Report of Scrutiny Panel B

Patient Safety in Acute Care Inquiry 2011

Panel Membership:

Councillor Capozzoli (Chair)
Councillor Daunt
Councillor Drake
Councillor Harris
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SOUTHAMPTON CITY COUNCIL ®

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INTRODUCTION

Scrutiny Panel B conducted the Patient Safety in Acute Care Inquiry over three meetings between July and November 2010. A further meeting had been planned for February 2011 but this was later cancelled (see below). The Panel agreed the final report in April 2011.

The Government's White Paper 'Equity and Excellence: Liberating the NHS' set 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, the Overview and Scrutiny Management Committee at its meeting on ? agreed that an Inquiry should be undertaken looking at patient safety in relation to adult acute care providers with a focus particularly on those issues where factors outside of the acute care setting have had an influence and care settings can learn from each other. The Overview and Scrutiny Management Committee requested that the Inquiry be undertaken by Scrutiny Panel B.

Objectives

The inquiry had three broad objectives, as agreed by ?:

- 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 in relation to patient safety and areas where lessons could be learnt and/or efficiencies made including in relation to the role of partners.

Evidence

Evidence was gathered by reviewing and analysing existing data and literature in relation to patient safety in Southampton and nationally and over three meetings which involved engagement with Southampton University Hospitals Trust (SUHT), NHS Southampton City and the Health and Adult Social Care Directorate of Southampton City Council. The focus of the inquiry was at a strategic level and individual cases and issues were not included.

The initial Inquiry plan had been intended to be broader and include a meeting on best practice. However, the scale of other work facing the Panel as a result of national and local change to the NHS, and the confidence of the Panel that SUHT are already working with best practice networks across the region, and acting as a pilot organisation for national best practice initiatives mitigated the need for this meeting.

(Terms of Reference and project plan attached as appendices)

BACKGROUND

Every day more than one 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 broad 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 paid 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.

FINDINGS AND RECOMMENDATIONS

The Inquiry has discovered that on the last few years SUHT has increased its focus on safety and improved its performance. They are linked into national and regional networks undertaking Department of Health pilots and performing highly in some areas including infection control. Patient safety is given a high profile in the Trust and driven by senior managers who have worked hard to create a safety focused culture.

However, the Panel did indentify areas where improvements could be made. Some of the recommendations are wider than just SUHT and acute care and consider patient pathways across the whole health and social care system. Where recommendations are SUHT specific they may also apply to other organisations although it was not within the remit of the Inquiry to explore this. Therefore, this report is intended to be useful to all health and social care providers and commissioners in Southampton and the Panel are keen to see implementation of the recommendations across organisations.

Reporting Patient Safety Information

Patient safety performance reporting is a complex area. There are a myriad of different sources that the public can access to gain an understanding of patient safety (including Dr Foster reports, CQC assessments and registration documents, national statistics and National Patient Safety Agency data and local safety reports). However, these are often difficult for patients and the public to interpret and contextualise.

The Panel felt that while SUHT's publicly available patient safety reports are comprehensive, it was often difficult for lay people to fully understand the reports – use of unexplained acronyms, percentages not alongside real numbers and vice versa, contextual information not included. While it is recognised that the reports are essentially Trust Board papers it should be remembered they are also public documents and useful to patients and stakeholders.

Additionally the Panel were not aware of the many good initiatives and pilots that were underway in relation to patient safety prior to the Inquiry. Negative press reports highlight issues and incidents and while there is still room for improvement much progress has been made in recent years and the Trust should take steps to ensure good news stories are also reported and publicised.

Recommendation:

1. *To ensure the public can fully understand the data presented in SUHT's Progress Reports on Safety reports needs to be succinct with contextual information to explain the numbers and percentages detailed in the report.*

2. *SUHT needs to promote best practice and share information on their progress more widely, to provide a more balanced perspective on performance.*

Patient Safety Walkabouts

The Panel were impressed with the unannounced patient safety walk walkabouts that are currently undertaken at SUHT. Of particular note was that they take place both day and night and are led by senior managers.

The Panel felt that they are important in several respects including:

- increasing awareness of patient safety issues among staff;
- encouraging staff to discuss incidents and near misses;
- engaging with patients regarding safety issues;
- demonstrating a commitment to patient safety and acting as a role model for staff; and
- increasing senior management visibility to a wide range of staff.

Most importantly the Panel were pleased that the walkabouts had delivered changes in practice to reduce safety incidents. The Panel are very keen for this element of best practice to be implemented more widely across Southampton in all health and social care settings and would encourage other providers to engage with and learn from SUHT's experience of implementation.

