Care UK Urgent Care Centre Serious Incident – Summary Report

This report summarises the position in August 2012 regarding the serious incident (SI) that was identified at the Brent Urgent Care Centre (UCC) in March 2012.

Following the declaration of the SI, an investigation team was convened to undertake a Root Cause Analysis of the incident to establish root causes and identify lessons learnt. The team was Chaired by Dr Sami Ansari, Clinical Director, NHS Brent and supported by Ms Terilla Bernard, Locality Improvement Manager, NHS Brent. The report was written by Ms April King, Clinical Governance lead for Care UK.

This report to the Brent Health Overview and Scrutiny Committee is set out in the following sections:

Section 1: Summarises the background of the incident and the findings of the Root Cause Analysis investigation undertaken by Care UK.

Section 2: Sets out the steps taken to follow up with patients affected by the incident and progress on this to date

Section 3: Sets out the steps taken to deal with the child protection concerns arising from the incident and subsequent investigation

Section 4: Sets out the actions taken by NHS Brent to date and ongoing monitoring arrangements

Section 1: Background of the incident and findings of the Root Cause Analysis investigation undertaken by Care UK

Brent Urgent Care Centre (UCC) became operational on 28th March 2011. It is situated at the front of the Central Middlesex Hospital (CMH) Emergency Department. The service provides urgent primary care services to patients with minor illness or injury. Brent UCC does not provide an X-ray service. All radiology patients are referred to the X-ray department of the Central Middlesex Hospital, within the same building, who perform the x-ray and send the patient back to the UCC for first line clinical review.

Detection of the incident
On the 6th of March 2012, the newly appointed Local Medical Director for Brent UCC advised the General Manager that he had noticed a significant number of outstanding x-ray cases on the IT system. The General Manager put measures in place to have these patients' radiology records clinically reviewed and their discharge notes faxed to the GPs. As a result of this activity on Wednesday 14th March 2012 Brent UCC received a phone call from a patient's GP surgery enquiring as to, why patient discharge summaries, dating back to August 2011, were only being sent out in March 2012.

Further examination of the issue identified there were 5978 records on the IT system which had not been closed appropriately; all relating to patients who had had an X-rays which dated back to start of the service on the 28th March 2011.

Aspects of processes relating to the incident were previously raised on five separate occasions set out in the table below:

Date	Issue raised
14th July 2011	Clinical Systems Training Administrator first identified the x-ray queue stood at 2083 cases waiting to be faxed out. There was no confirmation these reports had been clinically reviewed and validated.
18th August 2011	As part of the Care UK Governance Patient Safety Review of the radiology process it was identified there was no formal process for reviewing all the radiology reports, only the red flags were being reviewed on an ad hoc basis.
August 2011	Central Middlesex Hospital PACS team identified and informed the Interim Service Manager at Brent UCC that the PACS reports were not being printed off
September 2011	Care UK Interim Local Medical Director queried the x-ray queue with the previous General Manager and the new Service Manager. The interim Medical Director was informed it was the fax queue and it was nothing to worry about.
21st November 2011	Business Systems trainer identified the high number of patients on the x-ray queue (4500). This was reported to the previous General Manager and the new Service Manager.

On none of these occasions was the identified problem reported onto Care UK's Incident Management system.

The incident was reported formally on the following dates:

Date	Report
19th March 2012	The incident was recorded on Care UK's internal incident reporting data base (Datix).
30th March 2012	The General Manager informed NHS Brent
4th April 2012	The incident was recorded on the STEISS system

Care and Service Delivery Problems:

Brent Process Flows – Patients returning from Diagnostics:
A review of the radiology pathway using the reactive barrier analysis tool has been undertaken and identified the following barriers were working correctly.

- The PACS system identified the number of PACS reports not being printed off. This was identified by CMH who highlighted the issue to Brent UCC (CMH) staff in August 2011.

- Brent UCC (CMH) IT System does not allow the radiology patients' discharge records to be dispatched to the patients' GP until the following actions have been taken:
    - The radiology report has to be scanned into the system.
    - The clinical review box has to be ticked complete.

The barriers in place identified the numbers of radiology x-rays/reports waiting to be reviewed and printed. These barriers were also a vital tool to aid the day to day monitoring of the radiology process. From performing this review it is evident the barriers were working correctly, although the pathway itself was not being followed, and the process control tools were not being used effectively.

Lack of knowledge of the radiology process/root cause
A fundamental lack of knowledge of the radiology process led to miscommunication and staff not following the correct radiology process. A review of the radiology pathway with the Double Analysis tool has been undertaken and identified when the radiology pathway was not being followed.

