetam | Levetiracetam | contacted co-ordinator to see if should be given. Unsure if staff on day duty had given it and patient also unsure if she had got the tablet on both occasions. Dr stated it is safer to hold the drug than to over dose the patient as can only be increased by 250mg at a time and patient was due 500mg. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect frequency of dose (omitted dose) | insignifica | moderate | possible | medium |

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| Personal Information | 21/12/2019 | Acute Services | Surgery and Elective Care | Daisy Hill Hospital | Female Surgical /Gynae | pharmacy dispensary sat prescription presented to pharmacy for patient. patient had been discharged fri 20th prescription for Tamiflu amoxicillin and propylthiouracil<br>no documentation on discharge as to why propylthiouracil was commenced and dose on Kardex and discharge did not match BD on Kardex and TID on discharge. also had not been administered on ward marked as 6 | Propyl thiour acil | | contacted ward and F1 on duty to resolve F1 on duty steven had not written discharge and did not know patient nursing staff were not familiar with patient and hence did not know if propylthiouracil was definitely indicated<br>I accessed NIECR to ascertain if this was possibly pre admission and found patient also appeared to be on lamotrigine but this had not been prescribed patient has now left the ward. Later in the day nursing staff contacted the on call pharmacist to say patient had returned to ward and advised that this was to be started but my understanding is there was no documentation to support this<br>email sent to consultant Dr Ahmed for follow up as there is no indication on the discharge letter and hence no communication to the GP with regard to this. | Insignif icant | Patient Inciden ts | Medic ation/ Biolog ics/Fl uids | Prescribin g Processes | Incorrec t frequen | insignifica | moderate | possible | medium |
| Personal Information | 17/12/2019 | Acute Services | Medicine and Unsched uled Care | Daisy Hill Hospital | General Male Medical , | Patient had discharged from the ward to AC@HT<br>Query over Tazocin dose/indication- went to ward to see if indication for Tazocin was documented<br>Pt prescribed BD Taz for asp pneumonia?? No reason for BD dosing<br>Prescribed Enoxaparin 20mg OD - no reason for under dose<br>Medication discontinued: Omeprazole (discharged on prednisolone)Salbutamol and clenil inhalers, simvastatin and fluticasone nasal spray no documented reason?<br>Bloods taken on admission 13/13/19- none since-no idea if antibiotic working | Tazoci n | | Informed AC@HT consultant Dr El Faki- contacted micro to query use of Taz and Metronidazole- ?empyema- waiting to hear back<br>Taz changed to TID on discharge as per AC@HT doctor<br>Enox changed to 40mg also | | Patient Inciden ts | Medic ation/ Biolog ics/Fl uids | Prescribin g Processes | Incorrec t frequen cy of dose | insignifica | moderate | possible | medium |
| Personal Information | 06/12/2019 | Acute Services | Surgery and Elective Care | Craigavon Area Hospital | 3 South | patient had received cytotoxic drug via SRC, urology reg contacted re releasing same as nurses at ward level not trained for same & explained that urology usually release and dispose of same. Urology reg wanted to speak to NIC who reiterated the same. Reg then came to ward to complete task. Once urology reg had left it was noted that the SRC drainage bag had not be changed nor the cytotoxic medication disposed off. | epimbi cin | epimb icin | SR Toner contacted for advice, PPI and double gloved the SRC drainage bag was changed and the bag containing the cytotoxic medication disposed off in an empty cytotoxic burns bin and same locked afterwards. | Minor | Patient Inciden ts | Medic ation/ Biolog ics/Fl uids | Post-administr ation Patient Monitorin g | Failure/i nsufficie nt/inco mplete monitori ng | insignifica | moderate | possible | medium |

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| Personal Information | 10/12/2019 | Acute Services | Pharmacy | Craigavon Area Hospital | Pharmacy Dispensary | final checking JAC order for a ward. Peppermint oil 0.2ml Enteric coated capsules were ordered and labelled as per order. the MR peppermint oil (Colpermin)was dispensed | Peppermint Oil | Peppermint Oil | technician redispensed correct one. | | Patient Incidents | Medication/ Biologics/Fluids | Dispensing Processes | Incorrect medication/fluid | insignifica | minor | possible | low |
| Personal Information | 11/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 2 South Stroke | Patient due Longtec 60mg and pregabalin 50mg at 2200. Longtec not available at ward level as none in stock in CD cupboard. Due to pressures on ward and having to cover breaks down the medical side due to staffing levels SN forgot to go back and contact pharmacy on call regarding the same. Further pressures and sick patients meant SN was unable to go back round all kardexes to ensure medications were given therefore missed both medications. | Oxyco done | Longtec | PRN Shortec Administered when missed dose was discovered to minimize patients pain. Patient informed of same and that same will be reported. Ward manager informed of same. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect frequency of dose (omitted dose) | insignifica | minor | possible | low |
| Personal Information | 21/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | A female resident was admitted to ourselves from CAH, with no medication or proper medication list. When in hospital this lady was on Clexane, but no Clexane was sent in with her. | Enoxaparin | | I rang the hospital and explained that usually on discharge a patient is sent out with a full months supply of medication. I also enquired about the Clexane, but was inform by the Sister on the ward that the patient only received the Clexane for the 2 days that she was in the hospital. I also got in contact with the family to bring in the medication from home. | | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Not prescribed required medication (reconciliation error) | minor | minor | possible | low |
| Personal Information | 16/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | AMU | PATIENT WAS ADMINISTERED MEDICATIONS AS PER KARDEX. PATIENT ALERT AND ORIENTATED AND REFUSED ALL MORNING MEDS AS STATED THEY WERE NOT HER NORMAL MEDS. AWAITED MEDICAL WARD ROUND AND DISCOVERED BY SHO THAT THE MEDICATIONS PRESCRIBED FOR HER WERE INCORRECT. | | | KARDEX ALTERED TO CORRECT MEDICATIONS, IR1 COMPLETE, MEDICAL TEAM AWARE. CORRECT MEDICATINS GIVEN | Minor | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Incorrect medication/fluid | insignifica | minor | possible | low |
| Personal Information 7 | 15/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 3 North Winter Ward | patient commenced on syringe pump<br>doses prescribed inappropriate as they where prescribed as a range, and hyoscine was prescribed as butylbromide 400 microgram as opposed to hydrobromide.<br>no start time specified on pump chart either.<br>diamorphine recommended by hospice - trying to use morphine within trust currently and avoid diamorph prescribing for syringe pumps | Diamorphine | | Palliative nurse specialist noticed on reviewing patient on Monday following incident<br>new syringe driver chart prescribed<br>datix form completed and copy of patient syringe pump chart kept for leanring<br>palliative nurse to discuss diamorphine advice with hospice | | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Incorrect dose | insignifica | minor | possible | low |

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| Personal Information | 26/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | AMU | Patient admitted to hospital completing DHx and Med rec<br>type 2 diabetic with high sugars and poor control on long term steroids for RA<br>Patient commenced on sitagliptin in combination with linagliptin and gliclazide<br>reduced eGFR and BMs remained in 20s | sitagliptin | linagliptin | Advised medical team to correct sugars<br>advised to titrate gliclazide dose and hold of sitagliptin dose and made referral to diabetic team SB/LE/RM by email<br>Spoke with Rachel this morning and kindly reviewed patient and changed meds as appropriate.<br>Datix submitted and GP surgery informed | | Patient Incidents | Medication/Biologics/Fluids | Prescribing Processes | Contraindication due to interactions with other medications | insignifica | insignifica | possible | low |
| Personal Information | 16/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | AMU | pt karkex written up for 50mg flucortisone - pt actual dose 50 micrograms. also pt missed 2 doses of flucortisone 50micrograms. flucortisone supplied by pharmacy tech and nurse informed. | Fludrocortisone | Fludrocortisone | as the pharmacy tech on ward, brought to attention of ward pharmacist who bought to dr who re-wrote the correct medicine & dose. no dose given to patient. | Minor | Patient Incidents | Medication/Biologics/Fluids | Prescribing Processes | Incorrect dose | insignifica | minor | possible | low |
| Personal Information | 01/12/2019 | Acute Services | IMWH - Cancer and Clinical Services | Craigavon Area Hospital | 1 East Maternity/Gynae | PATIENT ON WARFARIN FOR AF. YESTERDAY EVENING DOSE NOT GIVEN | Warfain | Warfain | IMFORM Dr AND INR SENT TO LABS | Minor | Patient Incidents | Medication/Biologics/Fluids | Administration to Patient | Failure to administer | minor | minor | possible | low |
| Personal Information | 06/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | Patient prescribed medicine Kardex when first clerked in. Medications given from Kardex when due. Patient then confirmed as having TB. Medical reg wrote up new Medicine Kardex then ripped previous Kardex in half and threw it into the Clinical Waste bin. When asked to retrieve said Kardex stated 'it was in the bin' and 'didn't know which one'. Did not inform nursing staff at any point that a new Kardex had been written. staff nurse looking after patient realized it had been done as the Kardex was new and no medications she had previously given were recorded. | | | Sister in Charge aware. Medicine Kardex retrieved from bin. Datix completed. | Minor | Patient Incidents | Medication/Biologics/Fluids | Prescribing Processes | Duplicate prescription | insignifica | insignifica | possible | low |
| Personal Information | 08/12/2019 | Acute Services | Surgery and Elective Care | Daisy Hill Hospital | Female Surgical/Gynae | Patient admitted to FSW from ED @ 19.00. Due warfarin @ 18.00 - same not prescribed or given in ED. Documented @ 20.00 doctor informed of need for prescription. NIC unaware. 00.30 noted still awaiting warfarin to be prescribed. Doctor + night coordinator aware. warfarin administered @ 01.30 following prescription.<br>Patient was clerked in ED, time is not documented.<br>Patient medical team aware of incident. | Warfain | | Both day team and night doctor aware of need for prescription. Night co-ordinator aware. | Insignificant | Patient Incidents | Medication/Biologics/Fluids | Prescribing Processes | Delay in prescribing | insignifica | minor | possible | low |

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| Personal Information | 04/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | Emergency Department DHH | Patient AF IV fluids commenced at 19:50, to run over 12 hours/ 83mls per hour. Informed by Staff Nurse at 23:15 hours, IV fluids running at 100mls per hours. Correct IV fluids erected | Sodium Chloride | Sodium Chloride | IV Fluids stopped. Medical team informed, advised to restart Fluids at correct rate of 83mls/hr, recommenced at 23:15 hours. Family informed | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect rate of administration | insignifica | minor | possible | low |
| Personal Information | 28/12/2019 | Acute Services | Surgery and Elective Care | Craigavon Area Hospital | Trauma Ward | Patient had not been given critical medication metformin for diabetes at 1800 hours on 24/12/19 and 25/12/19. | Metformin | Metformin | Spoke with Doctor on ward round on 25/12/19 and stated that patient had not received a dose of metformin on 24/12/19 at 1800 hours. Nil ordered at time and to monitor Blood sugars at present same handed over to staff. With regards to missed dose on 25/12/19. Doctors informed on ward on 28/12/19. Again nil ordered. Blood sugars stable and to continue to monitor same.Reflection pieces completed by both staff nurses on duty at the time of incidence. Record of discussion completed with one staff nurse still one to be completed with other staff nurse as not on duty at present. Medication observation carried out with one staff nurse still to carry out medication observation on one staff nurse as not on duty at present. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Failure to administer | minor | minor | possible | low |
| Personal Information | 19/12/2019 | Acute Services | IMWH - Cancer and Clinical Services | Craigavon Area Hospital | Oncology Clinic, Mandeville Unit | SIDE ARM OF GIVING SET CONTAINING CHEMO ATTACHED TO TOP PORT AND NOT BOTTOM PORT, HENCE ONLY 1 CHEMO INFUSED, OTHER CHEMO FAILED TO INFUSE. WHEN NOTICED ONCOLOGISTS INVOLVED IN PATIENT'S CARE STATED THAT TO CONTINUE WITH INFUSION AS PATIENT HAPPY TO PROCEED WITH SAME. ONCALL PHARMACIST CONTACTED WHO ALSO STATED THAT IT WAS ENTIRELY SAFE TO INFUSE REMAINING CHEMO INFUSION AS PX OVER SAME TIME. PATIENT VERY UNDERSTANDING AND HAPPY TO GET REMAINING CHEMO TREATMENT. WIFE PRESENT AND INFORMED ALSO. | Irinotecan | Irinotecan | ONCOLOGISTS DR HARTE AND DR PARKE MADE AWARE AND HAPPY TO PROCEED WITH TREATMENT | | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Failure to administer | insignifica | minor | possible | low |

