The initial review of paper records identified concerns regarding **11 cases**. These patients have been advised, clinical management plans are in place, and urgent issues actioned.

A further 236 oncology patients are being reviewed by an independent Urology consultant to ensure that their management plans and treatments are in line with guidance. These patients have been/are being contacted directly.

Have patients come to harm?

There are **nine cases** which are now part of a Serious Adverse Incident Review. A review of each of the **nine** patients care has been commissioned and is being led by an Independent Chair supported by a Consultant Urologist Expert. Each of these patients has been contacted by the Trust to inform them of the review process, arrangements have been made for patients in this group who need review appointments.

How will patients affected by this be notified?

Patients who have been identified as requiring review were contacted directly by the Trust as soon as issues with their care were identified.

Can the Trust reassure patients that the Urology service is safe, and that patients are receiving appropriate care?

Yes, our Urology team based in Craigavon Area Hospital provide care for thousands of patients each year and the current review is focused on a small proportion of these cases.

Have concerns previously been raised about this consultant

Part of the review process will look at all aspects of care provided, including a review of complaints received.

How many patients have been identified as potentially being affected?

To date the Trust review has identified **nine** patients that elements of their care require a Serious Adverse Incident review to take place. As the Trust review progresses there may be additional cases identified.

Have any of these patients died or been harmed as a result of being this doctor's patient?

The Serious Adverse Incident review process will seek to identify issues with the care provided to each patient to ascertain if harm occurred and what actions require to be taken to prevent this recurring in future.

Why hasn't the Trust identified the doctor involved?

The Trust has provided information regarding the doctor's identity to relevant professional and government agencies.

Is the doctor still working for the Trust?

The doctor is no longer working for the Trust or employed in Health and Social Care Services.

How long did this doctor work for the Trust?

The Doctor was employed by the Southern Health and Social Care Trust for 28 years.

Will this doctor face disciplinary or legal action as a result of this review?

The doctor is no longer an employee of the Trust therefore and future action would be the responsibility of the General Medical Council.

Will there be a PSNI investigation into this?

The remit of the review is to examine care provided by the Consultant using a chronological and incremental approach when reviewing the Consultants workload. This review is review in line with Department of Health, Public Health Agency and Health and Social Care Board processes.

Were any concerns raised about this doctor before the dates being looked at in this review i.e. before January 2019?

The General Medical Council are currently investigating professional aspects of the Consultants practice, an outcome will be provided by the General Medical Council in due course.

What action(s) were taken as result of these concerns?

As above

Will the Trust now review all patient care provided by this doctor to all patients during his employment at The Trust?

Any potential extension of the Trust review will be based on the outcomes of the current January 2019 to June 2020 review. A decision on this will be made in agreement with the Health and Social Care Board, Public Health Agency and Department of Health and will consider specialist advice from The Royal College of Surgeons.

Southern Health and Social Care Trust

Quality Care - for you, with you

Acute Clinical Governance and Social Care

MEETING WITH ACUTE DIRECTOR

Date: 27th February 2020

AGENDA

1.0	**SAI/ SEA reports** **8 SEA** **12 SAI plus 4 Maternity cases** **Complaints** [redacted] **– complaint reopened issue happened 6 years ago. There is certainly learning from this complaint.** **Responses – few outstanding – complaints officer will come up daily to action.** **Staff given 10 days to respond – followed up.** **MLA – up to date** **Ombudsman – up to date** [redacted] **– report** independant report [redacted] **few actions to be responded to – out with HOS.** **Process followed by Western Trust re: SAI process and review.** Rapid Review Group ToR.DOC RE Agenda RRG 13 February 2020 team
	1. Level 1 Report 20.01.2019 Patient.docx 1. Level 1 Report 20.01.2019 Patient.docx 1. Level 1 Report 20.01.2019 Patient 14.docx 1. Level 1 Report 20.01.2019 Patient 13.docx 1. Level 1 Report 20.01.2019 Patient.docx RCA 69120_Urology Report_5 cases_FINA

6.0	**AOB** **Dashboards- all ready for display and rolled out during teaching sessions. To be discussed at sister's meeting.**

THE PUBLIC SERVICES OMBUDSMAN (NORTHERN IRELAND) ACT 2016

MEMORANDUM TO A PERSON AGAINST WHOM A COMPLAINT IS MADE

1. A complaint has been made under the Public Services Ombudsman (Northern Ireland) Act 2016. The complainant has alleged that you took or authorised the action to which the complaint refers.

2. The object of this memorandum is to afford you the opportunity provided under Section 30 (3) of the Act to comment to the Ombudsman on any allegations contained in the complaint.

3. You are not obliged to offer any comment at this stage, but you should, in any case, complete and return to the Ombudsman the Notification slip below within three weeks of receiving this memorandum.

4. If you do decide to comment, you may do so either through your Chief Officer or directly to the Ombudsman at the address at the bottom of this memorandum, and either now or, if the investigation proceeds further, at a later stage in the investigation. If you decide to comment directly and at this stage, your comments should accompany the Notification slip.

5. A copy of the attached statement of complaint has been sent, in accordance with Section 30(3) of the Act, to the Chief Officer of your organisation.

Northern Ireland Public Services Ombudsman
Progressive House
33 Wellington Place
BELFAST
BT1 6HN

NOTIFICATION TO THE OMBUDSMAN BY A PERSON AGAINST WHOM A COMPLAINT IS MADE

To: The Northern Ireland Public Services Ombudsman
Progressive House
33 Wellington Place
BELFAST
BT1 6HN

Ref: Irrelevant information re

I have received the Memorandum and details of the complaint relating to the above case. Personal Information redacted by the USI

*1. I do not wish to comment directly to the Ombudsman at this stage.

*2. I attach my comments on the complaint.

(*Delete as appropriate)

Name:……..

Signed:……

Date:……

Northern Ireland
Public Services
Ombudsman

Provision of Clinical Advice for Northern Ireland

Background Information (to be completed by Investigating Officer)

erence name an num r : Irrelevant information Personal Information redacted by the USI

Agreement/Contract Reference:

Commission Number:

Listed Authority complained of: Southern Health & Social Care Trust

Investigating Officer: Katrina Duddy

Investigating Officer's contact details:

Personal Information redacted by the USI Personal Information redacted by the USI Personal Information redacted by the USI

Clinical Advice required:

o

Background:

Personal Information redacted by the USI brought a complaint on behalf of his mother Personal Information redacted by the USI against the Southern Health and Social Care Trust. Personal Information redacted by the USI had been in the Craigavon Area Hospital from 13 February 2018 until 23 February 2018. She was diagnosed with diverticulitis and colitis. Upon discharge Personal Information redacted by the USI was cared for by her GP and the District Nurse. Personal Information redacted by the USI remained unwell at home and her son Personal Information redacted by the USI rang the Out of Hours service on 17 March 2018. Personal Information redacted by the USI was given telephone advice regarding his mother and advised that a request would be put in for a home visit and it would be marked urgent. Personal Information redacted by the USI was visited by an Out of Hours GP to her home on that same day. Personal Information redacted by the USI has complained about the care and treatment his mother received from the Out of Hours GP during this home visit.