Contributory Factors considered:

Induction/training: The three senior members of management, who were in post between service commencement and November 2011, did not undergo training of the radiology process at time of induction. Neither did they have any training at a later date. The Interim Service Manager (in post from 25/07/2011 – 31/09/2011) also did not receive training on the radiology pathway on commencement in the role.

Lack of clinical leadership: Initially in the staffing model there had not been a lead nurse. This was recognised as an oversight and Care UK have appointed a Lead Nurse and a Deputy Lead Nurse who work across the Brent UCC and the Ealing UCC.

There were also concerns raised in relation to the Medical leadership at Brent UCC in June and July 2011 both internally and externally, although it is not considered that this lead directly or indirectly to the incident. However a stronger Medical Leader may have lead to a more forceful escalation. The original Medical Director's contract was not renewed following the probationary period. An Interim Medical Director was put into post from September 2011 to February 2012. A permanent Medical Director was in post until September 2012 but has now left the organisation and a new appointment has been made.

Service Management: Concerns were raised regarding the original service manager's performance and this person left the company at the beginning of July 2011.

The Governance Patient Safety Review Audit (radiology process) the issues highlighted in this audit were identified in the final Governance Patient Safety Review Audit Report (August 2011). From this report an action plan was written by the previous General Manager. The previous General Manager was responsible for the implementation and the monitoring of the audit actions by the Senior Management Team at Brent UCC. The actions in relation to the radiology process were marked off as complete when they had not been. There were also several versions of the action plan, but none of the documents were version controlled, making it difficult to ascertain any progress.

Culture within Brent UCC: A Care UK Medical Director from a different region interviewed the doctors at Brent UCC, in confidence, to establish their views on the situation. This process did not raise any issues considered to have contributed to this SI.

Root Causes
Induction/training: The three senior members of management: who were in post between service commencement and November 2011, did not undergo training on the radiology process at time of induction. Neither did they have any follow up training. The Interim Acting Service Manager who was in post between August and October 2011 did not receive training of the radiology pathway.

Lack of knowledge of the radiology process: As they did not receive training on the radiology pathway, Brent UCC Senior Management Team members did not have a clear understanding of the radiology process. This led to miscommunication at every level and resulted in staff not following the correct process.

The Governance Patient Safety Review Audit (radiology process)
The issues identified in the Governance Patient Safety Review Audit (radiology process) undertaken in August 2011 and the associated actions were not implemented by the Senior Management Team at Brent UCC or monitored despite an action plan that indicated actions had been completed.

Assurance
A number of the checks and balances were put into place including:

- Audit plans
- Mandatory training plan and monitoring
- KPI monitoring
- Internal "CQC compliance audit"

However none of these assurances identified the risk of the incident and subsequently two specific reports have been developed to monitor process control. In addition a wider review of Care UK's governance framework has been commissioned by them to make recommendations about how the approach can be strengthened.

Lessons learnt by Care UK

- To ensure the correct calibre of Senior Management personnel and Senior Clinical Staff are in post prior to service commencement.
- The importance for all staff including Interim and Management Team to attend all clinical pathways sessions at induction.
- The importance of all Locum/agency staff to have a proper local on site induction of the clinical pathways.
- The need for a documented operational daily, weekly, monthly tasks framework. Closer operational monitoring for newly mobilised services to ensure processes are adhered to.
- For all Service Mangers and Deputies to be trained in incident identification reporting, investigation – Datix DIFF 2 training.
- To ensure where there is high usage of locum staff that robust inductions are in place, which have to include induction to the clinical pathways.
- For Brent UCC (CMH) Service Managers to have greater ownership of their Governance agendas within their service.

Lessons learnt in relation to Safeguarding Children processes by Care UK

- There needs to be greater accountability for all staff in relation to the ownership of Safeguarding, this cannot just be the responsibility of Brent UCC (CMH) Safeguarding Nursing Lead.
- The current local procedures in place for checking the Child Protection Plan Lists are time consuming and allow for human error.
- All Locum/Agency staff should only be hired with correct level of safeguarding training (GP's and Nurse Practitioners Level 3).

Recommendations

1. Review the recruitment processes for Senior Operational Staff and Senior Clinical Staff when starting new services in new service areas.
2. Implement robust training on the radiology process at Brent UCC from first contact to discharge for all staff including the Brent UCC management team.