Recommendation

3. *SUHT's Patient Safety Ward Walkabouts, both day and night, are an example of good practice. The Panel would like to see these rolled out further in other Southampton health and care settings.*

The Aging Population

In 2009 there were over 31,000 residents aged 65+ years in Southampton with 5,300 of these aged over 85. Based on current estimates by 2026 the figures will have increased to 38,900 aged 65+ with 7,400 of these being over 85. An aging population brings increased challenges for patient safety as a result of higher demand for services, a greater number of sicker patients with multiple complex conditions, and more vulnerable patients who pose a higher risk and have increased recovery times from injury.

The Ombudsman report "Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people" published in February 2011 cited an example from 2007 in SUHT where elderly care "fell significantly below the relevant standards". While this Inquiry took a strategic approach and did not look at either elderly care specifically or individual cases, the Panel recognise that the Ombudsman's report raises concerns and it would be remiss not to refer to it in this report. However, the Panel also acknowledge that the case in question was in 2007 and performance against patient safety indicators shows that there have been significant improvements at the Trust since this period, although current statistic show there are still issues with patient nutrition which need addressing.

Evidence provided to the Panel highlighted concerns that while both the NHS and Social Care have started thinking about the safety issues that will arise as the older population increases, further work is required. The care pathways for older people and how health and social care work together on this issue will be important. The Panel felt that as care pathways change and more people are supported at home for longer it will be important that budgets reflect this change and there is sufficient flexibility in the system to allow this. Joint commissioning and pooled budgets between health and social care will help facilitate this approach.

Keeping people healthier for longer to improve their quality of life and avoid costly hospitals admissions and intensive social care interventions will become increasingly important, Public Health play am important role in providing advice and service to keep people older people healthy. The Panel would like to see Public Health playing an active role in working with other council services that interact with older people to explore how they can support preventative work and the move of public health into the local authority will provide an enhanced opportunity to take this forward.

Another area that the Panel felt important was the facilitation of social responsibility in caring for older people and helping to keep them safe. The Panel would be keen to see the NHS and Social Care facilitating a big society approach towards our ageing population.

Recommendation

4. *The increasing older person population and changing patient pathways will bring new challenges for Patient Safety. Further joint work across the health and social care organisations in the City needs to be carried out to plan for this particularly in relation to joint commissioning and pooled budgets that support older people.*

5. ***The Panel would like to see the role that the 'big society' can play in supporting older people recognised and included in SCC's plan for taking the big society forward.***

6. The Panel would like to see Public Health playing an active role in working with other council services that interact with older people to explore how they can support preventative work and the move of public health into the local authority will provide an enhanced opportunity to take this forward.

Falls

According to a report by Age UK published in June 2010, falls among elderly people may be costing the NHS in England up to £4.6m a day, one in three people aged 65 and over fall each year, they are a major cause of injury and death among the over 70s and account for more than 50% of hospital admissions for accidental injury. Around 14,000 die annually after a fall.
Falls can take place in any location and fall prevention work ranges from home adoptions and pavement repairs to balance classes for older people.

Avoidable falls in hospitals are also an issue and the panel are aware that falls reduction is one of SUHT's top priorities. The Panel are pleased the SUHT is taking part in the Department of Health's falls pilot (Turnaround) and have a detailed Falls Prevention Project. They are also a member of the health system Falls Prevention Group which covers key stakeholders in the community including Primary and Social Care.

However, while there is a significant amount of fall prevention work underway in Southampton, this needs to be better promoted and given a higher profile across all organisations and all departments considering what role they can play.

Under the "sloppy slippers" scheme pensioners are offered the chance to swap their old slippers for a new high quality pair. The self-fastening slippers provide a better fit than slip-ons and reduce the risk of trips. Research by the University Hospitals of Leicester suggested 24,000 over-65s in the UK fall over at home every year because of poorly fitting footwear – especially slippers. While they have slippers fitted by specialist podiatrists pensioners can also have their risk of falls assessed, get advice and information, and be referred to other services. Southampton City Council ran the

scheme in 2010. However, the Panel are to have a better understanding of the outcomes as a result of the sloppy slipper exchange (either from Southampton or else where) and if there is evidence that it has reduced falls would like to see the scheme extended at targeted at locations where those elderly people and at high risk of fall can be accessed for example care homes and hospitals. Savings resulting from reduced falls could be used to fund such a scheme.