Personal Information redacted by the USI condition deteriorated at home and she was taken by ambulance to Craigavon Area Hospital on 21 March 2018, where she was diagnosed with a severe urinary tract infection. Personal Information redacted by the USI was treated for her urinary tract infection and was subsequently transferred to Lu n H tal for rehabilitation on 26 March 2018. Durin her time in Lu n

Hospital [redacted] had been using a 3 wheeled rollator for assistance with walking. [redacted] unfortunately lost control of the rollator and fell whilst using the bathroom on 30 March 2018. [redacted] was with a nursing assistant at the time of her fall. She was tended to and examined by a doctor and nurses immediately after the fall. [redacted] was X-rayed approximately one week later on 4 April 2018. The x-ray identified '*AP view of the pelvis is inadequate*'. Therefore an MRI was requested on 5 April 2018. [redacted] had an MRI scan on 18 April 2018. The MRI scan identified [redacted] had sustained a fracture on her hip. [redacted] was transferred to Craigavon Area Hospital for surgery on her fractured hip.

Issues of complaint:

1. Was the Care and Treatment provided to [redacted] by the Out of Hours GP service on 17 March 2018 in accordance with good medical practice?

2. Was the Care and Treatment provided to [redacted] between 26 March 2018 and 20 April 2018 in accordance with good medical practice. In particular,

   (i) Whether [redacted] was appropriately assessed in relation to her falls risk and whether her fall on 30 March 2018 was managed appropriately.
   (ii) Whether care and treatment provided to [redacted] following her fall on 30 March 2018 was in accordance with good clinical practice.
   (iii) Whether the decision to perform surgery on 20 April 2018 was appropriate and in [redacted] best interests.

Index of documents enclosed:

[redacted] Southern Health and Social Care Trust Records
Timeline for Examination X-ray Pelvis
X-ray via Email for 4 April 2018
Chronology of Care from Admission to Lurgan Hospital 26 March 2018 until transfer to Craigavon Area Hospital on 18 April 2018
Southern Health and Social Care Trust Policies and Procedures
Chronology of [redacted] Complaint
Southern Health and Social Care Trust's response to [redacted] complaint
Southern Health and Social Care Trust's responses to NIPSO enquiries
Medical Timeline

Clinical Advice (to be completed by Adviser)

Clinical Adviser's Name and Qualifications:

[redacted]

Relevance of qualifications and/or experience to clinical aspects of this case:

Fellowship trained MSK radiologist. I work in a specialist orthopaedic hospital and in the past have contributed to the development of the RCR guidelines on imaging in MSK.

Conflict of Interest (clarification of any links with Body or clinicians complained about, see conflict of interest policy):

No conflict of interest.

Documentation Reviewed:

I have reviewed the xray images of the pelvis and hip from 4.4.2018, and the report.

Background and Chronology:

Background: patient fall, possible fracture, xrays done, no obvious fracture seen, further imaging (MRI or CT) advised if clinically suspicious, according to the notes this was done later (18.4.18) and showed a fracture.
The report read as follows:

"Xray report pelvis 4.4.2018: AP view of the pelvis is inadequate. The hip is internally rotated and therefore is difficult to interpret. The lateral and oblique views of the left hip appear normal. There is degenerative change at the pubic symphysis. No obvious fracture. Right hip appears normal. Minor degenerative change of both hips.

If there is persistent pain and difficulty mobilising MRI or CT is advised. (MRI is the preferred study – providing there are no contraindications)."

There are guidelines from the Royal Collage of Radiologist applicable to this case:

iRefer: Royal College of Radiologists guidance, status 27.1.2020
T16 Pelvic injury with suspected femoral neck fracture:
Physical examination may be unreliable. Femoral neck fractures may be radiographically occult on initial XR, even with good lateral views. Additional projections or tomography may help. When XR is normal or equivocal and clinical suspicion high, MRI is recommended to show occult proximal femoral fractures or alternative soft tissue/bone lesions. CT is an alternative when MRI is unavailable or contraindicated. NM is helpful for stress/insufficiency fractures but is less specific than MRI and may take 2–3 days to become positive in the elderly.

Questions and Responses:

Questions for adviser

1. Upon reviewing the radiography x-ray performed on 4 April 2018, was the x-ray reported on correctly?

In my opinion the xray was reported on correctly. No obvious fracture is seen but that does not exclude one. If clinically appropriate MRI is advised / indicated.

2. In your professional opinion does the x-ray indicate an '*AP view of the pelvis is inadequate*'? Can you please advise what does this statement mean?

"Ap view of the pelvis is inadequate" refers to the positioning of the hip for the xray as outlined in the next sentence: "The hip is internally rotated and therefore is difficult to interpret."

3. What action should have been taken by the Radiologist in view of the finding that the x-ray was '*inadequate*'?

The advised action would be to suggest cross sectional imaging, ie MRI or CT, as was done by the radiologist.

4. If the x-ray on 4 April 2018 was not reported on correctly, what impact did this have on [redacted] care and treatment?

Not applicable, the xray was reported correctly

5. In your professional opinion was it reasonable that [redacted] fractured hip was missed?

Yes, it was reasonable to miss the fracture on these xrays, this is a known problem which is which the guidelines recommend cross sectional imaging if in doubt. This was done by the reporting radiologist. X-rays have limited diagnostic sensitivity and specificity.

6. Was the radiologist's recommendation '*if there is persistent pain and difficulty mobilising MRI or CT is advised*' appropriate and reasonable?

The radiologist's recommendation was entirely appropriate and reasonable and in keeping with current guidelines.

7. In your professional opinion was the radiologists reporting on [redacted] x-ray on 4 April 2018 in line with good medical practice?

. Yes, as in point 6

The reporting radiologist followed current guidelines to the letter.

The radiographs do not show a definite fracture, in these circumstances cross-sectional imaging, ideally with MRI, if not possible with CT, is advised if clinical suspicion persists.

In my personal opinion the reporting radiologist followed the current guidelines to the letter. The radiologist issued an accurate succinct report outlining what is seen, what may be missed and why and suggested further investigation. While I understand that a lay person may wonder why the fracture was missed when an x-ray was performed, this is a well acknowledged fact in radiology, hence the guidelines suggesting further imaging if in doubt.

Please refer to relevant guidelines in your responses. Where there are no guidelines or standards please provide a clear rationale for your answer and/or refer to relevant professional standards such as the GMC Good Medical Practice.

Identify any learning / service improvements:

I can't see any issue with the report. The interpretation is correct and the recommendation in keeping with current guidelines.
If anything the report is exemplary. The problem seems to be one of perception of the public that x-rays are always diagnostic. They are not, else there would be no need for other imaging modalities. X-rays are mainly a screening tool to be supplemented by other investigations as required.

Conclusions:
In my opinion the report of the radiologist was exemplary; I can see no mistake here at all. The problem seems to be the frequently encountered belief that if x-rays show no pathology there is none.

Name & Signature: [redacted]

Date:
3.2.2020

Northern Ireland
Public Services
Ombudsman

Our Ref: [redacted]

11 February 2020

Complaints
cc T. Reid

Mr Shane Devlin
Chief Executive
Southern Health & Social Care Trust
Craigavon Area Hospital
68 Lurgan Road
Portadown
CRAIGAVON
BT63 5QQ

CHAIRMAN/CHIEF EXECUTIVES OFFICE
12 FEB 2020
CX 4175

Dear Mr Devlin

THE PUBLIC SERVICES OMBUDSMAN ACT (NORTHERN IRELAND) 2016

I refer to the complaint which the Ombudsman has received from [redacted] of [redacted] about the actions of the Southern Health & Social Care Trust. [redacted] claims to have sustained injustice as a consequence of maladministration by the Trust.

