Surrey and Sussex NHS
Healthcare NHS Trust

TRUST BOARD IN PUBLIC		Date: 30th June 2016 Agenda Item: 2.4
REPORT TITLE:		Safety & Quality Committee Update
NON-EXECUTIVE SPONSOR:		Richard Shaw, Chair Safety & Quality Committee
REPORT AUTHOR (s):		Richard Shaw, Chair Safety & Quality Committee
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)		n/a
Action Required:		
Approval ()	**Discussion ( )**	**Assurance (✓)**
Purpose of Report:		
To provide an update of the activities of the safety and quality committee.		
Summary of key issues		
The report provides a summary of the key agenda items which were discussed at the Safety and Quality Committee in June 2016.		
Recommendation:		
N/A		
Relationship to Trust Strategic Objectives & Assurance Framework:		
SO1: Safe -Deliver safe services and be in the top 20% against our peers **SO2:** Effective - Deliver effective and sustainable clinical services within the local health economy **SO3:** Caring – Ensure patients are cared for and feel cared about		
Corporate Impact Assessment:		
Legal and regulatory impact		Compliance with CQC, MHRA and Audit Commission
Financial impact		Serious incidents often become claims
Patient Experience/Engagement		
Risk & Performance Management		Reporting, investigation and learning from serious incidents informs risk management
NHS Constitution/Equality & Diversity/Communication		
Attachment: N/A		

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Trust Board Report – 30th June 2016
Safety and Quality Committee Chair's Report

The Safety and Quality Committee met on 2nd June 2016. The meeting was given over to a deep dive review of Diagnostics, which has appeared as a theme in Incidents in the Trust. The aim was to explore the processes involved in different aspects of diagnosis and see if areas for improvement could be identified. The Committee received five short presentations and discussed the implications for safety. A sixth presentation on The Emergency Department will be made to the next SQC meeting on 7 July.

Histopathology
There had been an increase in the number of requests as a result of changes in practice and the complexity of tests. Six Sis had been declared in this area over recent years, four of which related to malignant melanoma, which is a complex area to diagnose. A range of different audits were being used to drive improvement.

Specimen Group
The Committee explored the implications of an SI where a sample taken from a patient had not been sent to the lab for analysis. Discussion focused on the robustness of process where fewer samples were taken daily, such as wards, outpatients and radiology, and also on the use of temporary staff. Sash+ will review the diarrhoea pathway and this will include the transit of samples.

Radiology
There was some discussion about the risks of outsourcing work and the robustness of governance. But the main focus was on the importance of having clearly established responsibility for reviewing and acting on the results of radiological tests, especially where a Z5 code indicated a high possibility of cancer. It was important to be clear whether responsibility lay with the requesting clinician, the radiologist or another clinician who may have taken over responsibility for the patient. An audit to examine assurance that Z5 codes are acted on was underway and would be reported to Clinical Effectiveness in July.

Consultant View
Ben Mearns introduced a discussion on the Millennium System, which identifies the responsible consultant for each patient. Discussion focused on the risk of results being missed in the Message Centre and the risks around re-assignment of results to a new clinician where the patient had moved. The System did not highlight abnormal results or flag urgent issues for immediate action. There may therefore be a risk of delays or oversights, and it was considered that there was room for improvement.

Cerner
There followed a discussion about IT systems in the Trust, some stand-alone systems and gaps in functionality that could potentially be rectified so as to make them easier for clinicians to use. It was noted that some improvements could be made to the Millennium System and that a consistent strategy was important.

Conclusions
The discussion provided useful insights into a topic that has been a recurrent theme in incidents and that cuts across several different departments. In conclusion it was noted that Emergency Department was an important omission from the day's discussions, as this is a department where patients move quickly to another part of the hospital or are discharged and there is therefore greater risk of laboratory analysis failing to follow the patient. A presentation on this

will be made to the next meeting of SQC. That aside, there was reasonable assurance that where benchmark data exists the Trust is not an outlier on diagnostics. There appears to be good use of audits to address and close off risks. There could potentially be opportunity to make better use of health informatics via training, and there may be potential for tightening up of some processes. Conclusions on next steps will be drawn after the presentation on ED.

Next Meeting

The next SQC meeting is at 2pm on Thursday 7th July.

Richard Shaw
Non-Executive Director
Safety & Quality Committee Chair
June 2016