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| Personal Information | 18/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | patient given 250 mls saline 0.9% with glucose 5% instead of sodium chloride 0.9%. doctor that prescribed and administered not in department to clarify same. | Sodium Chloride And Glucose | Sodium Chloride | Patient observations recorded and blood glucose recorded. patient informed. medical Registrar informed and reviewed - not concerned. nurse in charge made aware. documented and datix completed. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect medication/fluid | minor | minor | possible | low |
| Personal Information | 09/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | Patient [redacted] arrived from ED at 1830 in Discharge Lounge. No medical notes and just ED flimsy and nursing notes and Refused to transfer from trolley to Bed . Patient [redacted] was screaming and upset due to pain. Patient kept in trolley and Staff Nurse handover that patient had Shortec at 1715hrs awaiting for ambulance to returned to Lurgan Hospital Ward 1 . Patient been offered refreshment and patient [redacted] offered Toilet as well and change for urinary incontinent. Patient [redacted] calm with daughter present. Staff in Discharge Lounge chase medical notes and Kardex but ED said no medical notes for patient. Staff sent to ED to chase up the medical notes. Patient [redacted] complaint in pain explained to daughter and patient that were chasing the medical notes and Kardex to gave pain relief but daughter and patient insisting to gave pain relief to her MOther. Patient daughter gave to patient her own supply of Shortec without the Kardex. | Oxycodone | | WARD 1 LGH STAFF NURSE UPDATED REGARDING THE MEDICATION GIVEN BY THE DAUGHTER. CHASED FOR MEDICAL FILE AND KARDEX AND DOCUMENT IN PATIENTS NOTES. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Unauthorized self-medication | minor | minor | possible | low |
| Personal Information | 06/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | General Male Medical, | PATIENT ROUTINELY PRESCRIBED MORPHINE SULPHATE 10MG MODIFIED RELEASE (MST) BD (10:00 AND 22:00). WHEN READYING DOSE FOR 22:00 ON 06/12/19 I NOTICED THAT THE PATIENT HAD NOT HAD DETAILS OF 10:00 DOSE (06/12/19) RECORDED IN CONTROLLED DRUG RECORD BOOK. UPON FURTHER INSPECTION IT WAS DISCOVERED THAT THE PATIENT HAD INCORRECECTLY RECEIVED SHORT ACTING OXYNORM LIQUID FOR 10:00 ON 05/12/19 AND 06/12/19, AT THE INCORRECT DOSE OF 5MG EACH TIME. THIS WAS CHECKED WITH THE PATIENT WHO CONFIRMED THAT HE HAD RECEIVED A DIFFERENT MEDICATION/ DIFFERENT METHOD OF ADMINISTRATION ON THE TWO MORNINGS NOTED. | Oxycodone | Morphine | PATIENT IS AWARE AND APOLOGIES MADE ON BEHALF OF THE WARD. INCIDENT HAS BEEN RECORDED IN PATIENT'S NOTES. NURSE IN CHARGE OF NIGHTSHIFT IS AWARE AND CLINICAL CO-ORDINATOR INFORMED AS SENIOR NURSE ON DUTY. WARD MANAGER TO BE NOTIFIED AT FIRST AVAILABLE OPPORTUNITY. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect medication/fluid | minor | minor | possible | low |

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| Personal Information | 21/12/2019 | Acute Services | Surgery and Elective Care | Daisy Hill Hospital | Female Surgical /Gynae | Saturday morning pharmacy discharge for patient noted to be dossette contacted ward for sheet that is meant to come to pharmacy with discharges. Patient has already been discharged and no member of staff knew patient. Contacted Dr who wrote prescription Personal Information he did not know patient but was asked to write prescription as patients relatives were returning to ward for medication. | Fluclox acillin | | advised dr this was unsafe and no one on ward knew patiet. Contacted bed manager P Brown who kindly took details and contacted daughter. Daughter was under impression she was getting a dossette today but would administer medications if supplied in skillets for few days. Several mistakes on prescription flucloxacillin prescribed daily (should be QID) and other medications unclear if held etc. | Insignif icant | Patient Inciden ts | Medic ation/ Biolog ics/Fl uids | Prescribin g Processes | Incorrec t frequen cy of dose | insignifica | minor | possible | low |
| Personal Information | 24/12/2019 | Acute Services | Medicine and Unsched uled Care | Craigavon Area Hospital | 2 North Respirat ory | Amlodipine 200mg BD prescribed on electronic discharge - should have been Amisulpride 200mg BD. Epilim Chrono T BD prescribed on electronic discharge - should be Epilim Chrono 500mg T bd. | Amlod ipine | Amisu lpride | Electronic discharge amended by pharmacist prescriber. | | Patient Inciden ts | Medic ation/ Biolog ics/Fl uids | Prescribin g Processes | Incorrec t medicati on/fluid | insignifica | insignifica | possible | low |
| Personal Information | 28/12/2019 | Acute Services | Medicine and Unsched uled Care | Craigavon Area Hospital | 2 North Respirat ory | patient prescribed shortec 2.5mg (liquid), patient given shortec 5mg (capsule). CD not checked by any member of permanent staff on the ward. | Oxyco done | Oxyco done | Nurse in charge informed. FY1 informed. Patient informed. | Minor | Patient Inciden ts | Medic ation/ Biolog ics/Fl uids | Administr ation to Patient | Incorrec t medicati on/fluid | minor | minor | possible | low |
| Personal Information | 04/12/2019 | Acute Services | Surgery and Elective Care | Craigavon Area Hospital | Theatre s 1-4 CAH | Levo thyroxine prescribed by me and given to patient in the elective admission ward. Patients kardex was lying in other patients notes who was on levothyroxine. | Levoth yroxin e | | Datix, full explanation to patient and ward staff and surgeon informed. | Insignif icant | Patient Inciden ts | Medic ation/ Biolog ics/Fl uids | Prescribin g Processes | Incorrec t patient | insignifica | insignifica | possible | low |
| Personal Information | 26/12/2019 | Acute Services | Medicine and Unsched uled Care | Craigavon Area Hospital | 2 North Respirat ory | DOB 13/09/1060 Amitriptyline 75mg NOCTE Patient had been receiving this drug BD AM+PM | Amitri ptyline | Amitri ptylin e | Nurse in charge informed Consultant Dr Stewart informed | Minor | Patient Inciden ts | Medic ation/ Biolog ics/Fl uids | Administr ation to Patient | Incorrec t frequen cy of dose (extra dose ) | minor | minor | possible | low |
| Personal Information | 14/12/2019 | Acute Services | Surgery and Elective Care | Craigavon Area Hospital | Trauma Ward | Gave patient 150mg of Maxi tram instead of the dose 100mg written on Kardex. unaware was to be documented through CD book and no double signature documented. was unaware Maxi tram was classified as a CD on the ward. | Trama dol | Trama dol | when error was noticed NIC informed. documented in CD book with my own signature and patient has been stable throughout. NEWS stable. Patient asymptomatic. Reflection and IR1 complete. | Minor | Patient Inciden ts | Medic ation/ Biolog ics/Fl uids | Administr ation to Patient | Incorrec t dose | minor | minor | possible | low |

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| Personal Information | 10/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | Direct Assessment Unit | Patient was given paracetamol twice in a time period of an hour (total dose of 1.5G in an hour) Patient had two drug kardex, one started by the medics when reviewing patient and drug kardex from DAU, DAU drug kardex was not discontinued when medical kardex was commenced. Patient had temp of 37.9 spoke to DAU doctor who prescribed oral paracetamol, however patient had already had paracetamol with medics but I was not aware of this. | Paracetamol | Paracetamol | DAU doctor informed, ward sister informed, patient informed. Patient is for admission so nurse will hand over to ward that patient is not for further paracetamol today. | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect frequency of dose (extra dose ) | insignifica | minor | possible | low |
| Personal Information | 03/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 1 South Medical | WHEN CHECKING THE CONTROLLED DRUGS AT END OF SHIFT ON 3/12/19 I DISVOVERED A BAG OF IV FLUIDS WAS MISSING. | Potassium Chloride And Sodium Chloride | | WE INVESTIGATED BY LOOKING AT ALL PATIENTS ON IV FLUIDS AND DISCOVERED THAT A PATIENT HAD BEEN PRECRIBED THE MISSING FLUIDS ON THE 2/12/19 AND THEY HAD BEEN ERECTED WITHOUT BEING SIGNED OUT OF THE CONTROL DRUG REGISTER. BOTH NURSES HAVE BEEN SPOKEN TO AND ASKED TO READ TRUST POLICY. | Insignificant | Patient Incidents | Documentation | Controlled drug registers | Controlled drug (CD) record keeping error | Controlled drugs | | | |
| Personal Information | 02/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Ramone Day Clinical Centre | Patient took a reaction to the Drug Monofer, and we were unable to get medical help from the surgical team under whom she was admitted. The Drs who were contacted advised us to take patient to ED for assessment as an outpatient.<br>(Entry by Ward manager 3.1.2020)<br>I was informed immediately of the patient's reaction and medical response to staff requests for support/patient assessment to go to \|ED. I re-called ward again and explained while the patient's NEWs score was satisfactory at the time of calling I was unhappy with the situation and from observing the patient felt she looked worse than her initial clinical info suggested. I also explained that we were unable to transfer patient to a bed and that I said that I felt, as the senior nurse there, that it was an inappropriate request for us to take patient to ED that we needed their attendance to the DCC straight away. I was further instructed to call 999 if I needed medical assistance and was again refused assistance.....<br><br>I returned to the patient to check her status and she stated that she was feeling unwell, she sounded breathless and her face had an unusual deep colur of purple we administered O2 15Ls via | Monofer | | As above...<br>Doctors in ward 4S were contacted and informed the patient was having a drug reaction but refused to attend, suggesting we take the patient to ED or call 999. | Moderate | Patient Incidents | Medication/ Biologics/Fluids | Post-administration Patient Monitoring | Adverse drug reaction | Adverse drug reaction | | |

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| Personal Information | 12/12/2019 | Acute Services | Pharmacy | Daisy Hill Hospital | Renal Clinic | Patient d/c from RVH on pre-admission 8.75mg Bisoprolol. (ECR 5mg plus 3.75mg) On d/c 2.5mg and 1.25mg supplied Patient only taking 3.75mg - didn't know to take the new supply of 2.5mg and 1.25mg in addition to the 5mg POD | Bisoprolol | | Incidental finding after medication review Patient advised total daily dose 8.75mg | | Patient Incidents | Medication/ Biologics/Fluids | Medication advice | Unclear advice | BHSCT incident | | |
| Personal Information | 20/12/2019 | Acute Services | IMWH - Cancer and Clinical Services | Daisy Hill Hospital | Maternity Ward | sevredol 10mgs noted to be missing at1730 when checking in new box of sevredol received from pharmacy | Morphine | Morphine | informed sr in charge who contacted supervisor staff who went of duty contacted, and on call pharmacy contacted.Policy followed | Minor | Patient Incidents | Medication/ Biologics/Fluids | Storage Processes (in pharmacy or on unit) | Controlled drug register discrepancy | Controlled drugs | | |
| Personal Information | 21/12/2019 | Acute Services | Pharmacy | Craigavon Area Hospital | Pharmacy Dispensary | Medications transferred from pharmacy dept CAH. CD box received and on opening with second member of staff it was noted that the bag containing the bottle of Morphine Sulphate Oral Solution was damp and the label on the bottle also. The cap was not securely on and a purple plug also in situ | Morphine | Morphine | The label on the bottle stated there was 30mls of oral solution in the bottle. A syringe was used and observed by two trained staff to measure the bottle, the lid was not on securely with a purple cap in situ and the amount of solution amounted to 26mls therefore 4mls of spillage/leakage has occurred. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Dispensing Processes | Damaged/contaminated product | Controlled drugs | | |
| Personal Information | 07/12/2019 | Acute Services | Surgery and Elective Care | Daisy Hill Hospital | High Dependency Unit | Patient prescribed Monofer Iron infusion to be given over 30minutes to treat low Hb, infusion commenced at a slower rate, within minutes patient became unwell, displaying signs of reaction, immediate flushing, chest tightness, short of breath and finding it difficult to breathe. | monofer | monofer | Infusion stopped immediately, Nurse in Charge called for, Surgical FY1 present on ward who attended to assess patient, oxygen applied, anaphylaxis kit brought to bedside. Nil else requested, anaphylaxis kit not required as patient symptoms self terminated when infusion stopped. | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Post-administration Patient Monitoring | Adverse drug reaction | Adverse drug reaction | | |

Medication incidents CCS2

| ID | Incident date | Directorate | Division | Site | Loc (Exact) | Description | Drug administered | Correct drug | Action taken | Consequence | Incident affecting | Incident type tier one | Incident type tier two | Incident type tier three | DHSSPS impact | DHSSPS potential | DHSSPS likelihood | DHSSPS risk rating |
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| Personal Information | 22/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | Patient was written up a kardex in A&E for IV and PO antibiotic administration (Amoxicillin & Doxycycline). Allergies were not documented despite the patient having 13 allergies. Antibiotics and enoxaparin, as well as regular medicines, were administered without allergies documented on kardex. Patient was allergic to 'Galenamox' - brand name for amoxicillin which was prescribed and administered twice, and paracetamol which was also prescribed but not administered. | Amoxicillin | | I checked the patient had not experienced an adverse reaction to the two IV doses of amoxicillin which patient denies and no report documented in notes. I documented all allergies on kardex according to GP and confirmed with daughter on front of kardex. I made daughter and patient aware that amoxicillin had been administered. | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Contraindication due to history of allergy | insignifica | catastrop | possible | extreme |
| Personal Information | 21/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | new presentation of type 2 diabetes. blood sugar of 25. was given a stat dose of 15 units Actrapid. Inappropriate insulin and inappropriately large dose for a stat dose. Assuming a traditional correction ratio of 1 unit reduces blood sugar by 2 could have potentially caused this patient to have a hypo | Insulins | Insulins | ED pharmacist informed | Minor | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Incorrect dose | minor | catastrop | possible | extreme |
| Personal Information | 19/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | Patient had been prescribed Apixaban 5mg at 10am same had not been given and was not noticed until 1600 | apixaban | apixaban | When missed dose was noted a stat doses for both prescribed doses had been charted and given | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect frequency of dose (omitted dose) | insignifica | major | unlikely | high |