Independent Professional Advice

After considering the Trust's response to earlier enquiries, the Ombudsman received Independent Professional Advice (IPA) from adviser's on the issues which continued to concern Mr Anderson.

A copy of the advice received by the Ombudsman is enclosed. The advice is provided by a:

Out of Hours GP IPA
Consultant Physiotherapist IPA
Nursing IPA
Consultant Geriatrician IPA
Consultant Radiologist IPA
Consultant Anaesthetist IPA
Consultant Orthopaedic Surgeon IPA

The purpose of sharing the advice is to provide the Trust with an opportunity for further comment, if this is felt necessary.

You should note that the Ombudsman wishes to make it clear that it has not yet made a decision on [redacted] complaint and the advice which has been

Northern Ireland Public Services Ombudsman Progressive House 33 Wellington Place Belfast BT1 6HN
Telephone: 028 9023 3821 Text phone: 028 9089 7789 Freephone: 0800 34 34 24 Email: nipso@nipso.org.uk www.nipso.org.uk

received does not represent its confirmed view at this stage. Rather, the advice has been obtained to inform the Ombudsman's ongoing investigation; how the Ombudsman 'weighs' advice obtained from the independent clinical advisers within the context of a particular complaint, is a matter for discretion.

I would take this opportunity to remind you that under Section 30(5) of the above Act, an Ombudsman's investigation must be conducted in private and all information obtained in the course of the investigation is 'confidential'. Therefore, any unauthorised disclosure of the IPA advice will be a breach of confidentiality.

You will note that [redacted] and [redacted] are named in this complaint. I have enclosed a copy of this letter together with a memorandum setting out their rights under section 30 (3) of the Act. I would ask that you pass both of these documents including a copy of the **relevant clinical IPA advice** to each clinician for comments. I would be very grateful if all named persons could sign the notification form confirming they have saw sight of the **relevant clinical IPA advice** and the Trust return their signed forms to me on their behalf.

I would be very grateful if you could provide me with your comments on the Independent Professional Advice no later than 20 days from the date of this letter.

If you have any queries regarding this case, please contact me directly on [redacted] or by email at [redacted]

Yours sincerely

Katrina Duddy

KATRINA DUDDY
Investigating Officer

Cc [redacted]

Western Health and Social Care Trust

RAPID REVIEW GROUP
TERMS OF REFERENCE

1.0 Purpose

Rapid Review group will monitor and assess the review of SAIs, Red Incidents, High Risk Complaints, Claims and Inquests to maximize the potential for identifying and sharing learning as quickly as possible for sharing across the Organisation and where appropriate the Region

2.0 MEMBERSHIP

The Review Group Membership shall include the following representatives:

Members
Medical Director (Chairperson)
Director of Nursing (Joint Chair)
Associate Medical Director, Patient Safety and Governance
Assistant Director of Nursing Services, Governance / Safe & Effective Care
Head of AHP Services
Head of Clinical Quality & Safety
Corporate Risk Manager
Governance Manager
Pharmacy Representative
Professional Social Work representative
Administrator in first instance from Risk Management team

2.2 Quorum

To be agreed.

3.0 FREQUENCY

Meetings should be held weekly.

4.0 REPORTING ARRANGEMENTS

The Review Group will report to the Trust's Clinical and Social Care Governance Sub Committee of Governance Committee.

5.0 DUTIES

The Review Group will:-

- Review Red incidents, reported in preceding week and assess progress of review and identify if required which of these should be considered for reporting as Serious Adverse Incidents

- Review progress against query SAIs identified from the previous meetings
- Review progress on SAI investigations and seek explanations for delay in process.
- Review for final sign off SAI reports submitted by SAI chairs.
- Review ongoing Early Alert issues to ascertain if further action is required and review process to closure.
- Review progress on high risk complaints and consider findings from Coroners reports which highlight learning
- Consider any claims settled where learning has been identified.
- Identify learning for sharing corporately and or regionally including referring for clinical audit and training plans.
- Agree one lesson of week/safety message for sharing on the intranet
- Receive assurances from Directorates on progress on SAI action plans and family engagement checklists
- Provide a summary report to the Trust's Clinical and Social Care Governance Sub Committee of Governance Committee

6.0. REVIEW

The terms of reference and membership of the group will be subject to a bi-annual review.

Stinson, Emma M

From: Keenan Donna [redacted]
Sent: 16 February 2020 22:04
To: Kingsnorth, Patricia
Subject: RE: Agenda RRG 13 February 2020

Dear Patricia,

The Medical Director and associate, all operational directors, risk management, complaints, AD's for nursing and all programmes of care and notes taken by risk management team with action notes.

Best wishes,

Donna

From: Kingsnorth, Patricia [redacted]
Sent: 14 February 2020 10:58
To: Keenan Donna [redacted]
Subject: RE: Agenda RRG 13 February 2020

Dear Donna
Many thanks for forwarding this. Can you remind me again who actually attends the meetings. It is a really good to meet you yesterday.
Regards
Patricia

Patricia Kingsnorth
Acting Clinical Governance and Social Care Coordinator
Governance Office
Ward 2 Ramone
CAH
[redacted]

From: Keenan Donna [redacted]
Sent: 13 February 2020 23:01
To: Kingsnorth, Patricia
Subject: Agenda RRG 13 February 2020

Dear Patricia,

Please see attached agenda for the Rapid Review Group. The agenda varies slightly as we pay more attention once a month to the numbers of open incidents, SAI's, complaints etc per directorate looking at the length of time open etc. I will forward ToR tomorrow.

Lovely meeting you today.

Kind regards,

Donna

This email is confidential and intended solely for the use of the individual to whom it is addressed. Any views or opinions presented are solely those of the author and do not necessarily represent the views of the Trust or organisation it was sent from. If you are not the intended recipient, be advised that you have received this email in error and that any use, dissemination, forwarding, printing, or copying of this email is strictly prohibited.
If you have received this email in error please contact the sender.
The content of this e-mail and any attachments or replies may be subject to public disclosure under the Freedom of Information Act 2000, unless legally exempt.

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 Patient 11
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:	**4. DATE OF INCIDENT/ EVENT: 30/08/2019**
5. PLEASE INDICATE IF THIS SAI IS **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, 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: Dr J R Johnston- Consultant Medical Advisor	**11. TEAM MEMBERS PRESENT:** Mr M Haynes - Consultant Urologist Mrs K Robinson - Booking & Contact Centre Manager Mrs T Reid - Acute Clinical & Social Care Governance Coordinator

12. SERVICE USER DETAILS:

Patient 11 H&C: Personal Information redacted by the USI

Patient 11

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)

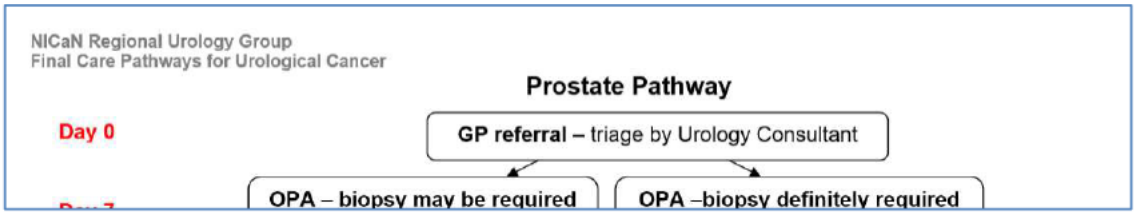
The NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016), was produced regionally to support the diagnosis, treatment and management of urological cancer.
This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.

