Surrey and Sussex NHS
Healthcare NHS Trust

Safety & Quality Committee

Thursday 2nd June 2016, 14.00-16.00
AD65 Trust Headquarters, East Surrey Hospital

Minutes of Meeting

Present:		
Richard Shaw	RS	Non-Executive Director (Chair)
Alan McCarthy	AM	Chairman
Pauline Lambert	PL	Non-Executive Director
Des Holden	DH	Medical Director
Fiona Allsop	FA	Chief Nurse
Paul Simpson (first hour)	PS	Finance Director
Barbara Bray	BB	Chief, Surgical Division
Ben Mearns	BM	Chief, Medical Division
Zara Nadim	ZN	Chief, WaCH
Katharine Horner	KH	Patient Safety & Risk Lead
Jonathon Parr	JP	Clinical Governance Compliance Manager
Colin Pink (first hour)	CP	Corporate Governance Manager
Vicky Daley	VD	Deputy Chief Nurse
Presenting papers:		
Bruce Stewart	BS	
Tony Newman-Sanders	TN-S	
Mohamed Luqman	ML	
Apologies:		
Alan Hall, Ed Cetti, Angela Stevenson, Ben Emly, Sue Moody		

		Action
1	**COMMITTEE BUSINESS**	
	1.1. Chair welcomed everyone to the meeting and apologies were noted. All attendees introduced themselves.	
	1.2. Minutes of the previous meeting The minutes of the last meeting were accepted as an accurate record.	
	1.3. Actions from previous meeting were discussed as follows RS informed the committee that actions for both June and July will deal with at the July meeting where the main focus of discussion will be winter pressures and opening up the discussion around growth of activity and safety. It was confirmed that DH will present an ppdate on Clinical Audit - next month, DH is waiting for the final audit position from the Divisions. • RS noted the two updates attached to the agenda under action plan. The analysis of incidents currently overdue for review is for action by the Divisions. An update will be incorporated in the quarterly incidents report due for review at the August meeting. • Complaints by bed days will also be reviewed as part of the Quarterly	

	Complaints Report, again due at the August meeting.	
	1.4 Highlights from Executive Committee for Quality & Risk **1.5 Highlights from Clinical Quality Review Meeting** **2.1 Quality Report** The EQCR and Quality Report were noted. RS explained that these would not be discussed in detail given the key focus of the meeting. He asked whether there were any questions from the committee. PL asked for clarification on an incident highlighted within the Quality report. BM explained that a member of the public had approached a child in paediatric ED, it was identified very quickly that he was not a member of staff. It is a no harm incident but it raise some concerns with regard to security. A full investigation is underway in medicine.	
3	**DEEP DIVE DIAGNOSTICS**	
	DH introduced the main focus of the meeting which was a deep dive into issues relating to diagnostics. Each of the diagnostic areas had been asked to present a short report to address the key issues of quality, service delivery and safety.	
	3.1 Histopathology report – presented by Bruce Stewart Turnaround times: BS highlighted a significant increase in the volume of requests received by the labs linked to changes in clinical practice for example bowel screening and urology testing. BS also explained that changes in the complexity of tests also resulted in operational pressure for example template biopsies are now used for prostate cancer which can result in 17 tissue samples for examination. BS demonstrated that the SASH key assurance indicators are mostly green apart from the turnaround times, but that these are reported to the Joint Management Board on a monthly basis for discussion. PS noted that an extract of this report should be presented to the SASH Board. BS added that meeting the Royal College of Pathology reporting standards are a key priority for the Pathology Joint Venture. BS explained that the cancer pathways have been reviewed in detail to ensure that diagnostics are able to support the Trust meet the 62 day targets. However the effect of this is that the less clinically urgent tests take longer. AM asked whether it was possible that the collective performance could be improved at the expense of performance within the Trust. It was agreed that this could be an outcome. PS noted that it was the expectation of the Joint Management Board that performance for SASH patients would be improved. Serious Incidents: BS explained that there had been six over the previous two years. The key issue is the diagnosis of malignant melanoma, which accounted for four of the six incidents. The diagnosis of malignant melanoma is known to be a complex area. The spread of incidents is over several years. Audit: BS reported that the team has an audit programme in action. The	