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| Personal Information | 23/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 2 North Respiratory | PATIENT WAS DUE WARFARIN- DOSE MISSED<br>NO INR COMPLETED FROM 20/12/19 AND PATIENT HAD BEEN REQUESTED TO HAVE DAILY BLOODS +INR COMPLETED. SAME NOT REQUESTED IN BLOOD BOOK. | Warfain | Warfain | MEDICAL REG INFORMED, NURSE IN CHARGE AWARE. CLINICAL COORDINATOR INFORMED<br>URGENT INR SENT ENOXAPARIN PRESCRIBED AND GIVEN AS INR 1.5 | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Failure to administer | minor | major | unlikely | high |
| Personal Information | 12/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | General Male Medical, | Patient had been admitted with erratic BM's, T1DM, and had been commenced on IV insulin infusion, patient had been actively vomiting and BM at bedtime was 5.2. Patient had not been prescribed bedtime insulin, nor was it handed over that patient was to remain on insulin and IV insulin. I was not aware of the guidelines, and as a result, patient did not receive bedtime insulin. | Insulins | Insulins | I contacted patient flow, who were able to confirm that insulin should have been given. Patient was closely monitored following same. Medics were informed. | | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Failure to administer | minor | major | possible | high |
| Personal Information | 13/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 1 North Cardiology | The above named patient appeared to have missed her 1800hrs Enoxaparin 60mg injection. | Enoxaparin | Enoxaparin | The patient was asked if she remembered getting the injection and she replied 'No'. The nursing documentation had no record of administration. The Clinical Coordinator was informed. She advised that she would liaise with the F1 and that a Datix be completed. Further discussion at approximately 0230hrs with a new Clinical coordinator. Suggested to continue to wait for F1 and 6am dose to be given. | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Failure to administer | insignifica | major | unlikely | high |

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| Personal Information | 30/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | Kardex written - probably based on NIECR GP list instead of recent early December 2019 discharge letter - and no antiplatelets prescribed. Patient's early December 2019 admission was for cardiac stent insertion. | Clopidrogel | | Clopidogrel and aspirin prescribed on Kardex as per early December 2019 discharge letter. Patient therefore did not miss any doses of antiplatelets. | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Not prescribed required medication (reconciliation error) | insignifica | major | possible | high |
| Personal Information | 23/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | Patient initially incorrectly prescribed Lantus and short-acting insulin. This was incorrect. Then prescribed Humalog MIX50 but at the incorrect dose. (The morning dose that the doctor used was the dose on NIECR printout - 24 units, but this was not the most recent dose as per the diabetic review and which I confirmed with the patient's wife - it should have been 44 units). The patient received 24 units. | Insulins | Insulins | Insulin chart amended to reflect preadmission dose, so that future dosing would be correctly informed. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Incorrect dose | minor | moderate | possible | medium |

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| Personal Information | 30/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | Emergency Department DHH | 12yr old girl presented to ED 10hrs post Paracetamol ingestion. Approx. 8 grams of Paracetamol consumed (167mg/kg). Paracetamol level 43 and was above the treatment line.<br><br>Call made to paeds ward by ED doctor to inform them of her of arrival and to see if the child could be transferred to paeds to commence treatment as reported that Parvolex could not be started in ED.<br>At that stage no beds on the paediatric ward which was also over capacity. SSPAU not currently open. ED doctor then said they would have to transfer the child to Craigavon to commence Parvolex infusion there.<br><br>In accordance with the guidelines, Parvolex infusion should have been commenced on the child's arrival to ED at 6am. Discussion with lead nurse and medical team in paeds and staff sourced from another area to open ambulatory to ensure there was no more further delays in the commencement of treatment for the child caused by waiting for transfer. Treatment was commenced and the child was transferred to ambulatory at 9am. | Acetylcysteine | Acetylcysteine | staff sources to ensure ambulatory unit was open so the child could receive treatment asap | Insignificant | Patient Incidents | Medication/Biologics/Fluids | Administration to Patient | Incorrect timing of dose (delayed) | insignificant | moderate | possible | medium |
| Personal Information | 09/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | AMU | Patient prescribed Ivabradine 20mg twice daily on Kardex. Patient on ivabradine 5mg twice daily pre-admission. Patient's heart rate was reduced <50beats per min. | ivabradine | ivabradine | Prescribing error noted on front of Kardex, patient's notes and ward booklet. Medical staff on lunch but nursing staff aware and follow up required with medical staff prior to next dose. | Minor | Patient Incidents | Medication/Biologics/Fluids | Prescribing Processes | Incorrect dose | minor | moderate | possible | medium |

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| Personal Information | 09/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | Female Medical | Patient is on L3 fluids and L4 puree diet as per speech and language therapist. On dietetic review it was noticed that the patient had an empty bottle of oral nutritional supplement different from what was prescribed on the drug Kardex. The supplement prescribed was Fresubin 2kcal crème (level 4 puree) but the supplement on the patients table was Fesubin 2kcal drink (level 1). | Fresubin Creme | Fresubin creme | The dietitian removed the incorrect supplement from the patients table, however the supplement bottle was empty. The patient was unable to clarify whether she had drank the supplement. The dietitian checked the drug Kardex to ensure the correct supplement had been prescribed which it had, she then spoke to SN Vera re: her concerns that the incorrect consistency of supplement may been given | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Formulation of medicine was wrong | insignifica | moderate | possible | medium |
| Personal Information | 27/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 1 South Medical | Pt was prescribed Teicoplanin (1st loading dose) for 6pm on 27/12/19- dose was not given. Staff nurse handing over to me stated that first dose was due at 6am on 28/12/19. Pt diagnosed with empyema- treatment was therefore delayed. | Teicoplanin | | Co-ordinator contacted. Dose given at 2300 | | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect frequency of dose (omitted dose) | insignifica | moderate | possible | medium |
| Personal Information | 20/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 1 North Cardiology | Patient came up to the ward at 2300. Insulin was not given in A+E or prescribed. Patient did not get his insulin until 01:05. | Insulins | Insulins | Recorded in patients notes. Clinical co-ordinator and F1 informed. | | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Not prescribed required medication (reconciliation error) | minor | moderate | possible | medium |
| Personal Information | 20/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 2 North Respiratory | novomix 30 prescribed on discharge for patient should have been novorapid. | Insulins | Insulins | Changed at clinical check stage. | | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Incorrect medication/fluid | insignifica | moderate | possible | medium |

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| Personal Information | 10/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | Emergency Department DHH | Patient arrived from A + E. It was noted on admission to ward that evening insulin (Humalog Mix 25) had been missed. It was noted in ED flimsy that ED staff had attempted to get staff on another ward to check for insulin as same not available in ED. However, same not obtained or followed up. Insulin was not given. | Insulins | | Medics informed. Blood sugar monitored - remained stable. Person in charge at time of incident aware. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect frequency of dose (omitted dose) | minor | moderate | possible | medium |
| Personal Information | 23/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Discharge Lounge | Patient transferred to Discharge Lounge to wait on family coming to collect her. Informed by OPAU nurse on leaving patient off that her clothes had been lost in A&E. OPAU Nurse stated she had looked in A&E for them but they couldn't be found, but that she had told family to bring in clothes. She had long winter coat on over clothes but no shoes. At 3pm daughter and other family members came to collect her, I was on telephone at the time sorting out another issue. I overheard daughter saying that she hadn't brought shoes in. I put call on hold and called daughter over and asked her to go and check in A&E as she could recognize shoes and clothes better, as she couldn't go home without them. She left to do this, my colleague was dealing with her discharge and when I had finished she had been discharged. When filing away notes at 16:45 approx. I found two envelopes relating to patient that had been misled and not sent with patient. I opened them to find highlighted note related to page 6 to hold two medications due to collapse episode. | Atenolol | | I told my colleague who had missed sending theses as family were in a rush to bring mum home. She rang NOK and asked her to stop taking these two medications as stated on medical assessment. She then informed her they had blister pack and couldn't identify them. My colleague stated she would have to try and check with team and get back to her – granddaughter stated she would be at home and contactable. I rang on-call pharmacist and he stated he couldn't identify them over phone or could he dispense other three she needed in am separately as it wasn't safe. We discussed other possibilities but could not come up with a solution on how to get these medications dispensed over holidays. I tried her own community chemist it was closed. I tried bed manager who advised me to contact OPAU team or Med Reg. I obtained OPAU Manager mobile no from a colleague (last port of call), I | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Post-administration Patient Monitoring | Incorrect/insufficient handover/transition | insignifica | moderate | possible | medium |

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| Personal Information | 24/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 2 South Medical | Insulin dose omitted | Insulins | | Person informed | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect frequency of dose (omitted dose) | minor | moderate | possible | medium |
| Personal Information | 16/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | Emergency Department DHH | Evening dose of regular insulin not prescribed while in ED. Correctional insulin required at midnight for rebound hyperglycaemia. | Insulins | Insulins | Correctional insulin prescribed and regular insulin prescribed for following morning. | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Not prescribed required medication (reconciliation error) | moderate | moderate | possible | medium |
| Personal Information | 30/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | Ptx received 1x dose of IV abs in Ed and was meant to go home on oral Abs... Ptx did not receive these meds. Returned 3/7 with worsening infection | Amoxicillin | | Ptx informed Sister Stephanie informed | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Failure to administer | moderate | moderate | possible | medium |

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| Personal Information | 30/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | Female Medical | Nursing home resident admitted with drowsiness on a background of CCF on LTOT. Found to have a pneumonia, required non-invasive ventilation.<br><br>At time of discharge it was found that the medications prescribed in the Kardex were different to that that the patient had previously been on. Errors included, addition of two blood pressure tablets the patient had never taken, addition of an antithyroid medication the patient may have taken previously according to family but hadn't been on for years, and errors in dosage of two medications - one for neuropathic pain and another for agitation (Carbimazole, bisoprolol, pregabalin, ramipril, quetiapine) | Bisoprolol | | This was escalated to consultant as soon as the errors had become apparent. The advice was open disclosure to patient and family which was done on 30/12/2019 at 16:30. Our plan is to keep this patient in for another day to check her thyroid function. She had been due for discharge today. | | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Incorrect medication/fluid | minor | moderate | possible | medium |
| Personal Information | 17/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 1 South Medical | Patient due to have critical med Keppra at 1800 on the evening of 17/12/19 and 18/12/19 both not given on both dates | Levetiracetam | Levetiracetam | contacted co-ordinator to see if should be given. Unsure if staff on day duty had given it and patient also unsure if she had got the tablet on both occasions. Dr stated it is safer to hold the drug than to over dose the patient as can only be increased by 250mg at a time and patient was due 500mg. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect frequency of dose (omitted dose) | insignifica | moderate | possible | medium |

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| Personal Information | 17/12/2019 | Acute Services | Medicine and Unsched uled Care | Daisy Hill Hospital | General Male Medical, | Patient discharged from the ward to AC@HT<br>Query over Tazocin dose/indication- went to ward to see if indication for Tazocin was documented<br>Pt prescribed BD Taz for asp pneumonia?? No reason for BD dosing<br>Prescribed Enoxaparin 20mg OD - no reason for under dose<br>Medication discontinued: Omeprazole (discharged on prednisolone)Salbutamol and clenil inhalers, simvastatin and fluticasone nasal spray no documented reason?<br>Bloods taken on admission 13/13/19- none since-no idea if antibiotic working | Tazocin | | Informed AC@HT consultant Dr El Faki- contacted micro to query use of Taz and Metronidazole- ?empyema- waiting to hear back<br>Taz changed to TID on discharge as per AC@HT doctor<br>Enox changed to 40mg also | | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Incorrect frequency of dose | insignifica | moderate | possible | medium |
| Personal Information | 11/12/2019 | Acute Services | Medicine and Unsched uled Care | Craigavon Area Hospital | 2 South Stroke | Patient due Longtec 60mg and pregabalin 50mg at 2200. Longtec not available at ward level as none in stock in CD cupboard. Due to pressures on ward and having to cover breaks down the medical side due to staffing levels SN forgot to go back and contact pharmacy on call regarding the same. Further pressures and sick patients meant SN was unable to go back round all kardexes to ensure medications were given therefore missed both medications. | Oxycodone | Longtec | PRN Shortec Administered when missed dose was discovered to minimize patients pain.<br>Patient informed of same and that same will be reported. Ward manager informed of same. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect frequency of dose (omitted dose) | insignifica | minor | possible | low |

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| Personal Information | 21/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | A female resident was admitted to ourselves from CAH, with no medication or proper medication list. When in hospital this lady was on Clexane, but no Clexane was sent in with her. | Enoxaparin | | I rang the hospital and explained that usually on discharge a patient is sent out with a full months supply of medication. I also enquired about the Clexane, but was inform by the Sister on the ward that the patient only received the Clexane for the 2 days that she was in the hospital. I also got in contact with the family to bring in the medication from home. | | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Not prescribed required medication (reconciliation error) | minor | minor | possible | low |
| Personal Information | 16/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | AMU | PATIENT WAS ADMINISTERED MEDICATIONS AS PER KARDEX. PATIENT ALERT AND ORIENTATED AND REFUSED ALL MORNING MEDS AS STATED THEY WERE NOT HER NORMAL MEDS. AWAITED MEDICAL WARD ROUND AND DISCOVERED BY SHO THAT THE MEDICATIONS PRESCRIBED FOR HER WERE INCORRECT. | | | KARDEX ALTERED TO CORRECT MEDICATIONS, IR1 COMPLETE, MEDICAL TEAM AWARE. CORRECT MEDICATINS GIVEN | Minor | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Incorrect medication/fluid | insignifica | minor | possible | low |
| Personal Information | 15/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 3 North Winter Ward | patient commenced on syringe pump<br>doses prescribed inappropriate as they where prescribed as a range, and hyoscine was prescribed as butylbromide 400 microgram as opposed to hydrobromide.<br>no start time specified on pump chart either.<br>diamorphine recommended by hospice - trying to use morphine within trust currently and avoid diamorph prescribing for syringe pumps | Diamorphine | | Palliative nurse specialist noticed on reviewing patient on Monday following incident<br>new syringe driver chart prescribed<br>datix form completed and copy of patient syringe pump chart kept for leanring<br>palliative nurse to discuss diamorphine advice with hospice | | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Incorrect dose | insignifica | minor | possible | low |

