IMPLEMENTATION OF

PATIENT SAFETY ALERTS

August 2011

CONTENTS

1 INTRODUCTION

This report is compiled by Action against Medical Accidents ('AvMA' – the charity for patient safety and justice). It is based on information published on the National Patient Safety Agency website about 'Patient Safety Alerts'. Patient Safety Alerts are issued by the National Patient Safety Agency (NPSA) about known problems that have repeatedly caused harm or killed patients, and which can be avoided if the actions in the alerts are implemented. These actions are supposed to be implemented by a stated deadline. We analyse information on which NHS trusts declared that they had or had not completed the required actions in all relevant patient safety alerts by the given deadline. For the purposes of this report we refer to completion of all the completed actions as 'compliance'.

This is AvMA's fourth report on this issue, updating on the situation revealed in its reports in February 2010, August 2010 and February 2011. In this report, we pay particular attention to 'Rapid Response Report' alerts. These are an 'extra-urgent' form of patient safety alert which are specially badged and have a tighter deadline.

The core information used for this report is now available on the National Patient Safety Agency's website at:
http://www.nrls.npsa.nhs.uk/patient-safety-data/

For full information about each patient safety alert see:
http://www.nrls.npsa.nhs.uk/resources/type/alerts/

This report presents the information in a more accessible and user-friendly format and offers further analysis.

The information is a "snapshot" of the position as it stood at 21st July 2011 and relates to all patient safety alerts issued since 2004 for which the deadlines had already passed.

2 SUMMARY OF MAIN FINDINGS

- Overall, 195 NHS trusts had not complied with at least one patient safety alert for which the deadline had already past. This is almost 50% of all NHS trusts.
- Of the 9 extra-urgent "Rapid Response Report" alerts issued in 2010 and which are already past the deadline for completion, not a single one has been complied with by every NHS trust. There are 269 instances of an NHS trust failing to comply with one of these types of alerts.
- A "Rapid Response Report" alert on "essential care after an inpatient fall" issued in January 2011 with a deadline of 14th July 2011 for completion, has not been complied with by 101 trusts.
- In total, there were 455 instances of a patient safety alert not having been complied with by an NHS trust. This is an improvement on 654 in our February 2011 report.
- 22 trusts had not complied with 5 or more alerts. This was an improvement on the February 2011 figure of 45.
- Some of the outstanding alerts are over 5 years past the deadline.

3 BACKGROUND

3.1 What is Action against Medical Accidents (AvMA) and why are we publishing this report?

Action against Medical Accidents (AvMA) is the UK charity for patient safety and justice. Established in 1982, AvMA was responsible for raising awareness about the need to improve patient safety well before the establishment recognised it. Partly as a result of our campaigning, but more importantly the price paid by thousands of people whose lives have been ruined or even ended as a result of medical accidents, patient safety has become number one priority for the NHS, and we now have bodies like the National Patient Safety Agency and Care Quality Commission. We support around 4,000 people every year who have been affected by medical accidents (or 'patient safety incidents' as the NHS calls them). We, and the people we work with, accept that healthcare is a complex business and accidents will sometimes happen. However, it is imperative that lessons are learnt to make things safer, and that the systems that we have fought so hard to have put in place ensure that that happens. Failing to do so adds insult to injury and leaves other patients at risk. In February 2010 we published our report "Adding Insult to Injury: NHS failure to implement patient safety alerts". It showed widespread non-compliance and a lack of any co-ordinated system to do anything about it. This was followed by our reports in August 2010 and February 2011, which showed that whilst there was some improvement, there was still widespread non-compliance and a failure on behalf of regulators to act. This time, we have chosen to take a closer look at the extra urgent 'Rapid Response Report' form of alert.

We use the report to present to the Department of Health, Care Quality Commission and NHS as a whole, stressing the need for improved patient safety. We also provide it to LINks (the local patient and watchdog groups (soon to be replaced with '"Healthwatch") so that they can use it in discussions with their local trusts.

