NHS
Luton
Clinical Commissioning Group

This is a response to the request from HM Coroner, Mr Tom Osborne, to provide information under Paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 Action to Prevent Future Deaths.

Introduction Evidence given at the inquest touching the death of Gianni KHAN revealed matters giving rise to concern to HM Coroner with regards to the 'streaming' arrangements for children with head injuries between the Luton and Dunstable University Hospital Emergency Department and the Urgent General Practitioner Clinic. HM Coroner has requested that I, as Chief Officer of Luton Clinical Commissioning Group, detail any action that has been taken, or which I propose to take, in line with Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013: Action to Prevent Future Deaths.

Background The Urgent GP Clinic was set up in December 2011 with the aim of providing a GP based service on the Luton and Dunstable University Hospital (LDH) site, as an element of an integrated approach to unscheduled care.

Whilst being co-located on the Luton and Dunstable University Hospital site it is independently run by Local Healthcare Solutions (LHS) and commissioned by Luton Clinical Commissioning Group (LCCG). It registered with the Care Quality Commission (CQC) in April 2013.

The Clinic operates as a GP surgery between the hours of 08.00 and midnight, 7 days a week, only accepting patients streamed by the hospital's Emergency Department (ED) using agreed protocols. These are patients with an urgent and unplanned healthcare requirement that necessitates a timely and direct health intervention in a primary care setting.

For this integrated service, streaming protocols were developed jointly with the Luton and Dunstable University Hospitals Emergency Department Clinicians and the Commissioner (Luton Clinical Commissioning Group). These are regularly reviewed at the Joint Service Review Meeting.

Between January and December 2013 the number of people attending the Emergency Department at the Luton and Dunstable University Hospital was 116,242 of which 37,564 were streamed to the Urgent GP Clinic.

The streaming is undertaken by a designated nurse who is a competent Emergency Department nurse and qualified to perform this role. Luton Clinical Commissioning Group fund a band 7 post, however the nurse is employed and managed by the Hospital. At the time of the incident a band 5 nurse was undertaking the streaming role as the designated nurse was taking a break.

On Saturday 21st December 2013 ten year old Gianni Khan attended the Luton and Dunstable University Hospital with his mother as she was concerned for his well-being after he had suffered an accidental blow to his head.

The streaming nurse, following the agreed protocol, made a judgement that no further

intervention would be necessary and felt that the child's condition could be managed within a primary care setting. He was therefore 'streamed' to the Urgent GP Clinic (UGPC).

It should be noted that streaming and triage are completely different processes, although at HM Coroner's inquest into Gianni's death, it was evident that this difference was not clearly understood.

Streaming is a system whereby patients are allocated to different pathways according to their needs. All ambulatory (able to walk) patients attending the Emergency Department are given an immediate visual assessment and 'streamed' by a competent Emergency Department nurse to either remain in the Emergency Department or be directed to the primary care setting of the Urgent GP Clinic.

For those patients who are considered to be appropriate for assessment and treatment at the Urgent GP Clinic, the Emergency Department receptionist records key patient demographic information and enters it onto SystmOne, the Clinical Registration System for Primary Care. They are not entered onto the Luton and Dunstable University Hospital Patient Information System.

Triage is an initial face to face, hands-on assessment by medical or nursing staff in the Emergency Department which determines a patient's priority for treatment and informs their urgency of need for further assessment or intervention.

The Luton and Dunstable University Hospital agreed to the 'streaming' of appropriate patients to the Urgent GP Clinic on the understanding that if a patient subsequently deteriorated they would be referred back to Emergency Department. Sadly, in this case, Gianni was not referred back and HM Coroner and our Serious Incident Overview Report concluded that this may have contributed to his death.

Action Taken

Following Gianni's death and the subsequent investigations by all health organisations involved, Luton Clinical Commissioning Group, carried out an assessment of the risk relating to children being streamed into the Urgent GP Clinic with head injuries. This was undertaken using the Clinical Commissioning Group's risk matrix (provided for reference in Appendix A). This established that the likelihood of harm occurring to children being streamed to the Urgent GP Clinic was 'unlikely' (0.1-1%) however the consequence/impact of that harm could be 'catastrophic' (incident leading to death), which led to an assessed risk rating of 'high'.

In order to mitigate the risk, following the inquest on 28 April 2014 and our Serious Incident Overview Report, Luton Clinical Commissioning Group, the Luton and Dunstable University Hospital and the Urgent GP Clinic agreed to exclude the following patient groups from the streaming protocol with immediate effect:

1. Any child[1] with a Head Injury
2. Any child conveyed to Luton and Dunstable University Hospital by ambulance
3. Babies 6 months and under

Patients from within these groups are now all assessed and managed within the Emergency Department.

[1] A child in emergency medicine is defined as a person up to their 16th birthday

Reassessment of the risk following implementation of the above actions has determined that the likelihood of harm to children is 'rare' (<0.1%) and the consequence/impact 'negligible'. The risk rating has now been reduced to 'low'.

Additionally, Luton Clinical Commissioning Group has enhanced its monitoring of the Urgent GP Clinic by ensuring regular monthly performance (Joint Service Review) meetings.

Further Action Required

An extraordinary meeting, chaired by Luton Clinical Commissioning Group and attended by representatives from the Luton and Dunstable University Hospital and the Urgent GP Clinic, was held on 20th May 2014. The purpose of the meeting was to identify, analyse, control and evaluate any further risks associated with the streaming protocol and agree the management of those risks.

