SCRUTINY PANEL B

MINUTES OF THE MEETING HELD ON 14 October 2010

Present: Councillors Capozzoli (Chair), Drake, Harris, Marsh-Jenks, Payne, Parnell and Dick

Apologies: Councillor Daunt

In Attendance: Councillor White Cabinet Member for Health and Adult Care

20. **APOLOGIES AND CHANGES IN PANEL MEMBERSHIP (IF ANY)**

The Panel noted that Councillor Dick was in attendance as a nominated substitute for Councillor Daunt in accordance with Council Procedure Rule 4.3 for the purposes of this meeting only.

21. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED: that the minutes for the Scrutiny Panel B Meetings on the 9th and 23rd September 2010 be approved and signed as a correct record. (Copy of the minutes circulated with the agenda and appended to the signed minutes).

22. **HAMPSHIRE PARTNERSHIP FOUNDATION TRUST PROGRESS WITH QUALITY ACCOUNTS**

The Panel considered and noted the report of the Director of Health and Adult Social Care, detailing a paper by the Hampshire Partnership Trust on the development of their 2010/11 Quality Account. (Copy of the report circulated with the agenda and appended to the signed minutes).

With the consent of the Chair, the Interim Deputy Director of Governance and the Associate Chief Executive for the Hampshire Partnership Foundation Trust detailed the report.

RESOLVED that the Hampshire Partnership Foundation Trust be requested to present an update the Panel on the progress and development of their 2010/2011 Quality Account at a later date .

23. **PATIENT SAFETY IN ACUTE CARE INQUIRY – SUHT CURRENT PERFORMANCE**

The Panel considered and noted the report of the Director of Nursing, Southampton University Hospitals NHS Trust (SUHT), detailing information on patient safety. (Copy of the report circulated with the agenda and appended to the signed minutes).

The Director of Nursing and the Medical Director detailed the report circulated with the papers and answered questions on the following topics:

- whether the errors in medication were significant in relation to the numbers of drugs prescribed on a daily basis. The Panel were informed that the numbers indicated within the report were an extremely small percentage of the medicines prescribed at the hospital. It was also stated that additional checks prior to administering of any drugs further reduced numbers the actual numbers of

patients receiving incorrect medicines. The Panel suggested that SUHT should review how these numbers are presented to avoid any misunderstanding;

- the culture of reporting near misses in relation to medicine prescription. It was explained that the trust valued the support of its employees and undertook to learn from all potential incidents of harm to patients. It was further stressed that the report systems were and important part of the learning and monitoring process within the hospital;
- Infection Control. The Panel were informed that the numbers detailed in the papers were used to direct and focus support for areas affected by a viral outbreak. The Panel were further informed that the Trust's performance had significantly improved but, lessons were being learnt and that targets were taken seriously. The importance of collating information, including for areas that they had no direct responsibility for, as part of the overall tracking of infection within the hospital was stressed to the Panel;
- the recent Department of Health lead project to reduce the numbers of pressure ulcers and avoidable falls received in the hospital. The Panel were informed that the greater emphasis on these areas had significantly improved the performance of the hospital resulting in positive effects all along patient pathways;
- inter–agency co-operation and patient pathways and the tracking of patient issues through the health community in order to reduce the number of cases getting to hospital;
- the current research into re-admittance figures and how these could possibly affect budgeting in the future.
- the importance of the safety walks within the hospital and how the information gathered on these walks had been channelled into improving patient care. The Panel discussed the frequency and the scope of the safety walks and learnt that all areas were included at all times.

RESOLVED that the information provided be entered in to the Inquiry's file of evidence.