Stonefield Street Surgery

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[redacted]

Ms L Hashmi
Area Coroner for North Manchester Area
HM Coroner's Court
The Phoenix Centre
L/Cpl Stephen Shaw MC Way
Heywood
OL10 1LR

08 January 2018

Dear Ms Hashmi,

Re: Regulation 28 Report to prevent future deaths

Thank you for your regulation 28 letter dated 21st November 2017 which relates to Miss Sarah Kiff. This lady was well known to the partners and staff at Stonefield Street Surgery following the diagnosis of advanced cervical cancer back in July 2013 and through her subsequent diabetic and palliative care reviews until she sadly succumbed to the cancer in October 2015. I am responding on behalf of the practice to the five concerns you raise. I will demonstrate that the events surrounding both the diagnosis and death of Miss Sarah Kiff, have been discussed through significant event analysis and as a result, we have developed better pathways and protocols within the practice. I will demonstrate that we have tried as a practice to learn from what has happened and we continue to learn from it.

I will discuss the points raised in turn:

1. **GPs at the practice did not follow NICE 2005 cancer referral guidance:**

   The practice has produced an annual audit report around new cancer diagnoses for several years, with the records of each patient being reviewed by a clinician looking to see if there were any lost opportunities to diagnose the condition earlier and to ensure NICE guidance was correctly followed. These Cancer Analysis Audits are discussed at the clinical governance meetings and any learning points are shared within the practice team.

A review of Miss Sarah Kiff's notes was undertaken on 14th October 2013 by Dr Lynn Hampson. It was recognized during the audit that at diagnosis Miss Kiff had Stage 4 disease with liver metastases. The history showed that she first developed symptoms of urinary infections and vaginal discharge in early 2013; however no formal pelvic examination had been undertaken. The doctors had been reassured because of a high vaginal swab confirming infection and a negative Ultrasound Scan. Unfortunately, there was then a gap of nearly five months before Miss Kiff represented with urinary symptoms and discharge and within a week of that presentation she was referred urgently to see a Gynaecologist.

The cancer analysis was discussed by the clinicians and it was recognized that there had been no examination by a doctor as per NICE guidance CG27, although a HVS had been undertaken by an experienced practice nurse. [redacted] thought that this was undertaken using a speculum with visualization of the cervix, and nurses agreed it was standard practice to take a HVS using a speculum to visualize the cervix, but at the time there was no practice protocol describing these expectations. Male GPs described how they were feeling less confident in performing pelvic examinations compared to their female colleagues due to the infrequency with which it was required in a practice that has three female GPs, a nurse practitioner and three practice nurses. At that time, it was agreed that any female patient needing assessment who had presented to a male doctor that had concerns about their skills in examination, would be handed over to one of the female GPs. Similarly, where male patients felt uncomfortable about having pelvic examinations performed by a female GP, then the same onward referral protocol would be followed. This agreement has been in place since October 2013. More recent discussions have also concentrated on the methodology for taking high vaginal swabs following your comments, and it has been reconfirmed that these are all done using cervical speculums, so that the cervix is visualized during the test. Any abnormality found by the nursing staff will be highlighted to one of the GPs. The practice now has an agreed protocol for performing HVS.

Following these initial discussions, [redacted] sent a letter to the scan providers, Lancaster House, dated 14th October 2013, asking that the consultant [redacted] review the ultrasound scan from Feb 2013, as the partners were concerned that a 6cm cervical lesion with metastases, diagnosed in July would probably have been visible in the February. No response was received. [redacted] wrote again on 27th May 2016, but no response has been received from the provider to either of these letters. This was raised in a Quality Feedback form to the primary care department of HMR Clinical Commissioning Group.

In July 2015 new cancer guidance NG12 was produced by NICE. These were discussed within the practice meeting, with each partner being provided with copies of the Macmillan summary guidance and copies of the BMJ flow chart which are laminated and on the wall of each consulting room. The deputy Practice Manager now ensures that all new NICE guidance is shared with clinicians monthly via email and the lead clinician in the relevant area is responsible for ensuring that any new recommendations are shared, and protocols altered where necessary. This process has now been in place for over 2 years.

2. **Medical record keeping and communication between the medical and nursing teams was poor. The doctors were not explicit about what they required the nurse to do in terms of PV examination and made assumptions that the nurses knew what was expected of them.**

All nurses within the practice receive training in performing swabs and doing vaginal examinations as part of the competency for gaining certification for the taking of cervical smears, using vaginal speculums. The current nursing team have described that they do use speculums to undertake HVS and where possible do visualize the cervix asking a GP to review if there are any abnormalities seen. However it has not been standard practice to document this in detail when taking a swab and it has now been agreed that more detailed records will be written noting if the cervix has been seen as per the new protocol. All four of the current nursing team are experienced practitioners and have been performing such examinations for many years. [redacted] who performed the original HVS is also likewise experienced and we would have expected her to raise a concern had she seen any abnormality during the examination. The GP did assume that having a HVS meant that the cervix had been visualized. Following your regulation 28 letter, the doctors and nurses have reaffirmed the intention for all HV swabs to be performed with direct vision of the cervix so that it is clear what is expected when a patient is referred for a swab. Likewise, it has been agreed that instructions for other diagnostics are also to be written clearly within the records and that patients are made aware of how these results can be accessed.