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.

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 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

Patient 11

(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

Patient 11

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. 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

Patient 11

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, Patient 11 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 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 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)

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 (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 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 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, 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 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 (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.

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: 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 Patient 11 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.

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

Reporting Organisation SAI Ref Number:	Personal information redacted by USI Patient 11	**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. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	**X**	
	Comment: ***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? **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? **Please select as appropriate (✓)**	**YES**		**NO**	**X**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **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? **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			

Patient 11

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**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	**20/01/2019**

[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 Information redacted by USI Patient 12
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:	**4. DATE OF INCIDENT/ EVENT: 30/08/2019**
5. PLEASE INDICATE IF THIS SAI IS **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, discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed.

Patient 12 a Personal Inform-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, TF 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 Mrs K Robinson - Booking & Contact Centre Manager Mrs T Reid - Acute Clinical & Social Care Governance Coordinator

Patien t 12

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.

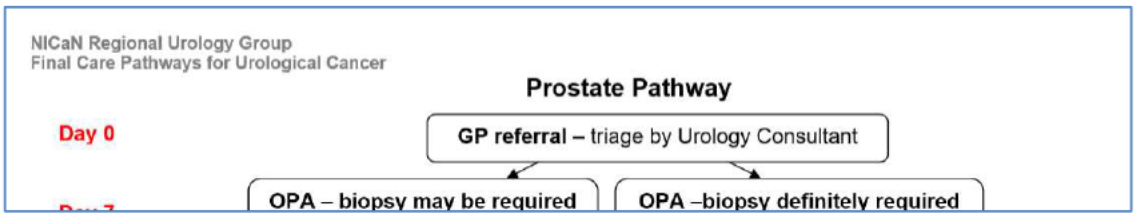
This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.

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 Craigavon Area Hospital (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 CAH, 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.

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 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 [redacted]. [redacted] 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 [redacted]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 [redacted]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 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 08 September 2016 Patient 12 a Personal Inform-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

- 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.

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

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

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 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-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 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 (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.

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: 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 Patient 12 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.

Patien t 12

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

Reporting Organisation SAI Ref Number:	Personal information redacted by USI 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. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	**X**
	Comment: ***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? **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? **Please select as appropriate (✓)**	**YES**		**NO**	**X**
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **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? **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			

Patien t 12

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**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	**20/01/2019**

[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 Information redacted by USI Patient 14
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:	**4. DATE OF INCIDENT/ EVENT: 30/08/2019**
5. PLEASE INDICATE IF THIS SAI IS **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, 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: Dr J R Johnston- Consultant Medical Advisor	**11. TEAM MEMBERS PRESENT:** Mr M Haynes - Consultant Urologist Mrs K Robinson - Booking & Contact Centre Manager Mrs T Reid - Acute Clinical & Social Care Governance Coordinator

12. SERVICE USER DETAILS:

Patient 14 H&C: Personal Information redacted by the USI

Patient 14

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.

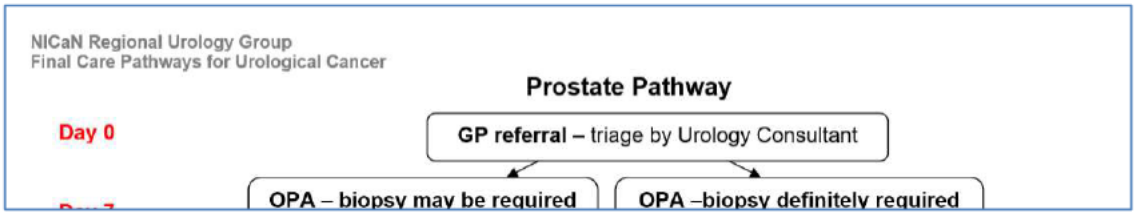
This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.

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 Craigavon Area Hospital, 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 CAH, 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.

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 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 (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 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

Patient 14

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.

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

Patient 14

- 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 to 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)

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 (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 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 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-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 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 (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.

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: 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)*:

Patient 14

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 Patient 14 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.

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

Reporting Organisation SAI Ref Number:	Personal information redacted by USI 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. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	**X**
	Comment: ***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? **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? **Please select as appropriate (✓)**	**YES**		**NO**	**X**
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **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? **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			

Patient 14

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*

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 Patient 13
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:	**4. DATE OF INCIDENT/ EVENT: 30/08/2019**
5. PLEASE INDICATE IF THIS SAI IS **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, 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 Mrs K Robinson - Booking & Contact Centre Manager Mrs T Reid - Acute Clinical & Social Care Governance Coordinator

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

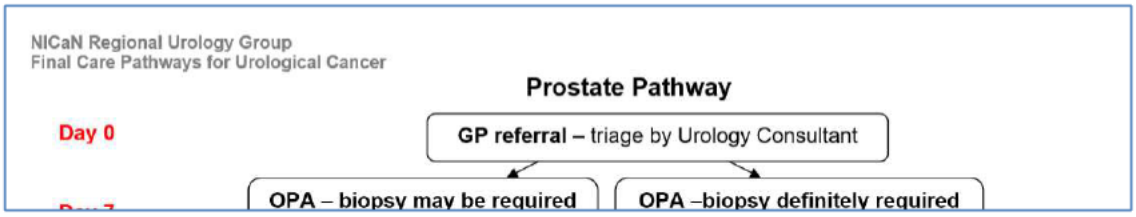
regionally to support the diagnosis, treatment and management of urological cancer.
This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.

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 Craigavon Area Hospital (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 CAH, 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.

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 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 (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 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.

On 28 July 2016 Patient 13 a 51-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 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 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)

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 (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*'.

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 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 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-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 <u>all</u> 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 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 (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.

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 Patient 13 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.

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

Reporting Organisation SAI Ref Number:	Personal information redacted by USI 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. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	**X**
	Comment: ***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? **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? **Please select as appropriate (✓)**	**YES**		**NO**	**X**
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **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? **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			

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**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	**20/01/2019**

[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 Information redacted by USI Patient 15
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:	**4. DATE OF INCIDENT/ EVENT: 30/08/2019**
5. PLEASE INDICATE IF THIS SAI IS **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 Person al 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 Mrs K Robinson - Booking & Contact Centre Manager Mrs T Reid - Acute Clinical & Social Care Governance Coordinator

12. SERVICE USER DETAILS:

Patient 15 H&C: Personal Information redacted by the USI

Patie nt 15

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 19 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.

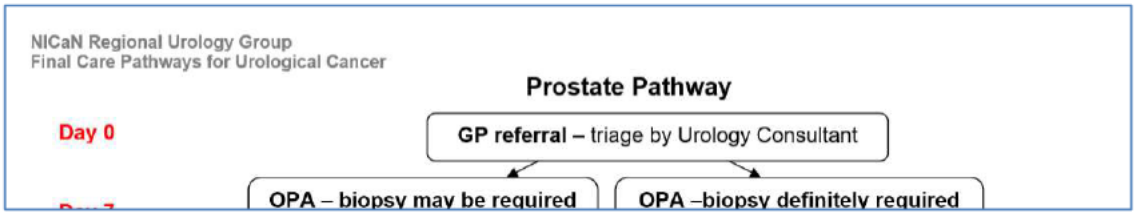
NICaN Urology Cancer Clinical Guideline (2016)
The NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016), was produced regionally to support the diagnosis, treatment and management of urological cancer.
This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.