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| Personal Information | 26/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | AMU | Patient admitted to hospital completing DHx and Med rec<br>type 2 diabetic with high sugars and poor control on long term steroids for RA<br>Patient commenced on sitagliptin in combination with linagliptin and gliclazide<br>reduced eGFR and BMs remained in 20s | sitagliptin | linagliptin | Advised medical team to correct sugars<br>advised to titrate gliclazide dose and hold of sitagliptin dose and made referral to diabetic team SB/LE/RM by email<br>Spoke with Rachel this morning and kindly reviewed patient and changed meds as appropriate.<br>Datix submitted and GP surgery informed | | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Contraindication due to interactions with other medications | insignifica | insignifica | possible | low |
| Personal Information | 16/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | AMU | pt karkex written up for 50mg flucortisone - pt actual dose 50 micrograms. also pt missed 2 doses of flucortisone 50micrograms. flucortisone supplied by pharmacy tech and nurse informed. | Fludrocortisone | Fludrocortisone | as the pharmacy tech on ward, brought to attention of ward pharmacist who bought to dr who re-wrote the correct medicine & dose. no dose given to patient. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Incorrect dose | insignifica | minor | possible | low |
| Personal Information | 06/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | Patient prescribed medicine Kardex when first clerked in. Medications given from Kardex when due. Patient then confirmed as having TB. Medical reg wrote up new Medicine Kardex then ripped previous Kardex in half and threw it into the Clinical Waste bin. When asked to retrieve said Kardex stated 'it was in the bin' and 'didn't know which one'. Did not inform nursing staff at any point that a new Kardex had been written. staff nurse looking after patient realized it had been done as the Kardex was new and no medications she had previously given were recorded. | | | Sister in Charge aware. Medicine Kardex retrieved from bin. Datix completed. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Duplicate prescription | insignifica | insignifica | possible | low |

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| Personal Information | 04/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | Emergency Department DHH | Patient AF IV fluids commenced at 19:50, to run over 12 hours/ 83mls per hour. Informed by Staff Nurse at 23:15 hours, IV fluids running at 100mls per hours. Correct IV fluids erected | Sodium Chloride | Sodium Chloride | IV Fluids stopped. Medical team informed, advised to restart Fluids at correct rate of 83mls/hr, recommenced at 23:15 hours. Family informed | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect rate of administration | insignifica | minor | possible | low |
| Personal Information | 18/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | patient given 250 mls saline 0.9% with glucose 5% instead of sodium chloride 0.9%. doctor that prescribed and administered not in department to clarify same. | Sodium Chloride And Glucose | Sodium Chloride | Patient observations recorded and blood glucose recorded. patient informed. medical Registrar informed and reviewed - not concerned. nurse in charge made aware. documented and datix completed. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect medication/fluid | minor | minor | possible | low |

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| Personal Information | 09/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Emergency Department CAH | Patient Per arrived from ED at 1830 in Discharge Lounge. No medical notes and just ED flimsy and nursing notes and Refused to transfer from trolley to Bed . Patient Per was screaming and upset due to pain. Patient kept in trolley and Staff Nurse handover that patient had Shortec at 1715hrs awaiting for ambulance to returned to Lurgan Hospital Ward 1 . Patient been offered refreshment and patient Per offered Toilet as well and change for urinary incontinent. Patient Perso calm with daughter present. Staff in Discharge Lounge chase medical notes and Kardex but ED said no medical notes for patient. Staff sent to ED to chase up the medical notes. Patient Per complaint in pain explained to daughter and patient that were chasing the medical notes and Kardex to gave pain relief but daughter and patient insisting to gave pain relief to her MOther. Patient daughter gave to patient her own supply of Shortec without the Kardex. | Oxycodone | | WARD 1 LGH STAFF NURSE UPDATED REGARDING THE MEDICATION GIVEN BY THE DAUGHTER. CHASE ED FOR MEDICAL FILE AND KARDEX AND DOCUMENT IN PATIENTS NOTES. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Unauthorized self-medication | minor | minor | possible | low |

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| Personal Information | 06/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | General Male Medical, | PATIENT ROUTINELY PRESCRIBED MORPHINE SULPHATE 10MG MODIFIED RELEASE (MST) BD (10:00 AND 22:00). WHEN READYING DOSE FOR 22:00 ON 06/12/19 I NOTICED THAT THE PATIENT HAD NOT HAD DETAILS OF 10:00 DOSE (06/12/19) RECORDED IN CONTROLLED DRUG RECORD BOOK. UPON FURTHER INSPECTION IT WAS DISCOVERED THAT THE PATIENT HAD INCORRECECTLY RECEIVED SHORT ACTING OXYNORM LIQUID FOR 10:00 ON 05/12/19 AND 06/12/19, AT THE INCORRECT DOSE OF 5MG EACH TIME. THIS WAS CHECKED WITH THE PATIENT WHO CONFIRMED THAT HE HAD RECEIVED A DIFFERENT MEDICATION/ DIFFERENT METHOD OF ADMINISTRATION ON THE TWO MORNINGS NOTED. | Oxycodone | Morphine | PATIENT IS AWARE AND APOLOGIES MADE ON BEHALF OF THE WARD. INCIDENT HAS BEEN RECORDED IN PATIENT'S NOTES. NURSE IN CHARGE OF NIGHTSHIFT IS AWARE AND CLINICAL CO-ORDINATOR INFORMED AS SENIOR NURSE ON DUTY. WARD MANAGER TO BE NOTIFIED AT FIRST AVAILABLE OPPORTUNITY. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect medication/fluid | minor | minor | possible | low |
| Personal Information | 24/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 2 North Respiratory | Amlodipine 200mg BD prescribed on electronic discharge - should have been Amisulpride 200mg BD. Epilim Chrono T BD prescribed on electronic discharge - should be Epilim Chrono 500mg T bd. | Amlodipine | Amisulpride | Electronic discharge amended by pharmacist prescriber. | | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Incorrect medication/fluid | insignifica | insignifica | possible | low |
| Personal Information | 28/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 2 North Respiratory | patient prescribed shortec 2.5mg (liquid), patient given shortec 5mg (capsule). CD not checked by any member of permanent staff on the ward. | Oxycodone | Oxycodone | Nurse in charge informed. FY1 informed. Patient informed. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect medication/fluid | minor | minor | possible | low |
| Personal Information | 26/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 2 North Respiratory | DOB 13/09/1060 Amitriptyline 75mg NOCTE Patient had been receiving this drug BD AM+PM | Amitriptyline | Amitriptyline | Nurse in charge informed Consultant Dr Stewart informed | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect frequency of dose (extra dose ) | minor | minor | possible | low |

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| Personal Information | 10/12/2019 | Acute Services | Medicine and Unscheduled Care | Daisy Hill Hospital | Direct Assessment Unit | Patient was given paracetamol twice in a time period of an hour (total dose of 1.5G in an hour) Patient had two drug kardex, one started by the medics when reviewing patient and drug kardex from DAU, DAU drug kardex was not discontinued when medical kardex was commenced. Patient had temp of 37.9 spoke to DAU doctor who prescribed oral paracetamol, however patient had already had paracetamol with medics but I was not aware of this. | Paracetamol | Paracetamol | DAU doctor informed, ward sister informed, patient informed. Patient is for admission so nurse will hand over to ward that patient is not for further paracetamol today. | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Incorrect frequency of dose (extra dose ) | insignifica | minor | possible | low |
| Personal Information | 03/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | 1 South Medical | WHEN CHECKING THE CONTROLLED DRUGS AT END OF SHIFT ON 3/12/19 I DISVOVERED A BAG OF IV FLUIDS WAS MISSING. | Potassium Chloride And Sodium Chloride | | WE INVESTIGATED BY LOOKING AT ALL PATIENTS ON IV FLUIDS AND DISCOVERED THAT A PATIENT HAD BEEN PRECRIBED THE MISSING FLUIDS ON THE 2/12/19 AND THEY HAD BEEN ERECTED WITHOUT BEING SIGNED OUT OF THE CONTROL DRUG REGISTER. BOTH NURSES HAVE BEEN SPOKEN TO AND ASKED TO READ TRUST POLICY. | Insignificant | Patient Incidents | Documentation | Controlled drug registers | Controlled drug (CD) record keeping error | Controlled drugs | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information | 02/12/2019 | Acute Services | Medicine and Unscheduled Care | Craigavon Area Hospital | Ramone Day Clinical Centre | Patient took a reaction to the Drug Monofer, and we were unable to get medical help from the surgical team under whom she was admitted. The Drs who were contacted advised us to take patient to ED for assessment as an outpatient.<br>(Entry by Ward manager 3.1.2020)<br>I was informed immediately of the patient's reaction and medical response to staff requests for support/patient assessment to go to \|ED. I re-called ward again and explained while the patient's NEWs score was satisfactory at the time of calling I was unhappy with the situation and from observing the patient felt she looked worse than her initial clinical info suggested. I also explained that we were unable to transfer patient to a bed and that I said that I felt, as the senior nurse there, that it was an inappropriate request for us to take patient to ED that we needed their attendance to the DCC straight away. I was further instructed to call 999 if I needed medical assistance and was again refused assistance.....<br><br>I returned to the patient to check her status and she stated that she was feeling unwell, she sounded breathless and her face had an unusual deep colur of purple we | Monofer | | As above...<br>Doctors in ward 4S were contacted and informed the patient was having a drug reaction but refused to attend, suggesting we take the patient to ED or call 999. | Moderate | Patient Incidents | Medication/ Biologics/Fluids | Post-administration Patient Monitoring | Adverse drug reaction | Adverse drug reaction | |

Medication incidents CCS2

| ID | Incident date | Directorate | Division | Site | Loc (Exact) | Description | Drug administered | Correct drug | Action taken | Consequence | Incident affecting | Incident type tier one | Incident type tier two | Incident type tier three | DHSSPS impact | DHSSPS potential | DHSSPS likelihood | DHSSPS risk rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information | 27/12/2019 | Acute Services | Surgery and Elective Care | Craigavon Area Hospital | ICU CAH | Pt receiving dialysis and handed over this am that no heparin running. Labs contacted ward to say that pt had prolonged coagulation. Dialysis machine checked and heparin running at 0.5mls/hr. | Heparin | | Dr & NIC informed. Heparin stopped. Rpt coags taken throughout the day. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Administered but not prescribed | minor | major | possible | high |
| Personal Information | 12/12/2019 | Acute Services | Surgery and Elective Care | Craigavon Area Hospital | Trauma Ward | Patient missed his dose of Rivaroxaban. | rivaroxaban | rivaroxiban | Informed the ward manager during handover, medication ordered from JACS System, Datix and reflections done. | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Failure to administer | insignifica | major | unlikely | high |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information | 13/12/2019 | Acute Services | Surgery and Elective Care | Craigavon Area Hospital | Theatres 1-4 CAH | 13/12/19<br>Theatre 4 Urology patient given Epirubicin, a Mitomycin C chemo substitute intra-operatively. Patient allocated bed space in Recovery in open ward as team leader unaware that a Mitomycin substitute was administered.<br><br>Theatre nurse handed over to Recovery nurse (Recovery nurse pregnant not exposed to any risk at handover), Epirubicin was administered and Consultant Urologist would release from bladder in Recovery. AS. | Epirubicin | Epirubicin | Recovery nurse informed me of above.<br>Patient transferred to sideward.<br>One SN dedicated to care for patient and follow isolation precautions.<br>I spoke with Lead nurse, Theatre Sister and then went to pharmacy to discuss with Pharmacist who would speak with Chemo pharmacist. Pharmacist called back to Recovery: same precautions as Mitomycin.<br><br>On return to Recovery, Consultant Urologist had released drug from bladder. Explained policy and SOP regarding Mitomycin, Consultant said he was aware of this and accepted full responsibility, and that the procedure was carried out safely.<br><br>I explained had Recovery been aware of intentions to give Mitomycin substitute we would have escalated to Patient flow to ensure patient was prioritised for transfer to 3 south Urology for safe administration /disposal of treatment. | | Patient Incidents | Medication/ Biologics/Fluids | Post-administration Patient Monitoring | Incorrect/insufficient handover/transition | insignifica | moderate | possible | medium |
| Personal Information | 01/12/2019 | Acute Services | Surgery and Elective Care | Craigavon Area Hospital | 3 South | Syringe Driver checks did not appear to have been completed on a patient from 30.11.19 at 19.15hrs until 08:30 hrs on 1/12/19. The label in the syringe had not been signed by two staff nurses, prescription chart had been signed by two staff members | | | Reported to nurse in charge of ward at the time (SN Newell) | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Post-administration Patient Monitoring | Failure/insufficient/incomplete monitoring | insignifica | moderate | possible | medium |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information | 21/12/2019 | Acute Services | Surgery and Elective Care | Daisy Hill Hospital | Female Surgical /Gynae | pharmacy dispensary sat prescription presented to pharmacy for patient. patient had been discharged fri 20th prescription for Tamiflu amoxicillin and propylthiouracil<br>no documentation on discharge as to why propylthiouracil was commenced and dose on Kardex and discharge did not match BD on Kardex and TID on discharge. also had not been administered on ward marked as 6 | Propyl thiour acil | | contacted ward and F1 on duty to resolve F1 on duty steven had not written discharge and did not know patient nursing staff were not familiar with patient and hence did not know if propylthiouracil was definitely indicated<br>I accessed NIECR to ascertain if this was possibly pre admission and found patient also appeared to be on lamotrigine but this had not been prescribed<br>patient has now left the ward. Later in the day nursing staff contacted the on call pharmacist to say patient had returned to ward and advised that this was to be started but my understanding is there was no documentation to support this<br>email sent to consultant Dr Ahmed for follow up as there is no indication on the discharge letter and hence no communication to the GP with regard to this. | Insignif icant | Patient Inciden ts | Medic ation/ Biolog ics/Fl uids | Prescribin g Processes | Incorrec t frequen | insignifica | moderate | possible | medium |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information | 06/12/2019 | Acute Services | Surgery and Elective Care | Craigavon Area Hospital | 3 South | patient had received cytotoxic drug via SRC, urology reg contacted re releasing same as nurses at ward level not trained for same & explained that urology usually release and dispose of same. Urology reg wanted to speak to NIC who reiterated the same. Reg then came to ward to complete task. Once urology reg had left it was noted that the SRC drainage bag had not be changed nor the cytotoxic medication disposed off. | epimbicin | epimbicin | SR Toner contacted for advice, PPI and double gloved the SRC drainage bag was changed and the bag containing the cytotoxic medication disposed off in an empty cytotoxic burns bin and same locked afterwards. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Post-administration Patient Monitoring | Failure/insufficient/incomplete monitoring | insignifica | moderate | possible | medium |
| Personal Information | 08/12/2019 | Acute Services | Surgery and Elective Care | Daisy Hill Hospital | Female Surgical /Gynae | Patient admitted to FSW from ED @ 19.00. Due warfarin @ 18.00 - same not prescribed or given in ED. Documented @ 20.00 doctor informed of need for prescription. NIC unaware. 00.30 noted still awaiting warfarin to be prescribed. Doctor + night coordinator aware. warfarin administered @ 01.30 following prescription. Patient was clerked in ED, time is not documented. Patient medical team aware of incident. | Warfain | | Both day team and night doctor aware of need for prescription. Night co-ordinator aware. | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Prescribing Processes | Delay in prescribing | insignifica | minor | possible | low |