3. Implement robust induction programme which includes the radiology process for all Locum/Agency staff.
4. Develop an operational process to ensure the radiology reports are reviewed by a competent clinician on a daily basis.
5. An operational process to be devised to ensure all radiology reports are scanned into the patient's notes and then ticked off as complete on the IT system.
6. To devise a detailed operational "daily, weekly, monthly procedures resource file" to ensure the knowledge transfer is secure and that operational monitoring of all processes is carried out.
7. For all newly mobilised services to have a "post go live IT test/audit" of patient pathways at regular intervals i.e. monthly for the first three months and then bi monthly for next six months and then quarterly. This is to be conducted by Care UK Business Systems Team.
8. Datix DIFF Two training to be mandatory for all Service Managers and their deputies to attend.
9. To reduce the service dependency on the use of locum staff.
10. Senior Management at Brent UCC to take ownership for their service's governance objectives.
11. IRMER (radiology guidelines) update training for all clinical staff referring to radiology.

Recommendations related to Safeguarding Children

1. Robust induction programme which includes the radiology process and the safeguarding referral pathways for all Locum/Agency staff.
2. Reinforce requirement for the Child Protection Plan lists (CPPL) to be checked.
3. Change "CPPL Check" to a mandatory field or a pop up box to ensure completion on the IT patient system.
4. Ensure all Locums are provided with the appropriate safeguarding children policies & referral procedures.
5. Ensure all staff undertake /refresh required Safeguarding training at the appropriate level. (All doctors and nurse practitioners Level three – Health Care Assistants Level 2, Admin Level 1).

Arrangements for shared learning

The details of potential risks for errors and failings will be shared with other sites within the organisation that use the Adastra IT patient system to raise awareness of possible breaches and to embed more robust processes and procedures.

The lessons learned and recommendations will be shared with the following teams and meetings within Care UK

- Care UK's IT and Business Systems teams
- Care UK Board Governance Sub-Committee Meetings (including Chairman & Chief Executive)
- Healthcare Divisional Directors' Board Meeting
- The Regional Directors' Operational Meetings
- The Health Care Integrated Governance Group
- Care UK IT & Business Systems teams
- Clinical meetings locally at Brent UCC
- Primary Care Lead Nurse Forum
- Medical Leads Forum

Section 2: Steps taken to follow up with patients affected by the incident and progress on this to date

Clinical Review:
At the point of identification of the incident there were a total of 5978 patients' electronic radiology reports on the X-ray queue of the Brent UCC IT patient system. There was no evidence or assurance these patients' radiology reports had been reviewed by a doctor at Brent UCC.

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 red patients have been contacted using a three stage process as follows:

Stage 1 – Contacting Patient	Brent
• Patient received at least 3 attempted telephone contacts • GP contacted to confirm/obtain further contact details, where held • "Contact us" letter sent by registered post	3
• Invalid telephone contact details identified • GP contacted to confirm/obtain further contact details • "Contact us" letter sent by registered post	1
• Invalid telephone contact details identified • No GP details held / patient deregistered • "Contact us" letter sent by registered post	3
Sub Total	7
• Patient successfully contacted and moved to stage 2	90
Total	**97**

Categorisation of remaining patients

Category	Definition	Nos of Patients
Mild	Missed abnormality No adverse consequences anticipated	5
Moderate	Missed abnormality Potential ongoing symptoms anticipated	2

Severe	Missed abnormality Potentially life threatening or severely disabling outcome anticipated	0

Tele Consultations

Stage 2 – Tele Consultations	Brent
Closed - no further action Including patients treated appropriately at the time of presentation.	59
Face to Face Consultation required Patients who require a face to face follow up consultation who we are attempting to contact to book an appointment.	6
Managed by Alternative Provider Patients who are undertaking treatment with an external provider.	1
GP Referral required Referral required to be actioned by GP	2
Advised to see GP, if required	3
Sub Total	**71**
Patients moved to Stage 3 Patients who have been contacted and were booked a Face to Face Follow Up appointment	19
Total	**90**

Face to Face Consultations

Stage 3 – Face to Face Consultations	Brent
Closed - no further action	8
To go back to GP, if required	0
Referral required – non fracture clinic	2
Referred to Fracture Clinic	9
Total	**19**

The GPs of the 11 patients who required onward referral have been notified.

At the time of writing this report only one patient has contacted Care UK to complain. This complaint was made verbally and related to the process undertaken to contact them and has been logged and resolved by Care UK.

NHS Brent has requested that Care UK follow up on the 9 patients who required onward referrals to ascertain the outcomes for those patients. At the time of writing this report (24th Sept 2012) this information has not yet been received by NHS Brent.