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*".

The index case Review Panel agreed 3 main contributing factors led directly to MH'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.*"

5.5 Look back exercise #2

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/LR/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 diagnosisT3a 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

Patient 15

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 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.

Patient 15

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.

<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".

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"*.

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 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.

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 <u>all</u> 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 Cons 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)

TRUST
Recommendation 1
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 2
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 3
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 4
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 5
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 6
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.

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: 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 Patient 15 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.

Patient 15

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

Reporting Organisation SAI Ref Number:	Personal Information redacted by USI Patient 15	**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. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	**X**	
	Comment: ***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? **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? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **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? **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			

Patient 15

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**				
	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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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:

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:

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 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.

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.

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.

Patient 13 – a Personal Inform-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 redacted 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.

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 manner.

Recommendation 8

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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

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", "[redacted]", "Patient 12", "Patient 14" and "[redacted]", 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", "[redacted]", "Patient 12", "Patient 14" and "Patient 11" that resulted in an

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3.0 SAI REVIEW TERMS OF REFERENCE

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.

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*

5.0 DESCRIPTION OF INCIDENT/CASE

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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5.0 DESCRIPTION OF INCIDENT/CASE

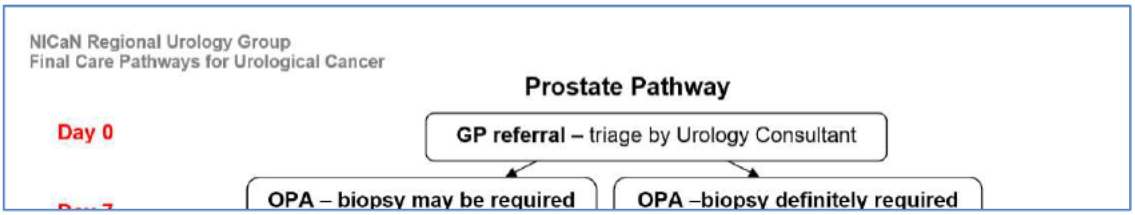
This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.

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 Craigavon Areas Hospital (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 CAH, 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. Cons1's OPD letters were being kept in a ring binder and were

5.0 DESCRIPTION OF INCIDENT/CASE

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 (HoS1) 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 Cons1 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

5.0 DESCRIPTION OF INCIDENT/CASE

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 [redacted]. [redacted] 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 [redacted]'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 [redacted]'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*

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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. 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

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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 69120) 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 Inform-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 Inform-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

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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.
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

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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 Inform-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.

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

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)

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*

(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

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

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,

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 Cons1 (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.

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.

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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, Director of Acute Services.

Health & Social Care Board (HSCB).

Chairs of Morbidity & Mortality Groups SHSCT.

"Patient 15", "Patient 13", "Patient 12", "Patient 14" and "Patient 11".

Southern Health and Social Care Trust

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. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: ***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? **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? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **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? **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			

Southern Health and Social Care Trust

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)*		
	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*

Southern Health and Social Care Trust

Quality Care - for you, with you

Acute Clinical Governance and Social Care

MEETING WITH ACUTE DIRECTOR

Date: Tuesday 6 January 2021
10am

AGENDA

	SAI/ SEA reports
1.0	**28 SAI 10 are urology** **Chair will update Melanie and Maria on Monday.** **He wants to meet the MDT together to explain the review and learning to date. This will be discussed on Monday.**
1.1	**Sections in red for information. Notes from hot debrief.** Weekly Governance Report 14.12.20 -27.
2.0	**Complaints** **The team are linking with the AD for completion of outstanding 20 complaints.**
3.0	**Surge plan.** Weekly Governance Report 03.08.20 -09.
4.0	**EOI - S+G Post out with Helen Walker for approval.**
	AOB

ACUTE DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings - 9am – 10am)

1. **Status of SAI's** - Summary of the status of SAI's between 14.12.2020 - 27.12.2020

Any reports received after Friday will not be reflected in the numbers below until the following week

More than 26 weeks	Less than 26 weeks	Within Timescales	Level 3	Total
4	10	4	10	28

2. **Early Alert**

Early alert re Microbiology pressures

3. **Issues escalated by Corporate or Directorate office at meeting**

Staffing and COVID Incidents

W125845 - CCU trained nursing staff taken from 1 north to staff other areas, leaving 2 trained staff on the floor (one staff nurse for each side). Unable to facilitate breaks as no clinical coordinator able to relief staff or to sit at the cardiac monitors. unable to carry the cardiac arrest bleep as not enough staff on the floor.

W125844 - Band 5 staff nurse taken from 1north on night duty to cover another ward in the hospital. This left 1north with 2 trained members of nursing staff on the floor. No band 3 on shift either. Due to the unsafety in staffing numbers, staff where unable to leave the ward for an allocated break.

W125846 - Staff had to work on both sides of the ward - against IPC advice - as patients requiring assistance of 2 to mobilise.

W125925 – Patient safety concerns re member of staff lack of experience medication rounds or caseloads

W125935 – Unsafe staffing – lack of knowledge for trachestomies

W125882 – Covid staffing pressures - While 1st staff nurse went on break patient required control drug analgesia and 2nd staff nurse was unable to administer due to no second checker. Alternative analgesia given with little effect. Nurse phoned bed manager and made aware of situation but no help was sent. Patient crying in pain and verbally complained to night staff regarding this overnight.

W125681 - On the night of 19/12/2020, I was allocated as the only staff nurse to HDU1 with a HCA

W125502 - Inadequate staffing levels for level 2 patients. Newly qualified staff nurse left with one hca, no other staff available. Unsafe patient management.

W125507 -ED Department overcrowded, and no social distancing.

W125716 - staffing issue as agency worker not fit tested

129045 – Agency staff no red PPE doing CPR. The masks available where completely unsuitable and correct fitting bFPP3 masks were not available for staff. Also a lot of the staff on FMW were not fit tested and MMW staff has to come and help with compressions.

W125734 – Patient admitted with known ca and neutropenic bursed in amber resus as no side rooms available significant risk and exposure
W125501 - On the night of the 16/12/2020. 2 nurses were allocated to HDU2. One of the allocated nurses is not trained in the care of a tracheostomy and therefore left the trained nurse unable to leave for break due to patient safety and therefore had to work for 12hrs without a break in red PPE.

Other Incidents
Night Report 29th – Cardiac Arrest HDU- vasovagal episode
Night Report 28th29th - CARIDAC ARREST CALL IN BLUESTONE UNIT – STAFF ISSUES ACCESSING UNIT – PT TRANSFERRED TO ED AND RIP –good learning from viewpoint of access and amber PPE used for cardiac arrest- being followed up by Resus officer.