3.2 Possible limitations of the data

The information published by the NPSA relates to the data held on the Central Alert System as at 21st July 2011 In other words it is a snapshot in time. Some trusts may have registered compliance with some of the patient safety alerts between then and publication of this report, so it does not necessarily reflect the situation as it is now. An update will be posted on the NPSA website at the end of August.

The information held on the Central Alert System is entirely reliant on the input from trusts themselves. It is possible, in theory, that some trusts may not have confirmed implementation of certain patient safety alerts on the Central Alert System, when they had in fact implemented them. It is also possible, in fact very likely based on the limited checks made by the Care Quality Commission, that some trusts may have confirmed that they have implemented patient safety alerts fully when, actually, they have not (the system relies entirely on self-declaration).

After our first report, some trusts commented that the required actions in alerts are given to different interpretations. Some suggested that they had not declared their work on some patient safety alerts 'completed' because they wished to be even more thorough than the alerts called for. However, the Department of Health is clear that completion by the deadline is a requirement, and advice is available from the National Patient Safety Agency or Central Alert System about what is required.

The data published by the NPSA includes data on NHS bodies which no longer exist, but which at the time of ceasing to exist (mainly due to mergers etc) had not confirmed implementation of patient safety alerts.

The data relating to primary care is even more likely to under-represent the extent to which alerts are not being complied with. GPs, dentists etc are not required to confirm whether

they have completed the required actions. Primary Care Trusts can declare actions 'completed' if they simply disseminate the alerts and complete the actions relating to their own organisation.

4 HOW THE CURRENT SYSTEM WORKS

The National Patient Safety Agency is the NHS body with responsibility for promoting patient safety in England. One of the ways in which it does this is to identify patient safety issues which are priorities to be addressed by issuing patient safety alerts. This is based on evidence that they:

(a) are a serious threat to patient safety, usually based on repeated loss of life or damage to health

(b) can be addressed through practical actions, which are evidence based.

Information about which patient safety issues meet these criteria may come to the National Patient Safety Agency as a result of reports of incidents to its National Reporting and Learning System, or through other reports or evidence given to or gathered by it. Issues are carefully assessed for seriousness and the practicality of addressing them before it is decided to issue a patient safety alert on the subject. There is consultation with experts on both the need for an alert and the content, including the "required actions" which the alert asks recipients to make, and a realistic deadline for NHS trusts to complete the required actions. This consultation extends to other stakeholders, including the Care Quality Commission, who consider each new alert before it is published.

Patient safety alerts have been issued by the National Patient Safety Agency since 2004. They are sometimes called "safer practice notices" and more recently the National Patient Safety Agency have developed "rapid response report" alerts where an issue is particularly serious and action needs to be taken even more urgently. All alerts contain "required actions" with a deadline for when they should be completed. For details of all patient safety alerts see the National Patient Safety Agency website: www.nrls.npsa.nhs.uk/resources/type/alerts

Alerts are sent to all NHS trusts in England. Any trust which believes that the alert which they have received is not relevant to them can notify the Central Alert System to that effect by entering 'Action not required'). When all required actions are considered completed, trusts enter 'completed'. Any other entry signifies that required actions in the alerts have not been completed by the deadline. (We have referred to this as failure to "comply" with alerts).

The Central Alert System was originally managed by the Department of Health but has been transferred to the National Patient Safety Agency. NHS trusts who are sent a patient safety alert are supposed to notify the Central Alert System if the alert is not applicable to them or when they have completed the actions in the relevant patient safety alert. The system is based on self-declaration by the trusts themselves. There is no guarantee that a trust which declares that it has completed all the required actions actually has. The system also relies on the trust informing the Central Alert System when it has completed the actions.

All NHS bodies are supposed to implement patient safety alerts issued by the National Patient Safety Agency by the specified deadline. This was one of the "core standards" set by the Department of Health**.** Core standard 1(b) said:

"Healthcare organisations protect patients through systems that ensure that patient safety notices, alerts, and other communications concerning patient safety which require action are acted upon with required timescales".