	team has re-audited the correlation of local reporting against the local cancer network reporting by the skin cancer network. There has been a re-audit of the use of immuno histochemistry against poorly differentiated squamous cell carcinomas. There is a regular ongoing audit of benign pigmented lesions which assesses whether further cases have been missed. These audits are due to be presented to the Clinical Effectiveness Committee. BS explained that it was the team's intention to undertake a prospective, double reported, blind audit of pigmented lessons following two incidents raised by Dermatology where biopsies had been reported as malignant but had subsequently proved not to be. BS noted that there had been concern regarding discrepancies between a single network expert and the SASH team. The purpose of this audit is to provide assurance about the competency of the SASH team, and the external reporter. BS reported to the committee that the traffic light system has been abandoned. The intention of the system was to provide clinico-pathological correlation, to convey a high degree of clinical suspicion from the requestor to the path lab. BS reported that in fact it became a tool for double reporting and quicker turnaround time. A joint review (pathology and dermatology) concluded that the best way forward was to ensure accurate clinical details on the request form. A dataset has been included in the pigmented lesion audit form to enable a review of this. BS summarised published error rates from across the world, it was noted that the error rates within SASH are lower. BM asked whether it is possible to re-examine the original slides, BS confirmed that it was and is routinely done in serious incident reviews. If a sample is found to be malignant it will be blind double reported internally, however this does not happen if the slide is assessed as benign. This is why the prospective audit is being undertaken. The team now has a local designated skin lead who undertakes the second report on suspected malignant melanomas, undertakes the audits and has the link with the MDTs. However the team has not yet moved to true sub-specialist reporting because there are not enough consultants within the team. BS noted that this is one of the advantages of the joint venture, that in time this might be achieved. Periodic audits are undertaken, 2-4 audits per year randomly chosen by the lab manager consisting of 20 cases per audit, across all reporting consultants, blinded and examined by the sub-specialty lead. They are scored for discrepancy. 234 audited no missed diagnosis. BS outlined an audit which examines local reporting against the skin MDT reporting where there has been a diagnostic disagreement which is clinically significant. The finding was 15-20% of samples, which is a concern. However, it should be noted that there have been some reversal of concern. 500 cases will be reviewed in the prospective audit. Each case will be reported simultaneously by the skin expert and the SASH team and double reported, reports audited for discrepancies will then be further reviewed. BS summarised by noting the extended timeframe of the incidents and the work that the team has undertaken, there is still work to do on confidence	