W125985 - I was informed of the arrival of the patient arrived at 4 South ward in CAH at 14:45 from DHH A&E department. I was not informed about this patient at all, nor had my consultant from DHH A&E department. The Urology team (Registrar and consultant) did not receive any handover from the night surgical oncall team as well about this patient (verbal or written). This is an unsafe transfer and an unsafe handover of the patient. – patient flow issues – ED admission rights should resolve
W125686 - Patient on variable insulin and fluid infusion (GKI) as well as Lantus at bed time. Lantus insulin administered as per prescription and instructions given earlier. Blood sugar 1.1mmol at 3am, 4 hours since previous blood glucose check.
CAHT NIGHT REPORT 19TH-20TH December - Patient admitted and died within 8 hours of admission from PNH- 2SM—this was a patient who developed covid in 1 S for M+M
W125626 - nurse handover page and timesheet found in ED waiting room toilet by a member of the public. handed in to front desk.- breach in data protection- agency HCA working in ED – Sharon Holmes is checking to see if patient information was breached.
W125725 - Kardex was then only written up at 4am which was when realized apixaban was missed.

Complaints
DHH ED - Personal Information redacted by the USI, patient sent home after x ray, referred again 4 weeks later -diagnosed with terminal lung cancer.—this worries me, we have a number of complaints/ SAI relating to delayed in lung cancer diagnosis despite being suspicious on X ray- this will be discussed with the screening team on Monday
DHH MMW – Personal Information redacted by the USI, bruising, poor hygiene, missed meals and refusal of sleep tablets.- meeting planned with family
Personal Information redacted by the USI – ED complaint with family concerned about mental health of patient, sent to acute but also to Personal Information redacted who acted immediately.
Increase in enquiries for Ramone Wards re lack of communications

MENTAL HEALTH AND DISABILITY DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings - 9am – 10am)

4. Status of SAI's

Summary of the status of SAI's between 14.12.2020 - 27.12.2020

Any reports received after Friday will not be reflected in the numbers below until the following week

More than 26 weeks	Less than 26 weeks	Within Timescales	Level 3 – No timescale	Total
19	21	5	4	49

5. Early Alert

Difficulties in covering nursing shifts in Bluestone & Dorsy (plus 1 update)

Granville Supported living outbreak

6. Catastrophic Incident

130390 –COVID-19 Death – Orchard House resident

7. Issues escalated by Corporate or Directorate office at meeting.

CHILDREN AND YOUNG PEOPLE SERVICES DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings - 9am – 10am)

8. Status of SAI's

Summary of the status of SAI's between 14.12.2020 - 27.12.2020

Any reports received after Friday will not be reflected in the numbers below until the following week

Less than 26 weeks	More than 26 weeks	Within Timescales	On Hold	Total
3	3	2	1	9

The CYPS Governance Team is in regular contact re: the 3 SAIs which are currently on hold.

9. Early Alert

Early Alert re The Neonatal Unit (NNU) in Craigavon Area Hospital is at full capacity of its 16 cots

10. Issues escalated by Corporate or Directorate office TBC at meeting

OLDER PEOPLE AND PRIMARY CARE SERVICES DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings - 9am – 10am)

11. Status of SAI's

Summary of the status of SAI's between 14.12.2020 - 27.12.2020

Any reports received after Friday will not be reflected in the numbers below until the following week

More Than 26 weeks	Within Timescale	Less Than 26 Weeks	Total
2	1	3	6

12. Early Alert

2 x GP OOH

13. Reopened complaints

12483 [redacted] - complainant did not agree with some of the information given in the response.

12157 [redacted] - complex complaint involving family dynamics

14. Issues escalated by Corporate or Directorate office TBC at meeting

LITIGATION

15. New Clinical negligence

New clinical negligence claims: 14th – 18th December 2020

Ref	Directorate	Division	Incident type	Incident date	Claim date	Opened date	Description
MNS/2606	Acute	CCS	Lack of adequate facilities/equipment	14/10/19	08/12/20	14/12/20	Plaintiff alleges multiple transfers between DHH and CAH due to CT Scanner not working in DHH caused delay in treatment
MNS/2607	Acute	AEMUC	Not known	15/09/18	24/11/20	14/12/20	Writ received – Claim for personal injuries, loss and damage sustained as a result of alleged negligence in treatment and care at DHH - further and better particulars requested.
MNS/2609	Acute	Cancer	Covid - 19	02/12/20	17/12/20	17/12/20	Plaintiff alleges breast surgery delayed due to COVID

No new clinical negligence claims received 21st – 25th December 2020.

16. Clinical Negligence Claims Listed for Hearing in December 2020

Clinical negligence cases currently listed for hearing during December:

Ref	Directorate	Division	Incident type	Incident date	Claim date	Opened date	Description
MN S71/552	Acute	MUC	Inappropriate treatment	06/11/08	07/05/2010	13/06/2010	Hearing was listed for 07/12/2020. Case subject to formal withdrawal with Trust bearing their own costs – Judge awaiting authority from legal aid for case to be withdrawn and judgment entered in favour of the Trust. Negligence surrounding stent procedure. Allegations of negligence relate to damage to left common removal artery at angioplasty. Angioseal failed.

17. Vaginal Mesh Cases

The Trust has 17 open cases where the allegations relate to vaginal mesh.

Stage	Number of Mesh Cases
Letter of Claim	**1**
Discovery	**4**
Investigation	**8**
Proceedings Issued	**3**
Trial date Set	**1**

A trial date of 17th May 2021 has been set for one of the cases. This is the first case regionally to reach a trial date. DLS advices are that there is some vulnerability in this case. Updates will be provided as the case progresses.

18. Urology Cases

Due to the announcement by the Minister for Health that a public inquiry is to be carried out in relation to the work of Urology Consultant who was employed the Trust it is anticipated that there will be an increase in related medico-legal requests and litigation cases. To date no new medico-legal requests or litigation claims have been received which specifically refer to this matter.

19. Coroner's Inquiries and Inquests

- No new Coroners Inquiries received 14th – 18th December 2020 or 21st – 25th December 2020
- No full Inquest Hearings listed in December 2020
- The following preliminary Inquest Hearings scheduled / took place in December 2020

Ref	Directorate	Division	Incident date	Claim date	Opened date	Description
CO 4281/2019	ACUTE	SEC	18/12/2019	23/12/2019	23/12/2019	Irrelevant information redacted by the USI

						Irrelevant information redacted by the USI
INQS104/23	MHD/Acute	PHYCHI	27/05/2017	05/07/2018	05/07/2018	Preliminary Hearing 21st December 2020 - The hearing on 1st March 2021 **has been adjourned.** Trust to provide the 'Regional interagency absconding protocol'. The Coroner is to obtain an expert report – he is approaching a general i.e. not forensic psychiatrist. The Trust can reserve their position with regard to obtaining their own expert report pending sight of this report. There may be the need to obtain expert evidence with regard to the approach of the PSNI The Coroner is to share a statement from the Police Ombudsman The next preliminary hearing is on 4th March 2021.

20. Number of Subject Access Requests exceeding timeframe for completion.

The Medico-Legal Team are unable to comply with the General Data Protection Regulations (GDPR) 2018 in respect of responding to Subject Access Requests within the statutory time-frames. This had been due to the sheer volume of requests (which had increased by approx. 1000 per year) and a lack of staffing to cope with the demand. The Governance Committee have been advised of the ongoing back-log; it has been brought to the attention of the Trust's SIRO and placed on the HROD Risk Register. An application was made to the Strategic Investment Committee for additional funding for staff. This was considered by the Strategic Investment Committee on 27th July 2020, and approval was provided in principle. Finance are now seeking to identify a recurring funding stream for these posts.