In February 2010, as a result of our first report, the Department of Health wrote to all trusts to remind them that trusts **'must'** complete all actions in alerts 'by the due dates' and 'confirm completion of actions on the Central Alert System'. See Appendix 2). As of April 2010 'core standards' ceased to exist, but all NHS trusts have to register with the Care Quality Commission. To do so they have to meet its requirements laid down in its registration regulations and accompanying guidance. Whilst, in spite of AvMA's representations that it should be, compliance with patient safety alerts is not spelt out as a high profile requirement in the statutory regulations themselves, the accompanying guidance which define what are 'essential standards' in effect do in all relevant outcome areas. (See the Care Quality Commission's letter (Appendix 1).

There is still no co-ordinated system for monitoring trusts' compliance with patient safety alerts, intervening where necessary, and extremely limited checking of the accuracy of trusts' self-declarations that they are compliant. There is an expectation that Strategic Health Authorities (there are 10 of them for different regions of England) should have a role in monitoring. They have a performance management role in respect of trusts in their region, and have access to the information on the Central Alert System. However, our research suggests that limited and inconsistent use of this data is made by some Strategic Health Authorities. The Care Quality Commission's predecessor, the Healthcare Commission, undertook a special review of compliance with certain patient safety alerts in 2007/08 and 2008/09 liaising with the National Patient Safety Agency to identify 'key' alerts to focus on as part of inspections of NHS trusts, which were a way of checking on the trusts' self declarations under the old 'Annual Health check'.

The Care Quality Commission has, following discussions of our previous reports, developed two indicators about patient safety alerts for its 'Quality & Risk' Profiles. It is working with the National Patient Safety Agency and Department of Health on new arrangements to monitor compliance with safety alerts as part of its ongoing systems to evaluate compliance with 'Essential Standards of Quality and Safety'. This will be a more proactive system than the former arrangements under the Annual Health check.

5 REAL PEOPLE, REAL LIVES: Why Patient Safety Alerts are so important

5.1 Case Study – Lisa Richards-Everton: Husband's death caused by drug error – Amphotericin

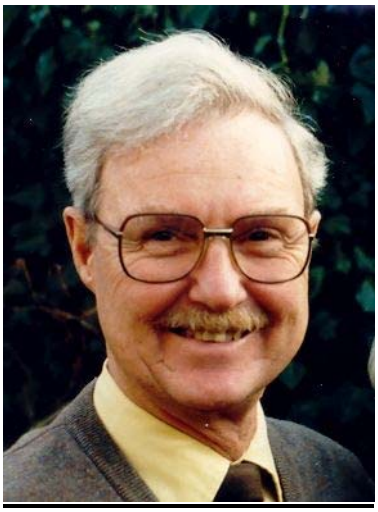
Paul Richards lost his life in July 2007 in Heartlands Hospital Birmingham as a result of confusion of two different types of the drug 'amphotericin', which led to him receiving a massive and fatal overdose. His widow, Lisa Richards-Everton, who is now looking after their three children alone, took some comfort from the fact that as a direct result of Paul's and other deaths, the National Patient Safety Agency issued a "rapid response alert" on the safer use of amphotericin to all NHS trusts in September 2007, with a number of actions required by 1st October 2007. To her dismay, Lisa discovered, as a result of AvMA's research published in February 2010, that 10 NHS trusts had still not completed the actions over two years after the deadline, and no-one appeared to be

chasing them up. Ironically, another patient safety alert issued in March 2007 (Promoting Safer Use of Injectable Medicines) may have saved Paul's life, had it been implemented at the time. Disturbingly, 104 trusts had still not implemented this alert nearly two years later than the deadline set. Lisa and her brother-in-law Stephen Richards attended a meeting which AvMA held with the Care Quality Commission on 16th June 2010 to discuss AvMA's original report. They were shocked to find that the Care Quality Commission up to that point had done absolutely nothing to chase up trusts who had been identified as having alerts outstanding – even those with multiple alerts outstanding. Not a single telephone call had been made. Not a single letter had been sent.