	and assurance in the system. A possible outcome of the audit work may be that is reassured by the competence of the in-house team and ceases to work with the network expert. The committee had no further questions. BS was thanked for his contribution.	
	3.2 Specimen Group Report – presented by Zara Nadim ZN started this section by summarising a serious incident in which a sample taken from a patient with a suspicious lesion was not sent to the lab for review. This prompted a review of the robustness of the system whereby samples are sent from outpatient areas to be lab. A pathology specimens group was set up to establish how the system can be improved. The revised process is based on the process undertaken in theatres. Once the sample has been taken by the clinician it is given to the nurse, both sign to confirm the name, and details of the patient. The sample is then placed in a bag to be sent to Pathology. ZN would like to make all samples trackable across the Trust. The aspiration would be to barcode the bag which could then be scanned at key points in the pathway providing an audit trail. This proposal will be incorporated into the work being undertaken on LocSSIPs. DH explained that the theatres have reasonable processes in place due to the number of samples taken on a daily basis. The concern was raised about the robustness of the processes employed in areas where samples are taken less often; ad hoc specimens on the wards, outpatient and radiology. DH asked how new or temporary staff are made aware of the signing process. The process is nurse led. In order for funding to be agreed for a tracking system DH asked ZN to produce an options paper which can be taken to Execs for approval. ML reported that for all samples taken in radiology, a request for the required test is generated on Cerner, a label produced and attached to the sample. The lab then confirm receipt of the sample on Cerner. The lab are therefore expecting the sample, TN-S undertook to establish whether an audit is undertaken of samples allegedly taken that then fail to arrive in the lab. BM noted that the SASH+ will be reviewing the diarrhoea pathway which will include the transit of samples.	
	3.3 Radiology Report – presented by Mo Luqman and Tony Newman-Sanders The committee had asked for clarification on radiology reporting responsibilities within the Trust. ML noted that the Trustwide policy is currently under review. However, the current position is that the Radiology team are responsible for reporting all images except inpatient plain films and both fracture clinic and orthopaedic outpatient referrals. There has been some discussion about whether this is appropriate, particularly inpatient plain film. There has been at least one incident where pathology on a chest x-ray has been missed and not documented in the clinical notes	

appropriately.

Radiology undertook a brief audit within ED to assess whether the x-ray report had been done within 48 hours of the patient leaving the ED. In 50% of cases there was no documentation in the clinical notes to show that a doctor has reviewed the X-ray before discharging or referring the patient. It is suspected that the position for inpatient reporting may be worse. Therefore the Radiology team intends to propose that they take responsibility for inpatient plain film reporting.

The radiology department uses a company called Medica for additional support. Medical have undertaken routine reporting and undertake overnight emergency work. This will continue for the foreseeable future. If consultant work plans change it may be possible to take this back in-house. Some MRI scans are being outsourced to Gatwick Park, both the scanning and reporting. There are plans to bring this back in-house.

DH asked how the Trust can be assured of the governance processes within the outsourced organisations. TN-S replied that the outsourcing companies have passed ISA accreditation process overseen by the Royal College of Radiologists this includes a 5% audit which is a more robust assurance process than most NHS organisations. TN-S added that it is the intention of the SASH Radiology department to undertake this audit. ML meets with Medica each month to review the contract and raise any issues (this includes diagnostic misses).

ML explained that radiology use a Z5 code to flag images where there is a high suspicion of cancer. This code is understood by clinicians and picked up by the Cancer team to ensure that the code results in appropriate action.

TN-S noted that in the past it has been the responsibility of the requesting clinical to ensure that he is aware of the results of tests that he/she had ordered and follows up the patient. However, case law (particularly in the US) is placing more responsibility on the reporting radiologist to get confirmation that the results have been received by the requestor and acted upon. TN-S noted that within the Trust this can be managed by the message centre inbox; however he acknowledged that there are some gaps in this process.

AM asked where accountability lies. TN-S explained that the referring consultant has the right to rely on the expertise of the reporting radiologist. Therefore if there is a reporting error, accountability lies with the radiologist. If the report is correct and available on the system, but is not actioned accountability would traditionally have sat with the requestor, however this is now changing. TN-S highlighted two difficulties faced by Radiology. The college guidance is that critical and report results should be reported within an hour. Most organisations are finding this an impossible target to reach. This is further complicated by the report going into an electronic in-box; there needs to be assurance that the report has been read and understood.