Section 3: Safeguarding issues and steps taken to deal with the child protection concerns arising from the incident and subsequent investigation

Clinical Review - for vulnerable adults over 18 years of age:
From the clinical review there was one “red” categorised patient who was identified as living in a care home. On further review of the consultation notes there were no safeguarding concerns identified.

Clinical Review - for patients less than 18 years of age:
Within the overall cohort of 5,978 attendances, children (under the age of 18) accounted for 1564 of this total. A part of the clinical review included identifying those children/young people who attended Brent UCC and had an x-ray from 28th March 2011 (service commencement) to 14th March 2012. The aim of this review was to identify those children/young people in particular those who had a supervision order (SO) in place and were on the Child Protection Plan List (CPPL).

Child Protection Plan List
Brent UCC CMH currently receives Child Protection Plan lists (CPPL) from the following Social Services Departments:

- Brent
- Ealing
- Hounslow

As there is no national Child Protection Plan List, Brent UCC has been unable to cross match any child who is on a list outside of the lists that we are currently provided.

Brent UCC failed to adhere to the agreed policy (Safeguarding Children – Brent Urgent Care Centre April 2011). A number of issues were identified as part of the SI investigation in particular the identification, logging, and onward referral processes that require tighter and more robust management and auditing programme by Care UK.

One contributing factor of Care UK failing to check patients at presentation was the format in which the CPP List was being received. The CPP List from Ealing Local Authority was being sent in a paper format. However, this issue was not flagged by Care UK and the NHS Brent Designated Professionals were not informed of any issues when NHS Brent carried out the CPPL audit in November 2011.

Care UK reviewed all of the children against the CPP lists available and found the following matches:

	Brent CPPL	**Out of Area (Ealing CPPL)**
Exact Match - Name and date of birth matched	2	2
Near Match - date of birth mis match	0	1
Patient who attended more than once	0	0
“Fuzzy Search” - Name but no date of birth on Non LAC Legal Status List.	1	0

As shown above, Brent CPPL matched two patients with an "exact match" and one patient through a "fuzzy search" as this child was entered on the “Non LAC Legal Status List” where date of birth is not recorded, therefore, an exact match couldn’t be made, the search indicated that they may be on the list; on further investigation it was found that Brent LA had no record of this child, therefore, CUK have not been able to

onward refer this patient to the LA. The Ealing children identified have been notified to Ealing LA.

From this review, there are lessons that can be learnt to ensure that going forward the Brent UCC can assure the commissioner the appropriate checks are in place which can be evidenced. In addition, it has identified a number of issues which contributes toward the potential failure of the process although this falls outside of Care UKs control (please refer to recommendations action plan).

NHS Brent Designated Professionals have visited the Brent UCC and reviewed all processes with the staff. An action plan on safeguarding is in place and under regular review.

Section 4: Actions taken by NHS Brent to date and ongoing monitoring arrangements

- To issue a remedial notice to Care UK under S57 of the contract in respect of the failure to adhere to the safeguarding requirements and policies
- To issue a remedial notice to Care UK under S57 of the contract in respect of the failure of internal governance arrangements
- To issue a remedial notice to Care UK under S57 of the contract in respect of the failure to implement the pathway for x-rays
- To add additional KPIs to the contract in respect of:
    - Discharge Notifications to GPs by 8am of working day following attendance
    - Notification of children to HV/SN of by 8am of second working day following attendance
    - % of re-attenders not registered with a GP
- To agree a full action plan with Care UK to ensure delivery of all recommendations within 2 months
- To monitor progress against the actions required to implement recommendations of the SI report at monthly contract meetings
- To write to all Brent GPs to summarise the findings of the investigation and advise on the actions been taken

The above actions have been undertaken. The action plan has been completed by Care UK within the required timescales and evidence submitted by them to support this. The completed action plan was reviewed in detail at a contract review meeting on 20th September 2012. Following this meeting and following review of the evidence submitted NHS Brent consider that all appropriate steps have been taken by Care UK to resolve the issues identified by the review of the incident and the remedial notice has been closed.

NHS Brent will continue to closely monitor performance and will revisit the issues raised by the review such as training levels and adherence to safeguarding procedures on a regular basis through contract monitoring arrangements and site visits.

In addition, from July 2012 NHS Brent is attending the monthly clinical governance meetings between Care UK and staff from NWLHT. The group is reviewing a number of clinical pathways and jointly reviewing the management of individual cases (not related to this SI).

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