Bill, Jonathan

From: Briscoe, Maura
Sent: 25 May 2004 16:27
To: Bill, Jonathan; McCarthy, Miriam; Carson, Ian
Subject: Ministerial Brief- Impartial Reporter

Doc1_.doc (26 KB)

Miriam
You wanted some input to the ministerial brief on what we are doing on adverse incident reporting. Please see attached. I am copying to Jonathan and Ian, as if Minister says some/all of this, then we need to be able to deliver it, in terms of policy and resource.

I think it is general enough, but Jonathan needs to have a look at it from a policy perspective.

Sorry wont be here tomorrow.
Maura

ADVERSE INCIDENT REPORTING

- A Safety in Health and Social Care Group (SHSCG) has been established under the auspices of Best Practice, Best Care Steering Group. The remit of this Group includes development of a strategic approach to the recording, reporting and investigation of adverse incidents and near misses.

- The SHSCG recently commissioned a report on current arrangements for the reporting and management of adverse incidents and near misses in HPSS organisations and specials agencies. This report highlighted that there is inconsistency in approach, across HPSS organisations, to "adverse incident" policies, procedures, reporting, recording and management. Having considered this Report, the Group aims to put its recommendations on the pathway forward to the Department, in the next few weeks.

- Following endorsement of the pathway forward by Minister, comprehensive guidance will be issued to the service on systems' approaches to the prevention and management of adverse incidents, and the promotion of a learning culture.

- Part of the recommendations of the Group will be to link with a national organisation, the National Patient Safety Agency (NPSA- created in July 2001). The Group is currently working with NPSA to develop a formal agreement between this Department and NPSA, to the benefit of patients, clients and HPSS staff. Subject to endorsement by Minister, it is anticipated that formal arrangements will be agreed in the next few months.

- At NPSA, there is a recognition that healthcare will always involve risks, but that these risks can be reduced by analysing and tracking the root cause of patient safety incidents. The aim of NPSA is to raise awareness among NHS staff on "patient safety" issues and to develop training, tools and systems to prevent incidents from happening. Where incidents do occur, to promote an open and fair culture among organisations that will encourage staff to report incidents so that lessons can be learnt and staff can use this information to avoid future risks.

- The SHSCG is keen to formalise links with NPSA to enable access for the HPSS to training, tools and guidance produced by NPSA. In addition, where solutions have been developed for high-risk areas, to facilitate local implementation of solutions.

- In the future, the HPSS may be able to link with the NPSA's National Reporting and Learning System, which in currently being rolled out to Trusts in England. This system facilitates anonymous reporting by NHS staff into a system, managed by NPSA, which is capable of collating information, thereby determining where further research and /or guidance is needed. However, any future link will not supersede the need to have robust local systems in place, which are capable of reporting, recording, investigating, and managing local adverse incidents, and cascading lessons learnt locally. Therefore, the main focus of the SHSCG, to date, has been to try and enhance local systems.

- As an initial step, the Department will issue, within the next few weeks, interim arrangements for the reporting and follow up of serious adverse incidents in the HPSS. This guidance aims to complement existing procedures. It would, however, provide an "early warning system" for the Department on major adverse incidents, which are likely to generate significant media interest and where regional guidance might be required to improve care for patients, clients and staff.