T-NS clarified that the ionising regulations state that for all x-rays a formal report by a fellow of the Royal College of Radiologists must be made on the patient's record. In view of operational pressures SASH, like many other Trusts, put in place a number of non-reporting agreements which delegate

	the reporting requirement to the inpatient clinicians on the assumption that they are clinically competent to assess the x-rays that they order. The problem occurs when a junior doctor reviews the x-ray and misses something. More often however, no record of the outcome is made which places the Trust in breach of the regulations. This is a key driver in the proposal to repatriate inpatient reporting back to radiology. BM described the following mitigations in place: • Admission pro-forma has a box in which the results of any x-rays should be entered. • Post-take ward round asks for the same detail. • Ward round standards require for radiology to be reviewed. • Message centre is updated to show which images have been reviewed. • Point of discharge the juniors are asked to note the radiology BM would like the option for ward based clinicians to request a second opinion from a radiologist. The committee discussed whether there was assurance that Z5 codes are acted upon. JP reported that there is an audit due to be presented to the Clinical Effectiveness Committee In July which addresses this issue.	
	3.4 Emergency Department Report – to be presented in July by Casba Dioszeghy	
	3.5 Consultant view – presented by Ben Mearns BM gave a short overview of the process: the millennium system assumes that there is a consultant responsible for each patient. When a test is ordered for the patient it is stamped with the name of the consultant allocated, at that time, to the patient. Results will be directed back to that consultant and the pool (inpatient team) of the clinician responsible for the patient's care at the point at which the result is generated. In some cases responsibility for the care of the patient has transferred from one consultant to another while the test is being processed. This ensures that both teams see the result. The results go into a system called "message centre" which looks and behaves like Outlook. There are a number of views, one being "30 day", which carries the risk that results over that time may be missed. When a result is opened the options are to review, endorse or refuse. If a clinician refuses a result because the patient is not under your care, the system prompts the user to reassign the result to a new clinician, along with notes. Reassigning results can be time consuming for clinicians. The problem is where a result is assigned to a clinician because the patient was briefly under their care but has been passed on. It is common practice that if the result is normal then the receiving clinical will endorse the result and not pass it on. Abnormal results would be passed on. BM highlighted the problems as follows:	

	• message centre is batched. • it does not highlight abnormal results to the clinician (bleep/page) this needs to be a manual process from the lab or radiology • message centre allows results to be pooled, a consultant can ask junior doctors to authorise results on behalf of the consultant. This is not routinely used. • blood results are in the notes, there is no audit trail in millennium. • nothing urgent is sent to message centre for immediate action. DH explained that if a patient is moved around the organisation the results can become increasingly historic in their attribution which is a risk. BM felt that clinicians do recognise patients who are in this situation and will look back at their results in millennium. He confirmed to the committee that there is an absolute expectation that results will be reviewed and endorsed. ZN made the point that it is possible to reject a patient without reassigning a new clinician. TN-S confirmed that this has been raised by ED too. KH noted that auditing the number of patients affected by this was an action out of a recent SI. BM summarised and welcomed the opportunity to work with TN-S to improve the technology available to clinicians.	
	3.6 Cerner – presented by Tony Newman-Sanders TN-S summarised the current technology available within the Trust and the planned system implementations. TN-S highlighted the risk of standalone systems within the Trust, for example maternity. Gaps in functionality: • logging in and out of systems could be made more user friendly • data capture would be facilitated by voice recognition system • analytics and business intelligence - to support pulling data back out of the system TN-S outlined a number of patient focussed systems which in time could be employed to help inform the patient about their healthcare. AM noted that the number of available systems demonstrates the need for a consistent NHS strategy. BM noted that it would be relatively easy to move PTS functionality across to millennium.	
	Conclusions DH concluded the meeting. ED will be invited to SQC next month to contribute their perspective to the discussion. The presentations have demonstrated that where benchmark data exists there is reasonable assurance that the Trust is not an outlier. In addition the Trust has put in place reasonable processes and is thoughtful about the audits undertaken to close off risks. DH highlighted the pigmented lesion audit as being important in restoring confidence in pathology team. The Trust needs to be maximising	

	the value of health informatics by providing training and education to staff. However the Trust needs to get the processes right to ensure that patients are not subject to valueless moves which complicate the technology.	
	6.1 Any other business No items raised.	
	DATE OF NEXT MEETING Thursday 7th July 2016 14.00 – 16.00 AD77	