NHS
Mansfield and Ashfield
Clinical Commissioning Group

NHS
Newark and Sherwood
Clinical Commissioning Group

Delayed or Missed Diagnosis -

Scope, Scale and System

Health Scrutiny Committee 18th May 2015

What is meant by delayed or missed diagnosis?

- Missed opportunities to identify a condition e.g. a patient not being sent for appropriate tests or investigations
- Failure to recognise a diagnosis or misinterpretation of results
- Delays in undertaking appropriate assessment of a patient
- Delays in reviewing tests or investigation results

The NHS defines a serious incident as: "adverse ***events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified***"(NHS England 2015)

What information is available to Clinical Commissioning Groups?

- Serious incidents are reported on a national system – the CCG's can see those that relate to the providers they commission
- Organisations have their own reporting systems for all types of incidents – for this presentation Sherwood Forest Hospitals Foundation Trust (SFHFT) shared information about these

What we told you last time

- There had been 3 Serious incidents reported
- Main reports from diagnostics (endoscopies, radiology)
- Communication was often a problem

The current picture

- 4 serious incidents reported in Nottinghamshire April 2014 –March 2015
- Main reports from diagnostics (endoscopies, radiology) especially for emergency patients
- Main areas of concern are the Emergency Department (ED) and Emergency Assessment Units (EAU)
- The CCG's received 34 complaints and PALS enquiries relating to missed or delayed diagnosis

What does this tell us?

- The numbers of serious incidents remains stable across the county
- There has been a significant increase in the numbers of less serious incidents reported within SFHFT
- This could be due to an improved reporting culture throughout the trust
- We do not know the scope of the issue within primary care
- The national picture is not well understood

Themes identified

- Failures in the communication of test results
- Delays in the interpreting of test or investigations
- Mistakes in the interpretation of tests or investigations
- Resilience of services especially out of hours

Contributory Factors could be..

- Knowledge gaps
- Rare / unlikely events dismissed from diagnosis
- Appearances can be deceiving – not all text book presentations
- Lack of competency / experience
- Misinterpretation that is understood with the benefit of hindsight

Conclusion

We are doing further work to understand the broader picture across the whole health economy. New co-commissioning arrangements with primary care will help with this.

The rise in incidents at Sherwood Forest Hospitals Foundation Trust (that do not meet criteria for reporting as 'serious') is being investigated to understand if this is a result of better reporting or reflective of deeper problems.