DECISION-MAKER:		PANEL B		
SUBJECT:		PATIENT SAFETY IN ACUTE CARE INQUIRY		
DATE OF DECISION:		29 JULY 2010		
REPORT OF:		EXECUTIVE DIRECTOR, HEALTH AND ADULT SOCIAL CARE		
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STATEMENT OF CONFIDENTIALITY
None

SUMMARY

Panel B has been tasked by the Overview and Scrutiny Management Committee (OSMC) to undertake a five meeting Inquiry into a health related topic. This paper seeks agreement to the Terms of Reference and Inquiry Plan

RECOMMENDATIONS:

(i) To agree the Terms of Reference and Inquiry Plan.

REASONS FOR REPORT RECOMMENDATIONS

1. To agree the scope and structure for the Patient Safety in Acute Care Inquiry.

CONSULTATION

2. The Terms of Reference for this Inquiry have been developed in consultation with the Chairs of OSMC and Panel B, Senior Officers, the Primary Care Trust, Hampshire Partnership Foundation Trust, Southampton University Hospitals Trust and Solent Healthcare.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. None. Panel B were asked to undertaken this Inquiry by OSMC.

DETAIL

4. At its meeting in April the Overview and Scrutiny Management Committee (OSMC) agreed that a health scrutiny inquiry should be carried out on the basis of "holding the local NHS to account both in regard to the value it obtains in spending almost £400m pa and/or the quality of the services it commissions."

5. Discussions with the Director of Public Health and the Executive Director of Health and Adult Social Care to develop draft terms of reference for this inquiry highlighted concerns about the breadth and therefore the potential quality of the proposed inquiry to be carried out in five meetings as well as its overlap with work that is currently being carried out by the Primary Care Trust (NHS Southampton).

6. Following a further discussion at OSMC in June, it was agreed that in the context of continuing rising costs of acute care in the city, this inquiry should focus on examining the quality of care being provided in acute care on the basis of patient safety.

7. Subsequent to this meeting, discussions have been held with members and partners to agree draft Terms of Reference for the Inquiry and an Inquiry Plan. The Terms of Reference have also been drafted to ensure the Inquiry takes account of the recently published White Paper – Equity and Excellence.

FINANCIAL/RESOURCE IMPLICATIONS

Capital

8. None.

Revenue

9. None.

Property

10. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

11. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007

Other Legal Implications:

12. None.

POLICY FRAMEWORK IMPLICATIONS

13. None

SUPPORTING DOCUMENTATION

Appendices

1.	Health Inquiry – Terms of Reference and Inquiry Plan

Documents In Members' Rooms

1.	None

Background Documents

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1. None	

Background documents available for inspection at:

KEY DECISION? **No**

WARDS/COMMUNITIES AFFECTED:	All

ITEM NO: 7 Appendix 1

Health Inquiry – Patient Safety in Acute Care
Terms of Reference and Inquiry Plan

1. Scrutiny Inquiry Panel: Scrutiny Panel B

Membership:

Councillor Capozzoli (Chair)

Councillor Daunt

Councillor Drake

Councillor Harris

Councillor Marsh-Jenks

Councillor Payne

Councillor Parnell

2. Purpose:

In context of the recently published White Paper – Equity and Excellence to examine how adult acute providers in the City respond to and learn from safety and adverse incidents where factors outside of the acute care setting have been a contributory factor.

3. Background:

The Government's White Paper Equity and excellence: Liberating the NHS sets out its objectives as to reduce mortality and morbidity, increase safety, and improve patient experience and outcomes for all. It states that "A culture of open information, active responsibility and challenge will ensure that patient safety is put above all else, and that failings such as those in Mid-Staffordshire cannot go undetected".

It goes on to say "In future, there should be increasing amounts of robust information, comparable between similar providers, on……. Safety: for example, about levels of healthcare-associated infections, adverse events and avoidable deaths, broken down by providers and clinical teams".