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| Personal Information | 28/12/2019 | Acute Services | Surgery and Elective Care | Craigavon Area Hospital | Trauma Ward | Patient had not been given critical medication metformin for diabetes at 1800 hours on 24/12/19 and 25/12/19. | Metformin | Metformin | Spoke with Doctor on ward round on 25/12/19 and stated that patient had not received a dose of metformin on 24/12/19 at 1800 hours. Nil ordered at time and to monitor Blood sugars at present same handed over to staff. With regards to missed dose on 25/12/19. Doctors informed on ward on 28/12/19. Again nil ordered. Blood sugars stable and to continue to monitor same.Reflection pieces completed by both staff nurses on duty at the time of incidence. Record of discussion completed with one staff nurse still one to be completed with other staff nurse as not on duty at present. Medication observation carried out with one staff nurse still to carry out medication observation on one staff nurse as not on duty at present. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Failure to administer | minor | minor | possible | low |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information | 21/12/2019 | Acute Services | Surgery and Elective Care | Daisy Hill Hospital | Female Surgical /Gynae | Saturday morning pharmacy discharge for patient noted to be dossette contacted ward for sheet that is meant to come to pharmacy with discharges. Patient has already been discharged and no member of staff knew patient. Contacted Dr who wrote prescription Personal Informatio he did not know patient but was asked to write prescription as patients relatives were returning to ward for medication. | Fluclox acillin | | advised dr this was unsafe and no one on ward knew patiet. Contacted bed manager P Brown who kindly took details and contacted daughter. Daughter was under impression she was getting a dossette today but would administer medications if supplied in skillets for few days. Several mistakes on prescription flucloxacillin prescribed daily (should be QID) and other medications unclear if held etc. | Insignif icant | Patient Inciden ts | Medic ation/ Biolog ics/Fl uids | Prescribin g Processes | Incorrec t frequen cy of dose | insignifica | minor | possible | low |
| Personal Information | 04/12/2019 | Acute Services | Surgery and Elective Care | Craigavon Area Hospital | Theatre s 1-4 CAH | Levo thyroxine prescribed by me and given to patient in the elective admission ward. Patients kardex was lying in other patients notes who was on levothyroxine. | Levoth yroxin e | | Datix, full explanation to patient and ward staff and surgeon informed. | Insignif icant | Patient Inciden ts | Medic ation/ Biolog ics/Fl uids | Prescribin g Processes | Incorrec t patient | insignifica | insignifica | possible | low |
| Personal Information | 14/12/2019 | Acute Services | Surgery and Elective Care | Craigavon Area Hospital | Trauma Ward | Gave patient 150mg of Maxi tram instead of the dose 100mg written on Kardex. unaware was to be documented through CD book and no double signature documented. was unaware Maxi tram was classified as a CD on the ward. | Trama dol | Trama dol | when error was noticed NIC informed. documented in CD book with my own signature and patient has been stable throughout. NEWS stable. Patient asymptomatic. Reflection and IR1 complete. | Minor | Patient Inciden ts | Medic ation/ Biolog ics/Fl uids | Administr ation to Patient | Incorrec t dose | minor | minor | possible | low |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information | 07/12/2019 | Acute Services | Surgery and Elective Care | Daisy Hill Hospital | High Dependency Unit | Patient prescribed Monofer Iron infusion to be given over 30minutes to treat low Hb, infusion commenced at a slower rate, within minutes patient became unwell, displaying signs of reaction, immediate flushing, chest tightness, short of breath and finding it difficult to breathe. | monofer | monofer | Infusion stopped immediately, Nurse in Charge called for, Surgical FY1 present on ward who attended to assess patient, oxygen applied, anaphylaxis kit brought to bedside. Nil else requested, anaphylaxis kit not required as patient symptoms self terminated when infusion stopped. | Insignificant | Patient Incidents | Medication/ Biologics/Fluids | Post-administration Patient Monitoring | Adverse drug reaction | Adverse drug reaction | |

| ID | Incident date | Directorate | Division | Site | Loc (Exact) | Description | Drug administered | Correct drug | Action taken | Consequence | Incident affecting | Incident type tier one | Incident type tier two | Incident type tier three | DHSSPS impact | DHSSPS potential | DHSSPS likelihood | DHSSPS risk rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information | 01/12/2019 | Acute Services | IMWH - Cancer and Clinical Services | Craigavon Area Hospital | 1 East Maternity/Gynae | PATIENT ON WARFARIN FOR AF. YESTERDAY EVENING DOSE NOT GIVEN | Warfain | Warfain | IMFORM Dr AND INR SENT TO LABS | Minor | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Failure to administer | minor | minor | possible | low |
| Personal Information | 19/12/2019 | Acute Services | IMWH - Cancer and Clinical Services | Craigavon Area Hospital | Oncology Clinic, Mandeville Unit | SIDE ARM OF GIVING SET CONTAINING CHEMO ATTACHED TO TOP PORT AND NOT BOTTOM PORT, HENCE ONLY 1 CHEMO INFUSED, OTHER CHEMO FAILED TO INFUSE. WHEN NOTICED ONCOLOGISTS INVOLVED IN PATIENT'S CARE STATED THAT TO CONTINUE WITH INFUSION AS PATIENT HAPPY TO PROCEED WITH SAME. ONCALL PHARMACIST CONTACTED WHO ALSO STATED THAT IT WAS ENTIRELY SAFE TO INFUSE REMAINING CHEMO INFUSION AS PX OVER SAME TIME. PATIENT VERY UNDERSTANDING AND HAPPY TO GET REMAINING CHEMO TREATMENT. WIFE PRESENT AND INFORMED ALSO. | Irinotecan | Irinotecan | ONCOLOGISTS DR HARTE AND DR PARKE MADE AWARE AND HAPPY TO PROCEED WITH TREATMENT | | Patient Incidents | Medication/ Biologics/Fluids | Administration to Patient | Failure to administer | insignifica | minor | possible | low |
| Personal Information | 20/12/2019 | Acute Services | IMWH - Cancer and Clinical Services | Daisy Hill Hospital | Maternity Ward | sevredol 10mgs noted to be missing at1730 when checking in new box of sevredol received from pharmacy | Morphine | Morphine | informed sr in charge who contacted supervisor staff who went of duty contacted, and on call pharmacy contacted.Policy followed | Minor | Patient Incidents | Medication/ Biologics/Fluids | Storage Processes (in pharmacy or on unit) | Controlled drug register discrepancy | Controlled drugs | | | |

Medication incidents CCS2

| ID | Incident date | Directorate | Division | Site | Loc (Exact) | Description | Drug administered | Correct drug | Action taken | Consequence | Incident affecting | Incident type tier one | Incident type tier two | Incident type tier three | DHSSPS impact | DHSSPS potential | DHSSPS likelihood | DHSSPS risk rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information | 10/12/2019 | Acute Services | Pharmacy | Craigavon Area Hospital | Pharmacy Dispensary | final checking JAC order for a ward. Peppermint oil 0.2ml Enteric coated capsules were ordered and labelled as per order. the MR peppermint oil (Colpermin)was dispensed | Peppermint Oil | Peppermint Oil | technician redispensed correct one. | | Patient Incidents | Medication/ Biologics/Fluids | Dispensing Processes | Incorrect medication/fluid | insignifica | minor | possible | low |
| Personal Information | 12/12/2019 | Acute Services | Pharmacy | Daisy Hill Hospital | Renal Clinic | Patient d/c from RVH on pre-admission 8.75mg Bisoprolol. (ECR 5mg plus 3.75mg) On d/c 2.5mg and 1.25mg supplied Patient only taking 3.75mg - didn't know to take the new supply of 2.5mg and 1.25mg in addition to the 5mg POD | Bisoprolol | | Incidental finding after medication review Patient advised total daily dose 8.75mg | | Patient Incidents | Medication/ Biologics/Fluids | Medication advice | Unclear advice | BHSCT incident | | | |
| Personal Information | 21/12/2019 | Acute Services | Pharmacy | Craigavon Area Hospital | Pharmacy Dispensary | Medications transferred from pharmacy dept CAH. CD box received and on opening with second member of staff it was noted that the bag containing the bottle of Morphine Sulphate Oral Solution was damp and the label on the bottle also. The cap was not securely on and a purple plug also in situ | Morphine | Morphine | The label on the bottle stated there was 30mls of oral solution in the bottle. A syringe was used and observed by two trained staff to measure the bottle, the lid was not on securely with a purple cap in situ and the amount of solution amounted to 26mls therefore 4mls of spillage/leakage has occurred. | Minor | Patient Incidents | Medication/ Biologics/Fluids | Dispensing Processes | Damaged/contaminated product | Controlled drugs | | | |

CCS - Divisional, Hos & Team Risk Register December 2019
By Owner

| ID | Opened | Title | Risk level (current) | Ref | Register Holding |
|---|---|---|---|---|---|
| Personal Information redacted by the USI | 28/02/2019 | SyngoVia imaging software is not covered by service contract. | HIGH | | DIV |
| | 03/09/2012 | 62 Day Cancer Performance | MOD | | DIV |
| | 24/10/2016 | AHP Capacity Deficit for Acute Oncology Staff | LOW | | DIV |
| | 16/12/2019 | Serious concerns highlighted following Peer Review visit of Systemic Anti - Cancer Treatment Service (SACT) November 2019. | MOD | | DIV |
| | 07/08/2019 | Lone Worker in Radiography | LOW | JR | DIV |
| | 03/01/2018 | Lone Worker in Laboratory | LOW | | DIV |

Received from SHSCT on 05 May 2023.  Annotated by the Urology Services Inquiry.

**FSS - Divisional HOS & TEAM Risk Register December 2019**
**By Owner**

| ID | Opened | Title | Risk level (current) | Ref | Register Holding |
|---|---|---|---|---|---|
| Personal Information redacted by the USI | 13/12/2016 | Car Parking and Traffic Management Problems DHH | MOD | | DIV |
| | 24/09/2019 | Non Destruction of Patient Records due to Infected Blood Inquiry | MOD | | DIV |
| | 20/08/2019 | No electronic interface between SSD instrument tracking systems and TMS | LOW | | DIV |
| | 20/08/2019 | Lack of Long Term Contingency for Laundry Dept | LOW | | DIV |
| | 20/08/2019 | Aging Decontamination Equipment | LOW | | DIV |
| | 11/06/2019 | Incomplete ED flimsy records | MOD | HF | DIV |
| | 11/06/2019 | Discharge letters not being completed | MOD | HF | DIV |
| | 11/06/2019 | Results not signed off on the wards | MOD | HF | DIV |
| | 20/11/2019 | Incomplete Consultant of the Week Rota or Consultants not recorded on PAS | MOD | HF | DIV |
| | 11/06/2019 | Breakdown of mobile bays in Health Records | LOW | HF | DIV |
| | 19/11/2018 | Typing backlogs for secretarial areas | MOD | KR | DIV |
| | 15/08/2017 | Backlog of filing in Obs and Gynae | MOD | KR | DIV |
| | 04/01/2016 | Dermatology Office Risks due to file storage issues | MOD | KR | DIV |
| | 09/12/2019 | Consultants Recruited without communication to relevant Admin Management Staff | MOD | KR | DIV |
| | 23/05/2016 | Falls from height DHH | MOD | MJ | DIV |
| | 25/09/2018 | Ineffective monitoring by current CCTV System CAH | LOW | MJ | DIV |
| | 25/09/2018 | Ineffective monitoring and reduced IT security of CCTV System on network DHH | MOD | MJ | DIV |
| | 16/05/2012 | Actichlor plus | LOW | MJ | DIV |
| | 04/01/2016 | Falls from height CAH | MOD | MJ | DIV |
| | 08/03/2016 | Waste Management South Tyrone Hospital | LOW | MJ | DIV |
| | 13/04/2016 | Waste Storage and Handling CAH | MOD | MJ | DIV |
| | 27/02/2018 | Use of 2 Work neutral detergent which is classified as 'Corrosive' without eye protection | MOD | MJ | DIV |
| | 28/08/2018 | Risk of injury when cleaning fixed beds in Bluestone | MOD | MJ | DIV |
| | 28/11/2012 | Car Parking and Traffic Management problems CAH | MOD | MJ | DIV |
| | 26/11/2012 | Risk of vulnerable patients contracting E coli 0157 from very low levels of contamination of ready to eat foods | LOW | MJ | HOS |
| | 26/06/2013 | Internal Bleep System Failure | LOW | SMcL | DIV |
| | 20/07/2016 | Lack of Emergency Major Incident Planning Software | MOD | SMcL | DIV |
| | 26/06/2013 | Risk of Telecoms Failure Across CAH, SLH, STH, and LH | LOW | SMcL | HOS |

