



Meeting Date	28 July 2020	Agenda Item	7.1
Report Title	Quality and Safety Committee		
Report Author	Sian Richards, Deputy Chief Digital Officer		
Report Sponsor	Matt John, Associate Director of Digital Services		
Presented by	Matt John, Associate Director of Digital Services		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to provide the Quality and Safety Committee with an overview and update on an incident relating to delays in the processing of the referrals from GPs to secondary care and the actions taken to mitigate the risks.		
Key Issues	<p>A technical incident occurred with the Welsh Patient Referral Service (WPRS). The systems is the primary method for managing electronic referrals from primary care to secondary care. The technical error resulted in patients' referrals information not being actioned in a timely manner resulting in delays to appointments. This was the case for 50 patients between January 2019 and 2020, fortunately to date there has been no clinical assessment of harm as a result of the delays.</p> <p>The system is being redesigned by NWIS with medium term mitigation in place until the technical fix is deployed.</p> <p>A full technical review will be completed by NWIS.</p>		
Specific Action Required <i>(please choose one only)</i>	Information	Discussion	Assurance
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recommendations	<p>The Quality and Safety Committee are asked to:</p> <ul style="list-style-type: none"> NOTE the report and the mitigating actions being taken 		

Management of an Incident]- 0awith Electronic Referrals

1. Introduction

The purpose of this report is to provide the Quality and Safety Committee with an overview and update on a safety and technical incident that occurred in January 2020 with the system that receives electronic referrals. The system is called the Welsh Patient Referral Service (WPRS) and is hosted and maintained by NHS Wales Informatics Service (NWIS). The systems is the primary method for managing electronic referrals from primary care to secondary care.

2. Background

The Welsh Patient Referral Service (WPRS) enables electronic Outpatient referrals to come directly from GPs to Consultants via Medical Records. The Consultants can carry out a number of electronic actions with each referral, including prioritising, returning to the GP (with an explanation), and redirecting the referral to either consultant or non-consultant services or clinics.

The WPRS consists of a number of key components:-

1. The Welsh Clinical Communications Gateway (WCCG) is for GPs to submit electronic referrals to hospitals, and for clinicians to send messages about these referrals back to GPs. GP's can also submit from WCCG a supplementary message and advice messages to the clinician after a referral was sent which then goes directly into their worklist in WCP.
2. The Welsh Administration Portal (WAP) and the Welsh PAS (WPAS) is for hospital records staff to process and send the GP referrals to clinicians for prioritisation and to match patient demographic details between GP records and hospital records.
3. The Welsh Clinical Portal (WCP) is for clinicians to view, assess and prioritise the referrals.
4. Welsh Care Records Service (WCRS) is utilised to store the WAP referrals, the referral documents are superseded when updates are received.

Once the GP submits the referral from WCCG, it is received into WAP where it is then reviewed and processed. It is then matched to the patient's WPAS record and added on for the appropriate speciality. Following WAP processing an initial record for the patient's referral is created in WPAS and the referral is simultaneously forwarded to the appropriate consultant's worklist in WCP for review and prioritisation. The Consultant may agree with or alter the prioritisation of the referral. Subsequent to Consultant review and prioritisation, the referral is then updated/confirmed in WPAS, the patient process is then complete, and the open referral is ready to be appointed.

Alternatively, the Consultant may decide to return the referral back to the GP, declining to see the patient in an outpatient clinic, and provide the reason in an electronic message that is delivered to the GP via WCCG, this then closes the referral in WPAS.

A supplementary message is a message generated in WCCG using an existing speciality referral, which the GP's can then send additional clinical and or additional pertinent information relating to that referral, there is no time limit to when a supplementary message can be attached to the original referral by the GP. This is in conjunction with the WPRS service. The supplementary message does not show in a WAP worklist for processing, it is automatically associated to the original referral in WCCG and both are placed in the Consultant's worklist in WCP, for them to re-prioritise the referral in conjunction with the supplementary information. A banner will also show at the top of the referral when there is new information.

Problem Specific Background

A technical fault was identified on the 07/01/2020 in the way the WPRS systems manage supplementary messages from GPs. The fault occurred at the point when a supplementary message was updated in WCP by the clinician, but then the original referral was already closed in WPAS either by a manual process or had automatically closed because an appointment had been booked.

The supplementary messages successfully transmit from primary to secondary care into WCP for the clinician. However if the original referral in WPAS was closed, once a decision is made in WCP by the clinician this updates on the closed referral as there is no new referral open and then the patient did not get added to a waiting list.

The fault was identified in January 2020. Between January 2019 and January 2020, 2405 supplementary messages were sent from WCCG by primary care. Of these messages, 1154 of these fell into the scenario that the supplementary message was sent after the referral was closed or appointed, as described above.

3. Assessment

The decision was made to manually review all 1154 case that occurred in 2019/20. From Friday 10th January, a team of 10 people were taken off their substantive roles in Swansea Bay Health Board, in order to review all of those supplementary messages. It took the team 8 working days to complete the work.

During this time, daily progress meetings were taking place with NWIS and internally. In addition the case was reported as a priority P1 incident to NWIS for resolution on the national service desk and a 'No Surprises' report submitted to Welsh Government. The case was escalated to NWIS Directors and a full technical review is now being undertaken.

All 1154 patients have been manually reviewed. Of the 1154, the final number of patients that required a clinical review was 50. Of these, 11 were marked USC (urgent suspected cancer) and 39 patients were routine or urgent.

As at the 1st of April 2020, all 11 USC patients identified have been reviewed and seen where required and it has been clinically assessed that no harm was caused to the patients as a result of the delay.

Of the 39 urgent/routine patients, 28 patients have already or went on to receive an appointment and a clinical assessment. It was confirmed that no harm was caused due to the delays for these patients.

As of the 03rd July 6 patients are waiting to be reappointed into clinics in due course as currently there are scheduling issues as a result of COVID-19. These appointments have taken some time and all outcomes will be reported once the appointments are completed. The booking office are aware of the remaining 6 referrals and are taking every opportunity to book the patients into suitable clinic slots.

A full analysis detailing the length of delay from receipt of the supplementary message to the patient being seen has been completed. The details are as follows the longest USC wait was 13 months and the longest routine / urgent patient was 12 months. The shortest delay was 5 days. However as noted above there was not harm to the patients as a result of the delay. There may be some further time delay for the remaining 11 patients due COVID 19 changes to clinics.

The SBUHB WPRS team have been working closely with the NWIS WAP team that built and host the system to agree and test a technical fix. The solution is now being thoroughly tested by the teams and is expected to be deployed in Q2 2020.

Operational mitigation processes are in place until the updated is deployed. As a mitigation, in the interim period a weekly audit report is being produced by NWIS-WAP team showing all supplementary messages identified where the referrals have a status of closed, which is sent to the registration department staff in SBUHB who are manually reviewing. The report is validated by the registration supervisory team.

NWIS are conducting a full review and investigation, which will be shared with SBUHB once completed.

4. Recommendation

The Quality and Committee are asked to:

- **NOTE** the incident associated with the referrals and the thorough review and mitigating actions taken
- **NOTE** to date no harm has come to patients as a result of the delays experienced, with 06 patients' still needing review.
- **NOTE** the pending full investigation report to be issued by NWIS that will be shared with wider stakeholders in due course