Update on the Investigation into incidents involving the Pathology Service for Brent and Harrow PCTs 23rd May 2013

1. Purpose of the paper

This paper provides an update the HOSC on the progress against the action plan which was included in the Root Cause Analysis paper and which has been adopted in full by the CCG, North West London hospital Trust, Harrow CCG and the pathology provider The Doctors Laboratory (TDL).

2. Background and context

In May 2009, Harrow PCT issued a letter to NWLHT the existing provider of the pathology service to Harrow GPs, notifying them that with effect from 2010/11, they intended to follow a tendering process to commission a new pathology service. Their stated intention was to lead the development of a joined-up approach to the commissioning and possible market testing of Direct Access pathology services.

The procurement process was paused in March and April 2011 to allow time to consider the implications of the NHS London review of pathology for the sector. It was considered prudent to proceed as the final London solution was likely to take 2-3 years to realise, and the existing pathology system at NWLH was in a critical state and not expected to be operational beyond October 2012.

The procurement scope included all of the general diagnostics pathology services i.e. Haematology, Biochemistry, Microbiology, Histopathology, Cytopathology. Out of scope of the procurement were:

- Consultant pathologists (they remain employed by the NWLHT)
- Transport (a separate procurement was required for this element)
- The mortuary
- Specialist Genetics Laboratories within the Kennedy Galton Unit of NWLHT

3. Timeline of significant events preceding the incidents

TDL were appointed as Preferred Bidder in September 2011 and aimed to go live on the 5th January 2012. A number of issues with the lease and licenses delayed the start until 1st May 2012. The contract management of this contract is a NWLHT on behalf of the three commissioners and the performance management of the contract sits with the CSU, with local support from the non-acute contracts manager for Brent and Harrow.

4. Incident

As previously described to the Committee the incident which led to the RCA fell broadly into two categories;

4.1 Pathology results were received from the Pathology Service in a different format than previously experienced. GP practices in Brent received pathology results presented in a manner that now makes it possible for one result being viewed, actioned, filed and archived with the subsequent result that other reports within the grouping, will be filed and archived in the patient's records without necessarily being viewed or actioned. This was a significant change from the manner in which results had previously been received in Brent and Harrow and represents a significant clinical risk.

4.2 Secondary to the above; spurious results, missing samples, missing test results and multiple, batched test results were later reported by GPs. There was also a failure on the part of the service provider to report some abnormal results and other abnormal results were not being flagged as such. GPs were also concerned that reference values appeared to have changed.

A Root Cause Analysis was initiated and chaired by a local GP, the report of which has been circulated to HOSC members previously, and an action plan drawn up to address the resulting deficiencies.

5. Courier Service

The courier service was not part of the pathology service and was procured through a separate tendering process. The existing service provider was the successful bidder and the service continues to be provided by Revisecatch Limited (Courier Systems) who were appointed in October 2012 for a period of 4 years and 7 months to tie in with the Pathology service.

Although not directly associated with the problems described above the storage, transportation and delivery times are being reviewed to ensure that they do not add to the instability of the samples due to fluctuation in temperature during storage at the GP practice or transportation to the laboratory.

6. Root Cause Analysis action plan

The RCA is overseen by the Contract Review Committee which has clinicians and managers from the three commissioning organisations (Brent, Harrow CCGs and NWLHT), TDL and the Courier provider. The RCA is managed through the operational group which is chaired by the GP who led the RCA.

The action plan is attached as Appendix 1.

7. Conclusion

The HOSC is asked to receive and note the report and the updated action plan.