In 2008/09 NHS Southampton City spent around 400m. £350m of this was spent directly on purchasing healthcare and the vast majority (£270m) on secondary care. Almost 50% of secondary healthcare spend was on general and acute care (and this specialism accounts for 32% of the Trust's overall spending). This is the largest single spending area for NHS Southampton City. The vast majority of general and acute care is commissioned from Southampton University Hospitals Trust although other agencies also provide acute care including community hospitals and the private sector such as the Spire and the Independent Sector Treatment Centre.

Against this backdrop, this Inquiry proposes to look at patient safety in relation to adult acute care providers but also focus particularly on those incidents where factors outside of the acute care setting have been a factor. In such cases the actions of both private and public sector organisations may have contributed for example social care settings/home support or nursing home/rest homes, the police and housing agencies.

Every day more than a million people are treated safely and successfully across the UK by the NHS. However, the advances in technology and knowledge in recent decades have created an immensely complex healthcare system. This complexity brings risks, and evidence shows that things will and do go wrong in the NHS; that patients are sometimes harmed no matter how dedicated and professional the staff. The main challenge is to ensure the safety of everyone who requires a health service.

Risk to the safety of patients can fall into a variety of board areas:

Risk/harm arising from healthcare intervention or non-intervention e.g.

- Medical devices/equipment
- Surgical errors
- Failure to treat
- Unsafe transfer of care

Risk/harm from care and environment issues for which there is a healthcare responsibility e.g.

- Patient accidents(including falls)
- Poor nutrition and hygiene
- Poor infection control
- Inappropriate action/relationship with healthcare staff.

Risk/harm unconnected to healthcare provision, but which may become known during provision of healthcare, and impact on the person's health and require additional treatments e.g.

- Hypothermia
- Poor pressure area care prior to admission
- Injury sustained from abuse or domestic violence
- Potential abuse by page or unpaid carers.
- Poor infection control
- Avoidable falls
- Poor nutrition and hygiene

Causes of concern should always be reported using local clinical governance systems and in some circumstances local safeguarding systems. It is important to understand these errors and their causes as this can act as a good barometer for the efficiency and effectiveness of the healthcare system. Securing efficiencies and improving value for money while at the same time improving the patient experience will become increasingly important as resources are directed into preventative services and providing care in more localised settings. From 1 April 2010, it became mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality

Commission as part of the Care Quality Commission registration process. The NHS White Paper states that it is the government's intention to strengthen the role of CQC by giving it a clearer focus on the essential levels of safety and quality of providers.

4. Objectives

- To consider the culture around and importance afforded to the reporting of patient safety incidents and adverse events by acute providers in the City;
- To examine the processes in place to ensure incidents are robustly followed up so that all contributing factors and root causes are identified and lessons learnt, with any recommendations implemented across all agencies involved;
- To indentify areas of best practice already in place relation to patient safety and areas where lessons could be learnt and/or efficiencies made including in relation to the role of partners.

5. Methodology and Consultation:

- Review and analysis of existing data and literature in relation to patient safety incidents and near misses in Southampton;
- Examination of the current process for dealing with patient safety incidents;
- Identify best practice in acute settings;
- Seek provider and stakeholder views.

6. Proposed Timetable:

The Inquiry will be undertaken by Scrutiny Panel B between July 2010 and March 2011 as follows:-

Meeting 1 - Thursday 29th July
Meeting 2 – Thursday 14th October
Meeting 3 - Thursday 11th November
Meeting 4 - Thursday 10th February
Meeting 5 - Thursday 17th March

7. Inquiry Plan-

Meeting 1

To agree Terms of Reference including the scope of the Inquiry.

National context – now and in the future.

Meeting 2

Current position in Southampton is now is in terms of:

- Data on patient safety and near misses
- National assessments on current performance
- Current processes for recording and responding to near misses

Meeting 3

To hear from managers, practitioners and patients/relatives on their experiences.

More detailed examination of the current situation/data and where there are issues and area for improvement.

The role of partners – hear from partners and consider what contributions partners could make to improving patient safety.

Meeting 4

Best Practice

- To here from a leader/s in the field
- To hear about success stories in the city
- To consider areas where improvements could be made

Meeting 5

To discuss and agree the final report.