Recommendations

5. *Strengthen cross sector working on falls prevention. Work that is going on also needs to be better promoted and mainstreamed.*

6. *The panel would like an evaluation outcomes as a result of the sloppy slipper exchange initiative. If there is evidence that it has reduced falls the Panel would like the programme to be extended and rolled out in health and social care settings. This could be funded from the saving generated as a result of a falls reduction.*

Pressure Ulcers

Pressure ulcers are a type of injury that affects areas of the skin and underlying tissue. They are caused when the affected area of skin is placed under too much pressure. Pressure ulcers can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle.

It is estimated that just under half a million people in the UK will develop at least one pressure ulcer in any given year. This is usually people with an underlying health condition. For example, around 1 in 20 people who are admitted to hospital with an acute (sudden) illness will develop a pressure ulcer. Two out of every three cases of pressure ulcers develop in people who are 70 years old or more. An estimated cost by Posnett of treating grade 4 pressure ulcers is £11,000 per patient. The cost of pressure ulcers to the NHS is estimated to be £2.5 billion.
Although SUHT saw an increase in hospital acquired pressure ulcers in 2010 the Panel understands that this was due to a change in report requirements which were extended to include the reporting of grade 4 pressure ulcers. The rate is now falling at the Trust are on target (76) to meet their target a 25% reduction in patients with grade 3 &4 pressure ulcers, an overall annual target of 81.

The Panel are pleased that SUHT was selected by the Department of Health to take part in the Turnaround pilot project to create an advanced method of regularly monitoring patients that cuts the risk of avoidable injuries while in hospital. Every two hours, nursing teams monitor all patients considered at risk of developing pressure ulcers or at high risk of falling using a new prevention tool developed by staff at Southampton General Hospital.

The Panel understands that the project has been extremely successful in delivering results and on the wards that it has been fully implemented there have been no avoidable pressure ulcers and look forward to it being fully implemented on all relevant wards in the near future.

However, the Panel are concerned that the numbers of patients admitted to the hospital with community acquired grade 3 and 4 pressure ulcers has not reduced. The Panel are keen to see SUHT sharing their learning from the pilot widely including with social care and GPs who can advise on the care of patients in the community. Where pressure ulcers have been acquired in community settings the Panel would like to see care homes working with SUHT to undertake joint root cause analysis and sharing learning.

Recommendation

7. *The Panel recognise that work is ongoing to reduce pressure ulcers, however there is a need to continue to improve cross sector working with Care Homes and GPs on this issue. The Panel recommends that the learning from the Turnaround project is shared across the whole care pathway in Southampton.*

Everybody's Business

While this Inquiry focused primarily on patient safety in acute care it is important to recognise the roles that other services can play in patient safety and the safeguarding of adults. The Panel has found that there is a lot of joined up working in Southampton on safety and safeguarding. In addition to the examples already cited in this report other examples include all health providers in the area are signed up to the multi agency safeguarding adults protocol and a process has recently been agreed for addressing safeguarding concerns within NHS provision. The process is based on the practice tools used by the Adult Social Care and Health Directorate to determine the level of intervention required to manage safeguarding investigations and subsequent actions. However, the Panel believe there is scope for further joint working across health and social care and other organisations and departments need to be more involved in the safety and safeguarding agenda.

As discussed above the ageing society will increase demand on the whole health and social care system. The Panel is keen to see all partners working together to ensure all capacity within the system is used. People need to be treated in the right place at the right time and prevention services, which are already becoming more important, will need to be given a higher focus.

During the Inquiry concerns were raised about artificial barriers stopping further joint working on safety and safeguarding. As work on patient pathways and keeping people at home longer develops it will become increasingly important to ensure that resources are in the appropriate place. Commissioning across health and social care will need to become more joined up and where investment in one organisation or service results in savings for another this should be recognised. Also duplication of services across organisations needs to be rationalised to ensure a joined up individual focused approach that promotes value for money. The Panel hope that the move towards GP commissioning will help support this joint budgeting approach.

As services continue to become more personalised and people have more choice and control over their care the role of other services in meeting their needs and ensuring well being will increase in importance. The Panel would like to see staff working in sectors such as leisure, housing, transport and environment giving a higher priority to spotting potential issues and ensuring concerns are shared. The Panel are pleased with the [website registration of personal assistants etc – look up and add].

As mentioned above the Panel recognise the important role that family, friends and neighbours can play in keeping vulnerable people safe and supporting them in the community. The Panel believe that the role of the 'big society' should be promoted and encouraged in relation to safety and safeguarding from speaking up about concerns and assisting with shopping, to checking on neighbours in extreme weather conditions.