**IMWH - Divisional, HOS & TEAM Risk Register December 2019**
**By Owner**

| ID | Opened | Title | Risk level (current) | Ref | Register Holding |
|---|---|---|---|---|---|
| Personal Information redacted by the USI | 11/06/2019 | Unacceptable waiting time for Urodynamics Appointments | MOD | | DIV |
| | 11/06/2019 | Reduced capacity of Fertility Clinic | LOW | | DIV |
| | 13/06/2012 | Trium archiving system CAH & DHH | LOW | | DIV |
| | 20/11/2018 | Unable in DHH to implement recommendation Re "Saving babies lives" | MOD | | DIV |
| | 11/06/2019 | Trophon system not in use in all relevant areas | LOW | | DIV |
| | 14/08/2019 | Midwifery Staffing Levels throughout SHSCT sites | HIGH | | DIV |
| | 15/10/2019 | Accomodation for Antenatal/Postnatal Clinics at Ballygawley Health Centre | LOW | | DIV |
| | 05/11/2019 | Limited Security in Admission & Assessment Unit and Maternity Outpatient Department CAH | LOW | | DIV |
| | 12/11/2019 | Security of Lone Workers on Night Duty in AAU CAH | LOW | | DIV |
| | 14/08/2019 | Home Births Risk if Emergency and required Urgent Ambulance Transfer | LOW | | DIV |
| | 26/06/2019 | Possibility of Breach of Patient Confidentiality as records are hand held | LOW | | DIV |
| | 07/08/2019 | Lack of fetal monitoring capability during transfer to main theatre from delivery suite. | LOW | JMcG | DIV |
| | 04/12/2019 | Waiting times for Colposcopy appointments | MOD | WC | DIV |

Received from SHSCT on 05 May 2023. Annotated by the Urology Services Inquiry.

**MUC - Divisional, HOS and TEAM Risk Register December 2019**
**By Owner**

| ID | Opened | Title | Risk level (current) | Ref | Register Holding |
|---|---|---|---|---|---|
| Personal Information redacted by the USI | 19/11/2018 | Delays in seeing Dermatology Red Flag Referrals at Outpatients | MOD | KC | DIV |
| | 19/11/2018 | Dermatology delays in patients having day case procedures | MOD | KC | DIV |
| | 31/07/2018 | Risk to Staff of Assault on Medical Wards/Areas | MOD | KC,LD,K McG | DIV |
| | 19/11/2018 | Unable to see new and Review Respirtaory patients at out patient clinics in a timely manner | MOD | KC | DIV |
| | 19/11/2018 | Unable to see Cardiology new and review patients in a timely manner | MOD | KC | DIV |
| | 19/11/2018 | Unable to see new and review Dermatology patients within the access target time of 9 weeks | MOD | KC | DIV |
| | 19/11/2018 | Unable to carry out Cardiac Catherisation procedures in a timely manner | MOD | | DIV |
| | 21/12/2016 | Lack of consultation rooms in Renal OPD | MOD | KC & MH | DIV |
| | 24/10/2013 | Overcrowding in Emergency Department CAH & DHH. | MOD | | DIV |
| | 08/06/2015 | Lack of pharmacy cover. | MOD | KC | DIV |
| | 08/06/2015 | Lack of junior medical cover | MOD | KC | DIV |
| | 08/06/2015 | Medical equipment in Cardiac investigations are old and some parts unable to be replaced | MOD | KC | DIV |
| | 08/06/2015 | Decontamination of TOE probe | MOD | KC | DIV |
| | 26/01/2016 | Diabetic Antenatal Clinic Risk | MOD | LD | DIV |
| | 30/04/2019 | RPC Guideline for TIA Management not achievable | VLOW | CMcG | DIV |
| | 05/08/2019 | Lack of Capacity in CAH and DHH | MOD | LD | DIV |
| | 05/08/2019 | Nursing posts not fully funded in DCC/Discharge Lounge | MOD | LD | DIV |
| | 12/08/2019 | Staffing for Telemetry System, Cardiac Monitoring | MOD | CC | DIV |
| | 12/08/2019 | Unable to see New and Review Gastroentorlogy, Rheumatology, Neurology, Diabetic & Endocrine patients at Outpatient Clinics in a | MOD | LD | DIV |
| | 07/08/2019 | Delays in seeing Red Flag Referrals for Gastroenterology | MOD | LD | DIV |
| | 07/08/2019 | Gastroentorology,Rheumatology and Endocrine delays in patients having day case procedures | MOD | LD | DIV |
| | 19/09/2017 | Gastoenterology/IBD Nurse Cover | MOD | LD | DIV |
| | 13/11/2017 | Cardiac CT angio, high demand | MOD | | DIV |
| | 13/11/2017 | Haemtology/Oncology Helpine provision in the out of hours period | MOD | KC | DIV |
| | 25/02/2016 | 1:1 special staffing not available when required | MOD | LD | DIV |
| | 29/11/2016 | Increased patient confusion when moved continually around wards | MOD | KC | DIV |
| | 05/12/2014 | Lack of a Biologic Suite CAH & DHH | MOD | | DIV |
| | 05/12/2014 | Clinical mangement of Medical Outliers. | MOD | | DIV |
| | 05/12/2014 | Increasing patient dependency impacting upon ward staffing. | MOD | KC | DIV |
| | 07/08/2008 | Insufficient beds in the system and high bed occupancy | LOW | MB | DIV |
| | 19/10/2009 | No contingiency plan in place in event of cardiac catheterisation lab failing. | HIGH | KC | DIV |
| | 29/11/2011 | File Management Issues- Hospital Social Work Department, CAH. | LOW | FF | DIV |
| | 24/05/2017 | Unable to achieve Training Objectives | LOW | | DIV |
| | 18/04/2019 | Discharge letters not completed for patients who attended the Day Clinical Centre for treatment. | LOW | | DIV |
| | 20/11/2019 | Fraud Awareness Possible non-compliance | LOW | KC | DIV |

| ID | Opened | Title | Risk level (current) | Ref | Register Holding |
|---|---|---|---|---|---|
| Personal Information redacted by the USI | 22/10/2009 | Transfer of patients with unstable neck injuries to the Regional Centre in Belfast | MOD | | HOS |
| | 08/09/2009 | Risk to health and safety of patients presenting to the trust with chest pain. CAH & DHH | LOW | | HOS |
| | 07/08/2008 | Risk of spread of infection due to inadequate facilities | LOW | MUC/08 | HOS |
| | 08/08/2008 | Safety and wellbeing of patients and staff due to lack of storage space | LOW | KC | HOS |

**Pharmacy Division**
**Directorate, Division, Head of Service and Team - Risk Register December 2019**

| ID | Opened | Principal objectives | Location (exact) | Title | Des/Pot for Harm | Controls in place | Progress (Action Plan Summary) | Risk level (current) | Register Holding |
|---|---|---|---|---|---|---|---|---|---|
| Personal Informati | 13/08/2008 | Safe, High Quality and Effective Care | Pharmacy | IV drugs reconstituted at ward level; risk of infection; risk of wrong dose, especially if many manipulations | IV drugs reconstituted at ward level; risk of infection; risk of wrong dose, especially if many manipulations. | IV drug manual rolled out through regional MI; FY1 induction training on preparation of intravenous medicines. regional preparation templates being developed for recognised red risk IV medicines - due Jan 2014. | Results of high risks identified fed back to the regional NPSA safety alert implementation group.<br><br>The Trust is complying with their recommendations as they are being issued to the service. Regional SOP's are being prepared.<br><br>A regional group of medicines information pharmacists has been set up to action this initiatives. | MOD | DIV |
| Personal Informati | 13/08/2008 | Safe, High Quality and Effective Care | Pharmacy | Discharge medication supplied directly from ward by nursing staff | Discharge medication supplied directly from ward by nursing staff; risk of dispensing error due to untrained and inappropriate staff; labelling - not in line with legislation; incorrect prescription now dispensed; 28 day supply; no clinical check. | Where possible all discharge prescription should be supplied by the pharmacy team; where this is not possible, supply directly from a ward must be carried out in accordance with an agreed procedure. Weekend and weekday opening hours extended to reduce frequency. | 17.10.17 Ongoing risk as pharmacy is not open 24/7 so some ward dispensing will still happen. Ongoing monitoring in place and ward staff encouraged to plan discharge in advance so this doesn't happen. | LOW | DIV |
| Personal Informati | 13/08/2008 | Safe, High Quality and Effective Care | Pharmacy | Manual handling risk associated with ward orders/fluids | Manual handling risk associated with ward orders/fluids. | Trained staff in Pharmacy; new ward stock trolleys purchased and being rolled out; rate-limiting step is availability of portering staff; boxes half filled only; risk by transport driver - assessed by Back Care Co-Ordinator; second porter now working in pharmacy; risk assessments done by S Kilpatrick; heavy work shared by technical staff; following injuries some staff on light duties - increased load on other staff; roll cages ordered for ward direct delivery to reduce lifting and handling loads. | 16.10.17 Ongoing risk in pharmacy due to the manual nature of some of the work in the stores areas. Ongoing monitoring and staff training in place. | LOW | DIV |
| Personal Informati | 13/08/2008 | | Pharmacy | Security of drugs during transit to other hospitals | Security of drugs during transit to other hospitals; are vans locked when left unattended?; no signatures for receipt of drugs when sent with transport other than pharmacy driver. | Tamper evident seals on all boxed (but not for supplementary orders). Transport manifest now introduced - including signatures for delivery driver and for staff receiving goods on delivery. | 17.10.17 Ongoing risk being monitored by the Pharmacy dispensary and store teams | LOW | DIV |
| Personal Informati | 14/08/2008 | Safe, High Quality and Effective Care | Pharmacy | No formal assessment of competency for clinical checking | No formal assessment of competency for clinical checking. | Trained staff, e.g. pharmacist/registered; department standards issued to all staff; experienced staff; clinical checking guidelines in place. Now part of VT training for band 6's and peer review being considered | Clinical checking procedures need to be developed for pharmacists. | VLOW | DIV |
| Personal Informati | 14/10/2013 | | | Clinical pharmacy cover for Trust wards | Only 50% of Trust wards have a full clinical service and there is no clinical cover on wards at the weekends. This is resulting in poor drug history taking, no clinical checks of Kardex and/or discharge prescriptions - thus increasing the risk to patient safety as medication incident may go undetected and result in patient harm. | All new IPTs for expanding services have clinical pharmacy support included. Pharmacy skill mix has been reviewed to ensure the maximum service is provided with current staffing. Current maternity leave and recruitment issues have again increased the risk. | 16.10.17 Risk remains unchanged | MOD | HOS |
| Personal Informatio | 13/08/2008 | Safe, High Quality and Effective Care | Pharmacy | Flammabile load in pharmacy too high; risk of fire | Flammabile load in pharmacy too high; risk of fire. | Discussed with Fire Safety Officer; store as much as possible in flammable cupboards; looked for alternative storage - old store re-proofed and most flammables have been moved out there; flammable cupboards in pharmacy moved to more suitable location. | 17.10.17 Old CAH store has been replaced with a modern bunded flammable store remote from the hospital building. Pharmacy staff continue to monitor fire load within both the pharmacies. | VLOW | TEAM |

**SEC/ATICS - Divisional, HOS and TEAM Risk Register December 2019**
**By Owner**

| ID | Opened | Title | Risk level (current) | Ref | Register Holding |
|---|---|---|---|---|---|
| Personal Information redacted by the USI | 30/11/2015 | Paediatric Patients treated in 3 South ENT treatment room - cannot guarantee nurses with upo to date paediatric training. | LOW | | DIV |
| | 15/10/2016 | Inpatient / Daycase Planned Backlog | HIGH | | DIV |
| | 15/10/2016 | Inpatient / Daycase Planned Backlog for Endoscopy | HIGH | | DIV |
| | 12/04/2019 | Access Times (Outpatients) - General (not inclusive of visiting specialties) | HIGH | | DIV |
| | 12/04/2019 | Access Times (In-patient/Day Case) - General | HIGH | | DIV |
| | 19/08/2016 | Demand of fracture referrals outweighs fracture capacity. | HIGH | | DIV |
| | 19/08/2016 | Due to the move down from level 6 to outpatient department to the current OPD accommodation is not suitable to sustain numbers. | HIGH | | DIV |
| | 27/05/2016 | Nurse Recruitment for Adult and Paed theatres | MOD | | DIV |
| | 24/02/2016 | Despite refurbishment of ward areas this financial year, due to winter pressures all work was not completed | MOD | | DIV |
| | 27/05/2016 | Anaesthetic cover for maternity services | MOD | | DIV |
| | 12/12/2017 | Discontinuation of guaranteed Service for Drager Oxylog Ventilators | MOD | | DIV |
| | 01/09/2015 | No equipment store available in Day Surgery Unit CAH | MOD | | DIV |
| | 19/11/2018 | Agency nursing staff not trained to SHSCT protocols | HIGH | | HOS |
| | 27/05/2016 | JAG Accreditation | MOD | | HOS |
| | 27/05/2016 | Post op Surgical Pts in the Recovery Ward | MOD | | HOS |
| | 27/05/2016 | Pre Op Assessment | MOD | ATICS | DIV |
| | 28/07/2008 | STH Theatres and Day Procedure Unit requires UPS/IPS syste, | HIGH | CCS/ATICS 28 | HOS |
| | 07/03/2017 | Patients requiring review at Breast Family History Clinic | MOD | | TEAM |