14th – 18th December 2020

There is currently a back-log of 228 requests that are in excess of 90 days across the following areas:-

Directorate	**Acute Services**	**MH&D**	**C&YP**	**OPPC**	**TOTAL**
Number of Outstanding Requests	168	22	34	4	228

21st – 25th December 2020

There is currently a back-log of 256 requests that are in excess of 90 days across the following areas:-

Directorate	**Acute Services**	**MH&D**	**C&YP**	**OPPC**	**TOTAL**

Number of Outstanding Requests	191	25	34	6	256

The back-log has increased from the previous week, the week-end days are included in counting towards the 90+days and therefore impacts on the work carried out during the week. As outlined previously, the reasons for back-log include (in addition to the staffing and volume issues) - difficulties accessing notes and records, and issues relating to redaction and consent to release.

MEDICATION INCIDENTS

21. Medication Incidents between 14.12.2020 - 27.12.2020

Medication Incidents between 14.12.2020 - 27.12.2020	

SAFEGUARDING

22. Link to SharePoint site regarding RQIA Notifications/Alerts

http://sharepoint/pr/perfimp/scc/_layouts/15/WopiFrame.aspx?sourcedoc=/pr/perfimp/scc/RQIA%20Notifications%20and%20Alerts/Alert%20Notice%20Board.xlsx&action=default

23. Valley Nursing Home – The potential buyer has withdrawn from the agreement. The Trust has commenced movement of the clients.
24. 1 Ongoing SAI in MHD
25. 1 Ongoing complaint within OPPC , adult safeguarding

INFORMATION GOVERNANCE

26. Number of Subject Access Requests exceeding timeframe for completion.

Directorate	ACUTE	OPPC	MHD	CYPS	FINANCE	P&R	HROD	CX
Number of outstanding Requests	14	-	11	18	-	-	1	-

These relate to Subject Access Requests which have not been completed within the legislative timescale (legal timeframe 30 days or 90 days for complex requests). These delays are in relation to the demands on Services to carry out redactions of these notes etc. In some cases there are requests which were made in 2019 and have not been progressed. In the last three months we have received three different complaints from the ICO in relation to the time taken to respond to requests.

27. Data Breaches reported to the ICO

Directorate	ACUTE	OPPC	MH&D	CYPS	FINANCE	P&R	HROD	CX
Breaches	-	-	-	-	-	-	-	-

There have been no data breaches reported to the ICO in this period. There has been one Complaint to the ICO In this period and this was in relation to the time taken to provide information to an individual in response to a Subject Access Request has now been closed and a response received from the ICO. They have indicated that the Trust is in breach of the Data Protection Act 2018 and retaining this on file in the event that future similar complaints are received.

NEW STANDARDS AND GUIDELINES RECEIVED AND ASSURANCES DUE OR SUBMITTED

28. Responses Due and Sent.

Title of Correspondence	Full Implementation Date for S&G	Directorates applicability

OPS and AS - Care Home Admission and Initial Review	Response Due 18/09/2020 – Email sent to HSCB 27/11/2020	OPPC
Reducing the Risk of Oxygen Tubing being Attached to Medical Air	Response due Thursday 17th December - Response sent 17/12/2020	Estates Acute, CYPS, MHD
Fit Testing Settings	Response due Friday 18 December	H&S Finance, OPPC, Acute

29. Work Ongoing

- Safe use of Valproate in women of childbearing potential (HSC (SQSD)19/17 and HSS(MD) 8/2018) - valproate register sub group meeting held on 26/11/2020 and demonstration of potential use of NIECR is being explored with BSO ITS. Cross directorate MDT working group meeting is scheduled for 10/12/2020 and outcomes from this register subgroup meeting to be presented and a consensus determined that can be fed back to the ECR Project Board meeting that is being held on 10/12/2020

- Foreign Body Aspiration during intubation, advanced airway management or ventilation – meeting held with Medical Technical Team and Mark Bloomer on 27/11/2020 and it was agreed that in regards to recommendations 1,2 and 3 of the alert these would be discussed at the next Trust Procurement Board meeting in January 2021. Alert was reviewed at Acute S&G forum meeting on 30/11/2020 and the alert is now to be circulated to relevant front line teams so that a risk assessment can be undertaken and any required action taken to mitigate against the risk.

30. Care of women presenting with post-menopausal bleeding – Follow up email sent to HSCB regarding the query in relation to recommendation 3 – email sent by SHSCT to the HSCB on 26/11/2020, acknowledged by HSCB on 02/12/2020 confirming email has been forwarded to regional lead for response

31. IV Fluid management and prevention of harm from hyponatraemia. Connie to advise Jilly the contact in PHA to speak to raise concerns already raised by SHSCT but not addressed in the revised letter. Dr Hugo Van Woerden is retired as of 27/11/2020 so Connie is seeking an alternative point of contact.

32. S&G Received

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type	NICE Assurance 3 month	Full Implementation Date for S&G
NG 188 COVID19 Rapid Guideline Managing the long term effects of covid19	18/12/2020	NG 188	NICE COVID-19 Rapid Guideline	n/a	n/a
NG 187 COVID19 Rapid Guideline Vitamin D	17/12/2020	NG 187	NICE COVID-19 Rapid Guideline	n/a	n/a
COVID-19 Regional Principles for Homebirth in Northern Ireland	17/12/2020	n/a	PHA Email	n/a	n/a
Revised - COVID-19 Guidance for Residential Children's Homes in NI	16/12/2020	n/a	DOH Letter	n/a	n/a
Eating Disorders Recognition and Treatment	16/12/2020	NG 69	NICE Clinical Guideline Update	n/a	n/a
Type 2 Diabetes in Adults Management	16/12/2020	NG 28	NICE Clinical Guideline Update	n/a	n/a
Diabetes Type 1 and Type 2 in Children and Young People Diagnosis and Management	16/12/2020	NG 18	NICE Clinical Guideline Update	n/a	n/a
Type 1 Diabetes in Adults Diagnosis and Management	16/12/2020	NG 17	NICE Clinical Guideline Update	n/a	n/a

Pancreatitis	16/12/2020	NG 104	NICE Clinical Guideline Update	n/a	n/a
Diabetes in Pregnancy Management from Preconception to the Postnatal Period	16/12/2020	NG3	NICE Clinical Guideline Update	n/a	n/a
COVID-19 Therapeutic Alert – Azithromycin in the Management of COVID-19 (SARS-CoV-2) Positive Patients	16/12/2020	HSS(MD)86/2020	CMO Letter	n/a	n/a
COVID Clarification on IPC Form – Pre-Admission Admission Risk Assessment	14/12/2020	n/a	HSCB/PHA Letter	n/a	n/a
COVID UK Isolation Period Shortened to 10 Days	14/12/2020	COVID	PHA Email	n/a	n/a
COVID Christmas Visiting into and out of Care Homes	11/12/2020	SH457	CNO Letter	n/a	n/a

HYPONATRAEMIA

33. Regional PIVFAIT Audits

CYP

- CAH CYP week ending 13/12/2020 - no cases
- CAH CYP week ending 20/12/2020 - no cases
- CAH CYP week ending 27/12/2020 - no cases

- DHH CYP – week ending 13/12/2020 - 1/1 = 100%
- DHH CYP – week ending 20/12/2020 - 2/2 = 100%
- DHH CYP – week ending 27/12/2020 - 1/1 = 100%