Luton Clinical Commissioning Group is absolutely committed to ensuring that the people of Luton receive a high quality, safe service when attending for emergency or urgent care and the following are further actions required to achieve this.

The Urgent Care Strategic Implementation Group will undertake a comprehensive review of the streaming process for both adults and children.

The Luton and Dunstable University Hospital will provide information on the impact of the changes to streaming on ED activity at 3 and 6 months to Luton Clinical Commissioning Group in respect of the following:

- number of children presenting to the ED
- number of children with a head injury
- number of children presenting under 6 months
- number of children conveyed by ambulance

The Luton and Dunstable University Hospital will provide head injury data analysis as requested by Luton System Resilience Group (previously Urgent Care Working Group), including a review of those cases presenting with head injury that developed into a serious/complex case. This will be analysed and acted on accordingly.

Our report on the investigations into this case identified inconsistencies in use of the locally developed Clinical Assessment Tool for Head Injuries in Children. The tool was developed by Luton Clinical Commissioning Groups Children's Strategic Implementation Group and forms one of seven Paediatric Urgent Care Pathways (head injury; fever; bronchiolitis; gastroenteritis; asthma; seizures; abdominal pain). These Urgent Care Pathways are based on NICE[2] guidance, are submitted to NICE's shared learning collection and previously have been positively quality assured and published on the NICE website. They are scrutinised annually against any change in guidance and seek quality assurance as needed from NICE.

The Clinical Assessment Tool for Head Injuries in Children is currently undergoing its review in line with NICE CG176 published in January 2014. A further improvement will see good version control identified on all pathways and procedural documents, to ensure the most up to date information is available and utilised.

[2] National Institute for Health and Care Excellence (NICE)

Based on the findings in the Serious Incident Overview Report of the incident, Luton Clinical Commissioning Group developed a list of recommendations, for both the provider organisations and the Clinical Commissioning Group itself.

Luton Clinical Commissioning Group will:

- Undertake a comprehensive review of the streaming process for adults and children and all streaming protocols currently in place, including exclusion criteria.
- Ensure that the review encompasses consideration for triage before streaming, streaming protocols and other national requirements for urgent and emergency care.
- Share the Serious Incident Overview Report with the 3 healthcare providers involved in the incident and ensure it is disseminated to all front line staff for review and discussion at team meetings to inform learning.
- Continue to improve on processes to gain assurance that Local Healthcare Solutions delivers their service against national risk management standards.
- Review and oversee clinical governance meetings between the Luton and Dunstable university Hospital and the Urgent GP Clinic to ensure an integrated approach and robust monitoring of service quality.

For the providers, Luton Clinical Commissioning Group recommends, will monitor and ensure completion on the following:

- Review and implement NICE CG176 with assurance to Luton Clinical Commissioning Group that this has been achieved.
- Assurance to Luton Clinical Commissioning Group on how policies and procedures are shared throughout provider organisations. This must include the process for updating changes within current procedural documents.
- Review of systems and organisational factors that may lead to gaps in underpinning knowledge.
- The Serious Incident Overview Report to be disseminated to all front line staff for review and discussion at team meetings to inform learning.

An action plan has been developed (appendix B) to facilitate robust monitoring of the above actions, which will be monitored through existing provider quality governance processes.

Additionally, through their own investigation of the incident, the Luton and Dunstable University Hospital agreed to the following:

- Refresh training for all staff involved in the streaming of patients from the Emergency Department to Urgent GP Clinic

Similarly, Local Healthcare Solutions have agreed and/or implemented the following:

- A Head Injury is now described as 'any injury above the chin including a facial injury'
- An information notice advising as to what services are provided in the Urgent GP Clinic has been displayed in the Urgent GP Clinic by the reception desk
- Local Healthcare Solutions is in the process of carrying out an audit on all its record keeping and will, when complete, share the findings with Luton Clinical Commissioning Group
- Local Healthcare Solutions has accepted NICE Guidance CG176 Head Injury as the only acceptable standard at the Urgent GP Clinic for managing patients

presenting with Head Injuries

- Local Healthcare Solutions will co-operate fully with NHS England GP Performance Team during any investigation into the performance of any clinician involved in this case
- Local Healthcare Solutions is in the process of resubmitting its 'Risk and Serious Incident Framework' for scrutiny and evaluation to Luton Clinical Commissioning Group Quality Department

Whilst the East of England Ambulance Service has agreed actions in response to their investigation findings these have not been included in this response as they do not constitute part of the streaming process. They are covered in the overarching action plan which will be monitored by Luton Clinical Commissioning Group.

There are also additional actions for Luton Clinical Commissioning group to improve processes that were identified within the Serious Incident Overview Report but again do not constitute part of the streaming process.

A key priority for Luton Clinical Commissioning Group will be a thorough review of emergency and urgent care commissioning arrangements in line with the findings of this investigation and Keogh[3] (2013) through a longer-term piece of work. This will be reflected in commissioning arrangements for 2015/16.

Luton Clinical Commissioning group will work with the relevant provider organisations to ensure all recommendations are risk assessed, actioned and implemented in line with our quality governance processes and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013: Action to Prevent Future Deaths.

[3] Keogh B. (2013) Transforming urgent and emergency care services in England - Urgent and Emergency Care Review - End of Phase 1 – Report; High quality care for all, now and for future generations.