Recommendation

8. *The profile of the role of other services in safety and safeguarding should be strengthened – from leisure in improving balance, housing in spotting issues including if inadequate housing is harming health, and finance in protecting assets.*

RESOURCING THE ACTIONS

The majority of the recommendations from this inquiry do not have any significant additional financial implications on the Council and its partners. Where there are costs associated with recommendations it is predicted that they would result in savings that could be used to fund them, however in some case (e.g. sloppy slippers) further research is recommended to confirm this is the case. The panel believe that the majority of recommendations within the report could be progressed by re-focussing council officer and partner's time and existing work programmes.

RECOMMENDATIONS SUMMARY

RECOMMENDATIONS	Lead organisation/s	Can the recommendation be applied to other Health and Social Care settings?
1. *To ensure the public can fully understand the data presented in SUHT's Progress Reports on Safety. Reports needs to be succinct with contextual information to explain the numbers and percentages detailed in the report.*	SUHT	All health and social care providers and commissioners should review the readability of their performance reporting
2. *SUHT needs to promote best practice and share information on their progress more widely, to provide a more balanced perspective on performance*	SUHT	All health and social care providers and commissioners may want to consider
3. *Pleased with SUHT's Patient Safety Ward Walkabouts, both day and night, as an example of good practice. Would like to see these rolled out further in other Southampton health and care settings.*	All health and social care providers with support from SUHT	All residential health and social care providers
4. *The increasing older person population and changing patient pathways will bring new challenges for Patient Safety. Further work joint work across the health and social care organisations in the City needs to be carried out to plan for this.*	SCC/PCT	All health and social care providers and commissioners
5. *The Panel would like to see the role that the 'big society' can play in supporting older people recognised and included in SCC's plan for taking the big society forward.*	SCC	All health and social care providers and commissioners should consider how they can help promote community involvement
6. *The Panel would like to see Public Health playing an active role in working with other council services that interact with older people to explore how they can support preventative work and the move of public health into the local authority will provide an enhanced opportunity to take this forward.*	Director of Public Health	SCC/PCT
7. *Strengthen cross sector working on falls prevention. Work that is going on also needs to be better promoted and mainstreamed.*	SCC	All health and social care providers and commissioners
8. *The panel would like evaluation outcomes as a result of the sloppy slipper exchange initiative. If there is evidence that it has reduced falls the Panel would like the programme to be extended and rolled out in health and social care settings. This could be funded from the saving generated as a result of a falls reduction.*	All health and Social Care providers with support from SCC	
9. *The Panel recognise that work is ongoing to reduce pressure ulcers; however there is a need to continue to improve cross*	SUHT/PCT	All health and social care providers

RECOMMENDATIONS	Lead organisation/s	Can the recommendation be applied to other Health and Social Care settings?
sector working with Care Homes and GPs on this issue. The Panel recommends that the learning from the Turnaround project is shared across the whole care pathway in Southampton.		
10. *The profile of the role of other services in safety and safeguarding should be strengthened – from leisure in improving balance, housing in spotting issues including if inadequate housing is harming health, and finance in protecting assets.*	SCC/PCT	

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 Willacy

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 hear 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.

Appendix 2

Summary of Meetings

DATE	MEETING THEME	TOPICS	EVIDENCE PROVIDED BY
1/07/10	Introduction to inquiry	To agree Terms of Reference including the scope of the Inquiry. Set the local and national context now and in the future.	Jane Brentor - Head of Care Provision, SCC Judy Gillow - Director of Nursing, SUHT Dr Michael Marsh - Medical Director, SUHT Ayo Adesina - Associate Director of Performance and Integrated Governance, NHS Southampton City
29/07/10	Where are we now	Current position in Southampton is now is in terms of: • Performance on patient safety • National assessments on current performance • Current and future issues This paper describes the work of the Adult Social Care and Health (ASCH) Directorate in improving patient safety.	Judy Gillow - Director of Nursing, SUHT Dr Michael Marsh - Medical Director, SUHT Ayo Adesina - Associate Director of Performance and Integrated Governance, NHS Southampton City
30/09/10	The role of Social Care	Exploring the role of Southampton City Council's Adult Social Care and Health (ASCH) Directorate in improving patient safety	Cllr Ivan White – Cabinet Member for Health and Social Care, Southampton City Council Carol Valentine - Head of Service - Personalisation and Safeguarding, Southampton City Council
21/04/11	Agree final report	Approve report for submission to Overview and Scrutiny Management Committee	

All presentations and notes on witness evidence available on request