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Southern Health and Social Care Trust

# Incident Oversight Group

**Tuesday 29th September 2020, 5:00pm**

**Via Zoom**

## AGENDA

| No | Item | Documents |
|---|---|---|
| 1 | Apologies | |
| 2 | Review of Action Log | Attached to email |
| 3 | Update on Communications with PHA / HSCB / DoH | |
| 4 | Any Other Business | |
| 5 | Date of Next Meeting 6th October 2020 | |

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# Incident Management

| ID | Element | Actions Required | Responsible | Date for Completion | Attachments | Complete |
|---|---|---|---|---|---|---|
| 1 | GMC Request for Information 27th July 2020 | GMC Response issued, further update information required regarding patient notes for original 5 SAIs | M Corrigan / S Wallace | 27th August | Response attached<br>4CA5AFA5.msg | Complete |
| 2 | MHPS Investigation (New) | AOB is no longer professionally accountable to the SHSCT and Dr O'Kane is not responsible officer - this has been the case since 29th July 2020.<br><br>Response from AOB solictor 9th September stating that as MHPS did not start prior to AOB's retirement that there are no grounds for continuing the process. DLS advice has been dou on AOB solictor communcation. DoH have also advised that given AOBs retirement MHPS should not be followed | M O'Kane / S Hynds / S Wallace | 30th September | | In progress |
| 3 | Administration Review | Dr Rose McCullagh and Dr Mary Donnelly are conducting an administrative process review as specified in the 2018 MHPS review outcome. Report due to be presented to the Director of Acute Services. Matina Corrigan to check progress with with the team. | R McCullagh / M Donnelly | 30th September | | In progress |
| 4 | Screening of potential SAIs<br>- Service User A<br>- Service User B<br>- Service User C<br>- Service User D<br>- Service User E<br>- Service User F<br>- Service User G | Four SAIs screened, (Service Users A, B, C and D). Further 3 cases to be screened | M Haynes / M Corrigan / P Kingsnorth | 15th September | SAI Screening complete - 3 confirmed SAIs - clinical summaries<br>\\svrfile11\users6$\stephen.wallace\Desktop\New<br>\\svrfile11\users6$\stephen.wallace\Desktop\New<br>\\svrfile11\users6$\stephen.wallace\Desktop\New | In progress |
| 5 | Communication with Service Users / Families | S Wallace / P Kingsnorth to discuss potential content of family communications with Jane McKimm. Further discussion with PHA / HSCB re approach also required on coordinated approach across all communications | M Haynes / P Kingsnorth / S Wallace / J McKimm | 30th September | | In progress |
| 6 | Conducting SAIs | Dermot Hughes has been appointed to lead on the SAI work. Initial meeting to occured 10th September to discuss format of engagement and process for conducting SAI reviews. Hugh Gilbert identified as SAI Subject Matter Expert for SAI | S Wallace / P Kingsnorth | 10th September | | Complete |
| 7 | Engagement of ISP to undertake waiting list work | Draft contract engagement document under development - pathways for service access to be mapped | M Haynes / M Corrigan | 15th September | Pathways under development | In progress |

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| | | | | | | |
|---|---|---|---|---|---|---|
| 8 | Review Scope | *Action plan to review key areas of concern developed by Urology Team<br>- Review of stent removals Jan 2018 - Dec 2019<br>- Review of elective activity Jan 2018 - Dec 2019<br>- Review of diagnostic results Jan 2019 to August 2020<br>- Review of Radiology requests Jan 2018 - August 2020<br>- Review of MDM episodes (circa 1100) Jan 2018 - August 2020<br><br>* Requirement to identify review lead both for administration and clinical input<br>* Requirement to identify follow up of any concerns identified<br>* Meeting with Urologists to take place to discuss how workload should be managed | M McClements / M Haynes / M Corrigan / R Carroll | 1st September | | In progress |
| 9 | Clinician Early Alert | M O'Kane / S Wallace to discussed Clinician Early Alert with DoH. DoH advised that informal communication with other Trust MDs and HRODs would be appropriate | Dr Maria O'Kane / S Wallace | 30th September | | |
| 10 | AOB work at other Trusts | To identify if AOB conducted sessions at other Trusts outside of SHSCT employment | M McClements / R Carroll / M O'Kane / S Wallace | 15th September | Preliniary enquries have not identified any addional sessional work directly with other regional Trusts | No |
| 11 | Dicussion with AOB secretary to understand Administrative processes | K Robinson / A Carroll discussed admin processes with AOB secretary. MMcC to discuss further to ascertain if any changes have been made to records following AOB retirement | M McClements / M Corrigan | 15th September | | No |
| 12 | Telephone Support Service | Telephone Support Service developed | M McClements / R Carroll / M Corrigan / M Haynes | 15th September | | |
| 13 | Copies of Patient Records (Service users A and B) to be provided to AOB) | Copies of notes to be sourced, copied and redacted | M Corrigan | 7th August | Redaction of notes being completed 7th August, viability of electronic sharing of notes to be considered | Complete |
| 14 | Early Alert to DoH | Early Alert issued to DoH and HSCB | Dr Maria O'Kane / S Wallace | 31st July | Early Alert issued to DoH and HSCB. Phone contact made from Dr O'Kane to Deputy CMO 6th August 2020 | Complete |
| 15 | Information on Appraisal, Job Planning and Complaints | Information on apprisal, job planning and complaints collated | S Wallace | 7th August | Information Collated - saved in shared folder | Complete |
| 16 | Incident Governance Oversight | Terms of reference developed - for agreement by oversight group / SMT CX | Dr Maria O'Kane / S Wallace | 10th August | ToR Paused | Complete |

## Kelly, Elaine

**From:** Wallace, Stephen
**Sent:** 17 August 2020 16:08
**To:** Chris Brammall [redacted]
**Cc:** Joanne Donnelly [redacted] OKane, Maria
**Subject:** RE: General Medical Council - Mr O'Brien Encryption
**Attachments:** 2020817_LtrGENERAL MEDICAL COUNCIL - MR AIDAN O'BRIEN GMC NO. [redacted].pdf; Appendix 3 (i) The Northern Ireland Cancer Network.pdf; Appendix 3 (ii) Revised Prostate Diagnostic Pathway December 2019.pdf; Appendix 4 (i) Service User A Notes.pdf; Appendix 4 (ii) Service User B Notes.pdf; Appendix 1 (i) Job_Plan_View_-_Mr_O'Brien,_Aidan_-_01_Apr_2018.pdf; Appendix 1 (ii) Job_Plan_View_-_Mr_O'Brien,_Aidan_-_01_Apr_2013.pdf; Appendix 2 Report to HSCB 29.5.2020.pdf

Dear Chris,

Please find attached letter from Dr Maria O'Kane re below request, this has been issued with encryption protection. Please let me know if you have any difficult in accessing.

Please do not hesitate to contact me directly if you have any queries.

Best regards
Stephen

[redacted]

From: "Chris Brammall [redacted]
Date: Jul 27, 2020 2:45 PM
Subject: General Medical Council - Mr O'Brien
To: "OKane, Maria" [redacted]
Cc: "Joanne Donnelly [redacted] >,"David Horkin [redacted] >,"Syed Ahmed [redacted]

Dear Dr O'Kane, after some discussions about Mr O'Brien and the information that you have already sent to us I have been asked to contact you again to obtain some additional information. I do appreciate that this is a lot of information that we are requesting and can confirm that we would be happy to receive this 'piecemeal' if this makes it easier to collate the information.

Please would it be possible for you to send me:

- A copy of Mr O'Brien's job plan
- Any update that you may have about contacting the RCS for advice on the parameters of a possible lookback / patient recall exercise and information that may have arisen out of any review
- An update about the new MHPS investigation that was being considered due to the additional concerns about Mr O'Brien that arose recently
- Any updates concerning the SAI reviews for the following patients identified in the information originally sent to the GMC (if SAIs have been completed, please could you provide copies of these?):
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
- Any updates concerning the SAI reviews for service user A and service user B as identified in the new concerns that were recently sent to the GMC



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- Any data that you may hold for comparison purposes regarding the triage process and Mr O'Brien's peers (for example, any audit data / data gathered in relation to other urology consultants) in relation to patients who may have been mistriaged
- The outcome (or a copy of) the independent review into the administrative procedures that is due to be concluded by September 2020 (when this becomes available)
- Any guidance or protocols that were put in place for the urology department in terms of triaging incoming referrals using the three tier system and how this was shared with the urology consultants including Mr O'Brien
- The relevant medical records for service user A and service user B as identified in the more recent concerns. I do understand that these are currently subject to screening for advancement as potential Serious Adverse Incidents but, please would it be possible to provide copies of the records to me by **17 August**?
- The relevant medical records for the following patients as identified in the concerns originally sent to the GMC. Please could these be sent to me by **17 August**?
  - Patient 10
  - Patient 14
  - Patient 11
  - Patient 13
  - Patient 12
- Please could you provide details of the circumstances of the cancellation of the meeting in September 2018 and the lack of senior management availability in December 2018 including details of any plans that were put in place for Mr O'Brien / other consultants to raise their concerns to senior management (this relates to Mr O'Brien's statement that: '*In 2018, following discussion amongst our colleagues, it was agreed that we would set aside a whole day, Monday 24 September 2018, to meet with senior management to discuss this very issue, among others. We were requested to submit those issues which we wanted to have discussed (I have separately attached my submission). No clinical commitments were arranged for that day. The meeting was cancelled, with loss of all clinical activity that could have been scheduled. The meeting was rescheduled for Monday 03 December 2018, again with no clinical commitments scheduled. No senior management personnel could attend.'*

Please could you send me the information that is currently available by **17 August 2020**, in particular the medical records for the patients listed above? I am on leave from 31 July and return to the office on 17 August so if you are able to send any responses during this time, please could you also send these to Joanne Donnelly Personal Information redacted by the USI, David Horkin Personal Information redacted by the USI and Syed Ahmed Personal Information redacted by the USI

Many thanks for your continued help Dr O'Kane

Chris Brammall
Investigation Officer
General Medical Council
3 Hardman Street, Manchester, M3 3AW

Email: Personal Information redacted by the USI
Website: www.gmc-uk.org
Telephone: Personal Information redacted by the U

Working with doctors Working for patients

The General Medical Council helps to protect patients and improve medical education and practice in the UK by setting standards for students and doctors. We support them in achieving (and exceeding) those standards, and take action when they are not met.

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General Medical Council

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The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750)



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Southern Health and Social Care Trust

*Quality Care - for you, with you*

17th August 2020 Ref: MOK/ec

**Via email** [redacted]

Chris Brammall
Investigation Officer
General Medical Council
3 Hardman Street,
Manchester

Dear Mr Brammall,

**RE: GENERAL MEDICAL COUNCIL - MR AIDAN O'BRIEN GMC NO.** [redacted]

Further to your email dated 30th July 2020 requesting further information regarding concerns raised in relation to Mr Aidan O'Brien, Consultant Urologist employed by the Southern Health and Social Care Trust, please see below itemised responses and where required, attached items.

| | |
|---|---|
| **A copy of Mr O'Brien's job plan** | Copies of the last two electronic job plans that are held in our job planning system for Mr O'Brien are attached in Appendix 1. Please note that they were not signed off by Mr O'Brien. These were previously sent to the GMC in response to this communication by Zoe Parks on 30th July 2020. |
| **Any update that you may have about contacting the RCS for advice on the parameters of a possible lookback / patient recall exercise and information that** | The Trust has hosted a discussion with the Royal College Surgeons Invited Review Service on the 28th July 2020 which explored the options for and extent of any potential lookback should this be required. A follow up call was conducted on 4th August with the |

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: [redacted] Email: [redacted]

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| | |
|---|---|
| **may have arisen out of any review** | Royal College of Surgeons Head of Invited Review manager where potential scale and scope of a lookback was discussed.<br><br>The Trust will be discussing the potential for progressing with any lookback with the Department of Health over the next week. |
| **An update about the new MHPS investigation that was being considered due to the additional concerns about Mr O'Brien that arose recently** | The Trust has commenced preliminary enquiries in respect of the additional concerns which have now arisen under the MHPS Framework. Mr O'Brien's former clinical manager Mr Haynes, as Associate Medical Director, is the clinical manager co-ordinating preliminary enquiries under para 15 of Section I of MHPS. Mr O'Brien has been notified of this and a request has been made for his input to the preliminary enquiries process. A formal investigation has not been commenced at this point.<br><br>Mr O'Brien is seeking advices in respect of his engagement in the MHPS preliminary enquires process and the Trust awaits his decision in this regard, via his solicitor. |
| **Any updates concerning the SAI reviews for the following patients identified in the information originally sent to the GMC (if SAIs have been completed, please could you provide copies of these?):**<br>• Patient 14<br>• Patient 11<br>• Patient 13<br>• Patient 12 | The Serious Adverse Incident Reviews for the listed patients have been completed. Copies of the review which was provided in a consolidated single report can be found attached in Appendix 2. |