IVF audit_Acute and CYP summary for wee

W126030 - baby on iv fluids dropped sodium levels to 129 new bag of iv fluids not erected until 5hours after results available as not prescribed by medical staff .I was alerted to this when I came on duty, no contact from parents overnight to advise them of this

34. Re-instatement of Regional Operational Policy Templates – June 2020. An extension is being requested re this. Early Alerts, Adverse Incidents and the Being Open have been worked on and will be shared with the Governance teams. Connie had received the draft version of being open, this will be presented at the Steering Group for validation and circulated to the Directorates for comment. Draft templates to be circulated to Coordinators


Memo reinstating HSC (SQSD) 24 19 Re

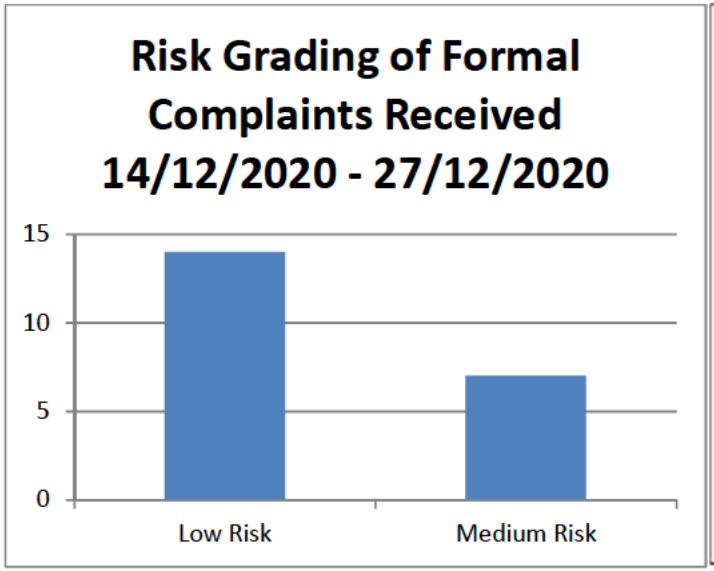
35. PPE Incidents – There is currently not enough information provided within the Datix incidents to provide sufficient detail in relation to PPE.


PPE Report.xlsx


Search using CCS2 code.xlsx

36. Complaints Study – [redacted]

37.



Comparison of the Datix Incident Reporting as of 22nd December for the equivalent 1st week of December 2019 and 2020 has been undertaken for an overview of current reporting Levels:

Acute Directorate – 2%↓ with 112 Incidents reported

CYP Directorate – 78%↓ with 23 Incidents reported

MHD Directorate – 16%↓ with 113 Incidents reported

OPPC Directorate – 11%↑ with 128 Incidents reported

Total 376 in Week 1 December 2020 compared with 405 week 1 November 2019

Attendees:

Apologies:

REPORT SUMMARY SHEET

Meeting: Date:	Senior Management Team 18th August 2020
Title:	Clinical and Social Care Governance Report
Lead Director:	Dr Maria O'Kane, Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	Information

Overview:

Provide SMT with an Oversight of Weekly Activity in relation to Clinical & Social Care Governance

Key Issues / Risks for SMT Consideration:

Working through SAI - 6 signed off

Outcome of SMT Discussion:

Southern Health and Social Care Trust

Quality Care - for you, with you

Weekly Corporate Governance Update Report 03.08.2020 - 09.08.2020

The purpose of this report is to provide an organisational overview in relation to key governance issues that have occurred / been reported in the previous week. This will include data in relation to:

• Adverse Incidents	• Complaints
• SAI's	• NIPSO
• Early Alerts	• RIDDOR
• Coroners Cases	• RQIA
• Clinical Negligence Cases	• Standards and Guidelines
• Information Governance	• Medication
• Hyponatraemia Audits	• Safeguarding

Adverse Incidents (Severity – Catastrophic)	New SAI's	Interface Incidents	SAI Reports Completed	Early Alerts & Updates	Coroner's Cases / Inquiries (New)	Clinical Negligence Cases	Hearings	Complaints requiring escalation	New High Risk Complaints	New NIPSO	NIPSO Reports	RIDDOR Reports	RQIA Requests	FOI
0	0	0	0	2	0	1	1	0	0	0	0		Templates	1

Comparison of the Datix Incident Reporting for the equivalent 1st week of August 2019 and 2020 has been undertaken for an overview of current reporting Levels:

Acute Directorate – 18%↓ with 139 Incidents reported

CYP Directorate – 64%↑ with 39 Incidents reported

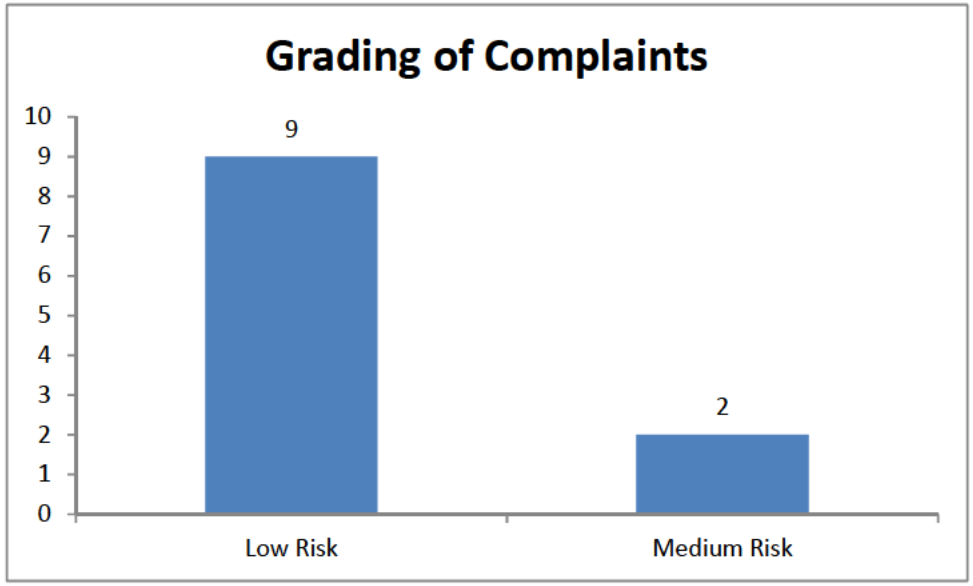
MHD Directorate – 28%↓ with 77 Incidents reported

OPPC Directorate – 63%↓ with 40 Incidents reporting

Total 400 in Week 1 August 2020 compared with 295 week 1 August 2019

Figures provided for high level comparison for operational directorates. Activity levels, service and staffing changes will all be contributory factors.

2



ACUTE DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings - 9am – 10am)

1. **Status of SAI's** - Summary of the status of SAI's between 03.08.2020 - 09.08.2020

   Any reports received after Friday will not be reflected in the numbers below until the following week

More than 26 weeks	Less than 26 weeks	Within Timescales	Level 3	Total
4	9	13	0	26

2. **Reopened Complaint**

   11341 - [redacted] – arrange family meeting

3. **Issues escalated by Corporate or Directorate office TBC at meeting.**

   3.1 Paediatricians and Surgeons meeting remains to be arranged. Informal discussions held with Mr Haynes and Dr Khan.

   3.2 W118093 – Patient in 3 North time line done safe guarding report

   3.3 W118075 – Update re injury – awaiting response from lead nurse

   3.4 W118154 – Delay in referral to SLT - Risk Midwife sorting out.- shared with Charlotte