Review of the medical records for Miss Kiff has highlighted that the record keeping was not adequate, and this has allowed the clinical staff to review the method for clinical note recording, ensuring in future that more detailed records are kept. Each clinician has now reviewed the GMC guidance on record keeping in *Good Medical Practice (2013)* at paragraphs 19-21.

3. **There was lack of continuity of care and a failure of doctors to fully appraise themselves of the clinical history ahead of consultations.**

Patients registered with the practice can book with any GP and therefore have the ability to see the same doctor if they so wish. This is generally encouraged by the doctors as it improves continuity of care. Miss Kiff chose to see different GPs and therefore there would have been some loss of continuity with the doctor having to revisit the clinical history on each occasion. Whilst it is the responsibility of all clinicians to ensure they are apprised of any relevant clinical history, due to the pressures of general practice and the limited consultation time it is sometimes difficult to be fully aware of the finer details of past medical history. Each patient will have a summary of significant clinical history which is easily visible at the start of a consultation in the clinical records.

Due to increasing complexity of many patients, the practice has altered consulting schedules so that blocks between every few patients allow the doctor time to ensure they are up to date with past and current clinical problems for each patient. The blocks result in the standard appointment time of 12 minutes instead of 10 minutes. I have already alluded in sections 1 & 2, to processes now in place to ensure that clinical records are more accurate and that the relevant examinations are performed.

4. **During the course of the evidence it became clear that male doctors were reluctant to carry out internal examinations on female patients as they felt it more appropriate for their female colleagues to do them.**

   The practice has already instituted mechanisms to ensure that female patients needing intimate examinations can, where preferred, be referred to a female colleague for this to be done. This is described under point 1.

   As an additional learning action, the practice has been able to get the support of [redacted] a Gynaecology Oncologist at Pennine Acute Trust, who has agreed to provide a training session for the clinicians at Stonefield Street Surgery in early 2018 around the recognition of Gynaecological malignancies and management of female problems. Some of the male partners are also looking to attend local Gynaecology clinics to help improve their competency in vaginal examinations.

5. **The processes in place for reviewing test results and ensuring they appear within the patient electronic records appear to be inadequate.**

   All test results relating to Miss Sarah Kiff are clearly visible within the patient electronic record. The EMIS computer system records date test requested date received, date of review and filing as well as any practice notes made by the doctor. The report comments on the Ultrasound Scan result for Miss Kiff, but the records clearly show that the report was received on the 25th February, seen and noted to be normal and filed in the patient record, so this was unfortunately not available for her appointment with Dr Younis on 22nd February 2013. This is all auditable within the clinical system.

   The practice has robust processes in place to ensure all diagnostics are actioned on the same day of receipt and where there is an abnormal result that these are followed up with the patient. The GP can readily look in the clinical records to review why the test was performed. On most occasions the GP who orders the test will be reviewing the results, but this is not always possible due to patterns of working. In addition, some providers return results to the registered GP rather than the one requesting the test.

   The practice protocol has been designed to ensure that where a result needs follow up the patient is made aware. The original protocol dates from December 2015 but this has recently been updated. Patient follow up is managed either through a practice note asking the administrative team to arrange a further appointment or the result being passed on to the relevant clinician. These actions are all auditable within the clinical records of the patient. The practice protocol describes that when tests are taken it is the responsibility of each clinician to make the patient aware of the intentions around actions following the diagnostics. It is a general rule that normal results are not notified to patients, however patients are asked to phone to learn the results of any tests and the clinicians receiving these will add a comment and file the report within the patient record. Where a normal result is received many patients are still seen for follow up.

In this response, I trust that I have provided reassurance that the practice has put into place robust processes and procedures to ensure that diagnoses are not delayed.

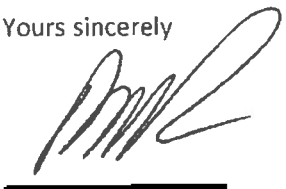
To summarise, the learning and actions taken are as follows:

- The practice has put into place mechanisms to ensure that NICE guidance is followed
- The practice continues to perform monthly Cancer Analysis Audits for all patients newly diagnosed with cancer and discusses any learning points within practice meetings
- All NICE guidance is reviewed monthly and disseminated to all clinicians
- The practice has a new written policy around methodology for undertaking HVS and the recording of findings
- A new policy has been created that describes internal referral processes between clinicians where there is a more appropriate professional to perform either an examination or procedure
- Record keeping: All Doctors have refreshed their knowledge of paragraphs 19-21 of the GMC's guidance *Good Medical Practice,* which describes good record keeping
- Dr Schaefer is providing training to all clinicians on Gynaecological malignancies
- Some male GPs will undertake upskilling in female pelvic examination techniques

Miss Kiff was added to the Gold Standard Framework (palliative care register) in November 2013 and her care was regularly reviewed in the monthly multidisciplinary team meetings, with several members of the extended team providing support during her ongoing therapy with The Christie Hospital. In addition, the practice performs a review of all patient deaths, and this was done following the death of Miss Kiff, with learning points being raised through the multidisciplinary meeting that happened coincidentally on the same day as Mrs Kiff died. The team members were all saddened that her last moments were not as discussed within her end of life plan.

I trust also that I have provided you with evidence that the practice has reviewed the care provided to Miss Sarah Kiff, and that we have learnt from what happened and put into place procedures to address the issues you raise. We continue to review our protocols and procedures to ensure the safety of patients, with robust processes in place to identify and learn from significant events.

Yours sincerely



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Senior Partner