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| | |
|---|---|
| **Any updates concerning the SAI reviews for service user A and service user B as identified in the new concerns that were recently sent to the GMC** | Both Service User A and B have been screened and meets the requirement for a Serious Adverse Incident review and are being progressed as per regional and Trust processes.<br><br>Since our last update a third case, Service User C has also been identified as meeting the requirement for a Serious Adverse Incident review. |
| **Any data that you may hold for comparison purposes regarding the triage process and Mr O'Brien's peers (for example, any audit data / data gathered in relation to other urology consultants) in relation to patients who may have been mis-triaged** | The Trust does not have formal data on the triage comparison between Mr O'Brien and his peers. All incidents have been identified by exception; no other triaging related incidents have been identified with any other Urology Consultant. |
| **The outcome (or a copy of) the independent review into the administrative procedures that is due to be concluded by September 2020 (when this becomes available)** | The review of administrative procedures is underway and will be shared following completion in September 2020 at which point a copy will be shared with the GMC. |
| **Any guidance or protocols that were put in place for the urology department in terms of triaging incoming referrals using the three tier system and how this was shared with the urology consultants including Mr O'Brien** | The Trust do not use the three tier system for triaging but follow the Northern Ireland Cancer Network (NICaN) referral guidance, which is based on NICE guidelines. Appendix 3 show the prostate and bladder guidance for triage (which is usually updated every year) and which is shared and used by all urology consultants in Northern Ireland. |



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| | |
|---|---|
| **The relevant medical records for service user A and service user B as identified in the more recent concerns.** | Copies of Service Users A and B redacted notes are attached as Appendix 4. |
| **The relevant medical records for the following patients as identified in the concerns originally sent to the GMC.**<br>• Patient 10<br>• Patient 14<br>• Patient 11<br>• Patient 13<br>• Patient 12 | Copies of the patient will not be available until 24th August 2020 and will be forwarded following this. |
| **Please could you provide details of the circumstances of the cancellation of the meeting in September 2018 and the lack of senior management availability in December 2018 including details of any plans that were put in place for Mr O'Brien / other consultants to raise their concerns to senior management** | The meeting that was scheduled to take place between Urology Consultants and management in September 2018 was cancelled following the unexpected sickness absence of the Head of Service for Surgery. The Consultant body agreed that in the absence of the head of service the meeting should not progress.<br><br>The meeting scheduled for December 2018 did not progress as 3 of the 6 Consultant Urology staff were unable to attend. |

I trust this provides the necessary detail required. Should you have any queries, please do not hesitate to contact me.

Yours sincerely

Personal Information redacted by USI

**Dr Maria O'Kane**
**Medical Director**

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by the USI Email: Personal Information redacted by the USI

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**Northern Ireland Cancer Network (NICaN) referral guidance**

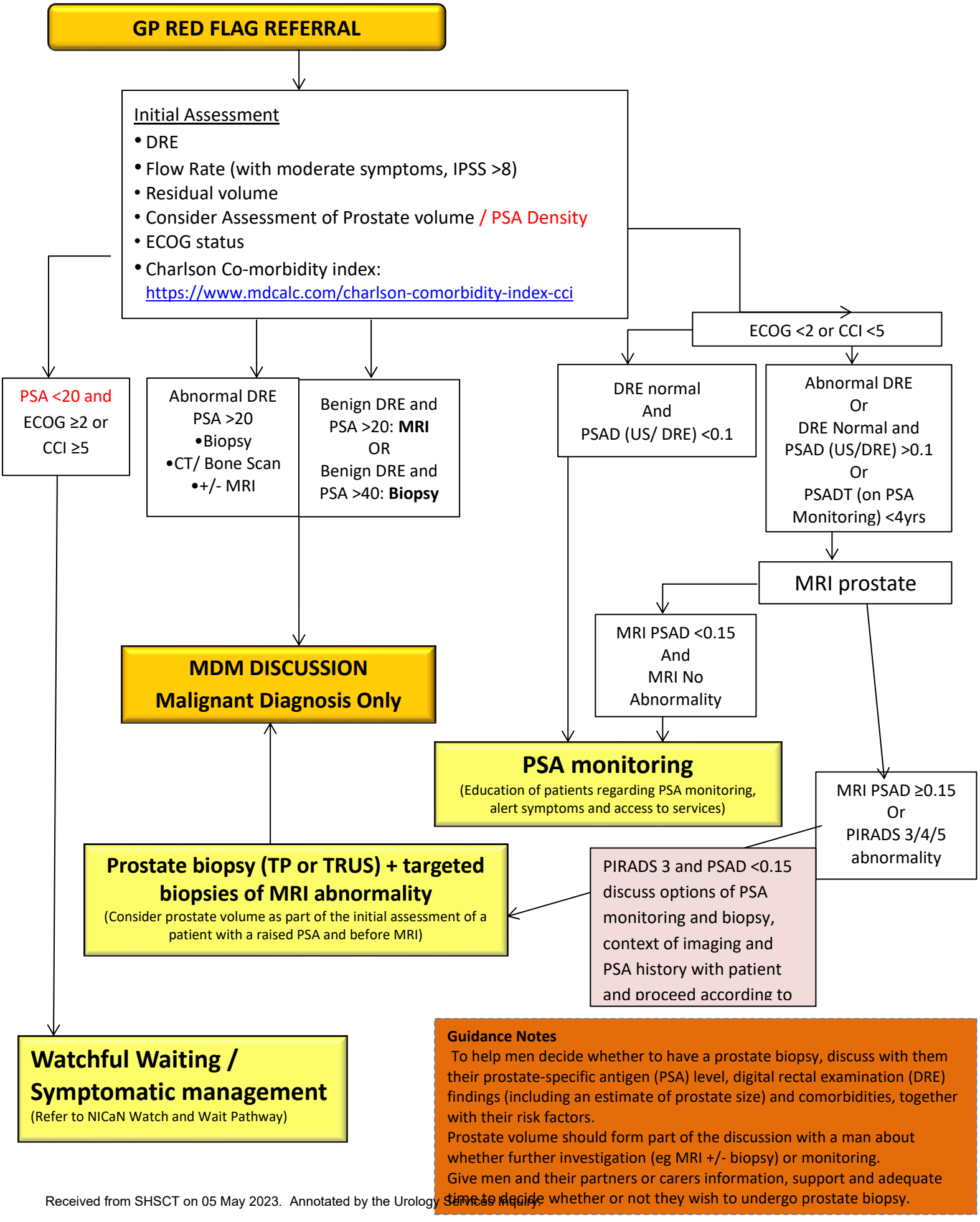
The Northern Ireland Cancer Network (NICaN) referral guidance issued in 2012 was informed by the NICE Referral Guidelines for Suspected Cancer 2005. NICE issued revised guidance, Suspected cancer: recognition and referral (NG12) in 2015 which sets out suspect cancer referral guidance for all cancers. The CRG recently undertook a review of the referral guidance for patients with suspect prostate cancer and proposed alternative guidance. Based on a review of other pathways across NHS England, HSE Ireland and considering evidence from the Prostate Cancer Risk Management Programme, Stockholm STHLM3 JNCI J National Cancer Institute 2016.

The revised guideline, whilst cognisant of the NICE recommendations, provides additional detail to help guide primary health care professionals in their decision making in relation to when to undertake PSA testing and when to refer patients as suspect cancer. The CRG completed a review of the Pre PSA Testing Advice leaflet given to patients by their GP and with the help of the NICaN Readers Panel updated this to ensure the information would offer the best advice to those who were considering having a PSA test. Pre-PSA Testing Advice Leaflet

The revised guidance has been approved by the NICaN Board, the HSCB and is supported by NIGPC: GP Suspect Prostate Cancer Referral Guidance Pathway Alongside the development of revised referral guidance for suspect prostate cancer the CRG is undertaken a review of the diagnostic pathway which is in the final stages of approval . This pathway will help navigate patients through the diagnostic pathway ensuring timely and appropriate investigations are completed to determine each patients treatment care plan.

Final Proposed Prostate Diagnostic Pathway December 2019

# NICaN SUSPECT PROSTATE CANCER DIAGNOSTIC PATHWAY




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SERVICE USER B

| | Date | Clinical Notes |
|---|---|---|
| → | 18.01.19 | Mr O Brien |
| Age | | Urology |
| URINE Protein | | PLAN |
| Sugar | | |
| Acetone | | |
| WEIGHT | | • MRV ? • DMSA |
| kg. | | • CPEX • ECHO |
| → | | • MDM |
| Age | | [redacted] |
| URINE Protein | | |
| Sugar | | |
| Acetone | | |
| WEIGHT | | |
| kg. | | |
| | 19.2.19 | PLAN |
| → | | |
| Age | | • RIGHT RADICAL NEPHRECTOMY |
| URINE Protein | | 06 MARCH 19 |
| Sugar | | [redacted] |
| Acetone | | |
| WEIGHT | | |
| kg. | | |
| → | | |
| Age | | |
| URINE Protein | | |
| Sugar | | |
| Acetone | | |
| WEIGHT | | |
| kg. | | |

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78/CA.2/1

# IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter i
Block Lette
Full Nam
Date of Bir
Unit No.
Ward/De
Address
Consultar

Personal Information redacted by the USI

NOTES

When used for In-patient follow-up ignore left-hand column

| Out-Patient Use Only | Date | Clinical Notes |
|---|---|---|
| → | 7/3/19 | TJW CONS Urology |
| Age | | |
| URINE Protein | | |
| Sugar | | |
| Acetone | – | DAY 1 Right Nephrectomy |
| WEIGHT | | |
| kg. | | |
| | – | ITU – Norcuronium |
| | – | Morphine |
| → | | – Mg 9X ⇒ |
| Age | | |
| URINE Protein | | |
| Sugar | | + DSD Syf. Dress Drains |
| Acetone | | |
| WEIGHT | | |
| kg. | | |
| | | (P) – Bloods – G+D – Chest Exercise / physio |
| → | | |
| Age | | |
| URINE Protein | | |
| Sugar | | |
| Acetone | | |
| WEIGHT | | |
| kg. | | |

LPC 03/08/021



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78/CA.2/1

# IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Personal Information redacted by the USI

NOTES

When used for In-patient follow-up ignore left-hand column

| Out-Patient Use Only | Date | Clinical Notes |
|---|---|---|
| → | 09/03/19 | Personal Information redacted by USI |
| Age | | |
| URINE Protein Sugar Acetone | | Day 1 Right nephrectomy. |
| WEIGHT kg. | | |
| | | ? stop Epidro |
| | Plan: | - Pain team review ✓ |
| | | - Keep drain until Monday. |
| → | | - ↑ oral fluids |
| Age | | - Chest physio |
| URINE Protein Sugar Acetone | | - Daily bloods. |
| | | C. A |
| WEIGHT kg. | 09/03/19 | Personal Information redacted by USI F1. |
| | | Hb 86(80) |
| | | ↓ WCC 10 (12) |
| | | Plt 179 (60) |
| → | | ↑ CRP 90 (54) |
| Age | | Na 136 (141) |
| URINE Protein Sugar Acetone | | K+ 4.8 (4.7) |
| | | ** eGFR 45 (>60) |
| WEIGHT kg. | | N.B. AKI. |
| | | Plan: fluids, encourage oral intake, medication review. |
| | | Personal Information redacted by USI |

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| | Date | Clinical Notes |
|---|---|---|
| → | 10/3/19 | Pre - Cons |
| Age | | |
| URINE Protein | | - feels well E+D ✓ |
| Sugar | | |
| Acetone | | - Told to Dr |
| WEIGHT | | - Epidural |
| kg. | | - Pain controlled |
| | | P - Anaest. - epidural review |
| → | | |
| Age | | |
| URINE Protein | | |
| Sugar | | |
| Acetone | 10/3/1 | [redacted] |
| WEIGHT | 18:00 | [redacted] |
| kg. | | Pain. |
| | | Pt keen to mobilise |
| → | | Open Nephrectomy on 6th March |
| Age | | |
| URINE Protein | | |
| Sugar | | |
| Acetone | | Epidural in situ D4 |
| WEIGHT | | - Pain free @ rest. |
| kg. | | - Regular paracetamol. |
| | → | Deep Breathing ✓ |
| | → | Sitting Out ✓ |
| → | → | E + D ✓ |
| Age | → | Ambulate ✓ |
| URINE Protein | → | Bowels x |
| Sugar | | Plan |
| Acetone | | |
| WEIGHT | ✱✱ | * Remove epidural tomorrow - enoxaparin held ✱✱. |
| kg. | | Tonight + tomorrow morning. |
| | | * Laxative. |
| | → | Contact if concerned. #1130 |
| | → | [redacted] #5177726. |

Contact pain team in morning to mobilise

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78/CA.2/1

# IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Personal Information redacted by the USI

NOTES

When used for in-patient follow-up ignore left-hand column

| Out-Patient Use Only | Date | Clinical Notes |
|---|---|---|
| → | | |
| Age | 11/3/19 | WP [redacted] |
| URINE Protein | | D2 nephrectomy |
| Sugar | | |
| Acetone | NEWO | eGFR 43 |
| WEIGHT | anyone | Hb 90 |
| kg. | | WCC 8.99 |
| | | drain 130 ml o/n |
| | | - feeb well |
| → | | |
| Age | | plan - bloods |
| URINE Protein | | - ? drain out tomorrow |
| Sugar | | |
| Acetone | | - TPOC |
| WEIGHT | | |
| kg. | | [redacted] |
| | | Hb 95 |
| | | wcc 8.3 |
| → | | U+E eGFR 50 (60) |
| Age | | CRP 68 (<5) |
| URINE Protein | | |
| Sugar | | |
| Acetone | | |
| WEIGHT | | |
| kg. | | |

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WPH000134

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