



Brent  
Clinical Commissioning Group

## **Update report to the Brent Health Overview and Scrutiny Committee on the Urgent Care Centre X-ray incident**

### Incident in Brief:

There was a discovery of a substantial number of x-rays (some un-reviewed) that were not automatically sent to the patient's GP surgery. - The Governance team undertook a full Root Cause Analysis Investigation (RCA) and submitted to NHS London at the beginning of June 2012. Throughout the investigation a Clinical Governance Manager from the Governance team worked closely with NHS Brent.

The UCC undertook a comprehensive programme of tracing those patients that required follow up appointments following the discovery.

The majority of patients were contacted in the following weeks and offered follow up appointments. This process involved contacting the patients by letter which was then followed up with a telephone call to ensure they had received and understood this information. It was clearly explained to each patient what had happened and the process agreed for following up their individual conditions.

The GP surgery was also informed and given the appropriate briefing about the condition, x-ray result and to expect the patient to attend a follow up appointment.

In cases where the patient had moved GP surgeries the patients were traced and the same process followed.

There were a number of "cold cases" (those who could not be initially traced), 11 in total, which took considerably longer to trace. It is not unusual for a number of these to remain outstanding when a Serious Untoward Incident is closed but by December 2012 all patients had been traced and contacted and had completed their follow up.

### Patient Impact

A process was put in place for these x-ray reports to be clinically reviewed by a competent team of radiographers and doctors. The cases were then categorised using the following traffic light system.

Category	Number	Description
Red	• 97	• Confirmed fracture/ other pathology which may have altered the course of treatment given.
Amber	• 153	• An abnormality identified but on review of patient consultation notes, appropriate care was provided.
Green	• 5728	• No fracture or abnormality identified and treated appropriately at time of consultation.

The 97 patients were contacted in a two stage process

Tele Consultations	Brent
<b>Closed - no further action</b> Including patients treated appropriately at the time of presentation.	66
<b>Face to Face Consultation required</b> Patients who require a face to face follow up consultation who we are attempting to contact to book an appointment.	6
<b>Managed by Alternative Provider</b> Patients who are undertaking treatment with an external provider.	1
<b>GP Referral required</b> Referral required to be actioned by GP	2
Advised to see GP, if required	3
<b>Sub Total</b>	<b>78</b>
<b>Patients moved to Stage 2</b> Patients who have been contacted and were booked a Face to Face Follow Up appointment	19
<b>Total</b>	<b>97</b>

Face to Face Consultations

<b>Stage 2 – Face to Face Consultations</b>	<b>Brent</b>
Closed - no further action	8
To go back to GP, if required	0
Referral required – non fracture clinic	2
Referred to Fracture Clinic	9
<b>Total</b>	<b>19</b>

All patients have now been successfully treated and discharged.

Sept 2013