Lisa said:
"The current systems in place are clearly not working. Urgent changes are needed. Since losing Paul 3 years ago I have learnt so much about the current systems or lack of them in our hospitals. It is shocking to know Patient Safety Alerts are issued and trusts appear to decide whether or not to comply. There seems to be no structure to the present system, and sadly lives are being lost as a consequence. The Government needs to take this report extremely seriously and put safe systems in place, to prevent unnecessary tragedies from occurring. Had tougher systems been in place and National Patient Safety Agency Alerts been followed, Paul would be here today. I had a recent meeting with the Care Quality Commission last year to find out what they are doing about the trusts who are not complying with National Patient Safety Agency Alerts, and to my horror I was told nothing had been done about the trusts who are not complying. I couldn't believe what I was hearing. Why are National Patient Safety Agency Alerts issued if no one takes any notice? This is costing a huge amount of money, which could be used to make Patient Safety top of the list, instead of Patient Safety being a cost cutting exercise. The Government needs to take Urgent action.

I will not give up, I will continue to fight for changes. I do not want Paul's death to be in vain."

5.2 Case Study – Amanda Cale: Father's death caused by drug error – Methotrexate



Amanda Cale lost her father as a result of problems with the drug Methotrexate. Her efforts to ensure lessons were learnt to protect others was in large part responsible for one of the first alerts issued by the National Patient Safety Agency.

"The death of my father Charles Bootle was officially recorded as Methotrexate induced Pneumonitis, in other words the drug he was taking to relieve his Rheumatoid Arthritis caused him harm. The NPSA worked long and hard to alleviate the potential problems associated with this otherwise useful drug, culminating in the first Patient Safety Alert issued for a drug, in July 2004.

Whilst I am grateful to see that the number of non-compliant trusts has fallen in the last six months I am angered to find that so many trusts have still to get their act together 9 years after the death of my father and 6 years after the Patient Safety Alert regarding the safer use of Oral Methotrexate was first issued. If one patient has been harmed in any of these trusts due to non-compliance of this or any other patient safety alert then they only have themselves to blame if the family sue. We chose not to seek financial compensation on the death of my father. Like most other affected families we asked only that the system be changed to prevent further harm. What

is the point of all this hard work to promote better safety for patients if compliance is not obligatory? Personally I would like to meet the governing bodies of the remaining trusts and ask them to explain to our family and all the patients affected by this drug why they think it is acceptable to ignore these vital safety alerts.

I am also saddened to hear of the loss of the National Patient Safety Agency and pray that the new regime will work as hard to promote and instigate improved patient safety".

5.2 Case Study – Dr Stuart Gray & Rory Gray: Father's death caused by massive overdose of Diamorphine

Mr David Gray died in February 2008 of a massive overdose of Diamorphine administered by an out of hours GP from Germany. His sons, Dr Stuart Gray (pictured left) and Rory Gray (pictured right) have been working with AvMA ever since to ensure that lessons are learnt about the safe use of Diamorphine and other powerful drugs, as well as out of hours care and regulation of foreign doctors. Mr Gray's death might have been saved if the patient safety alert 'Ensuring safer practice with high dose ampoules' or 'safer use of injectable medicines' had been implemented. Since then, an alert on 'reducing errors with opioid medicines' has been issued with a deadline of 30th January 2009 for compliance.

Dr Stuart Gray, said:

"It is deeply disturbing to be informed that so many NHS bodies still completely disregard the National Patient Safety Agency safety alerts. The National Patient Safety Agency alerts are issued for a reason - to prevent deaths and morbidity from unsafe clinical practices and procedures. They are not issued lightly, but after careful consideration and consultation once a safety issue has been identified. I cannot comprehend why any NHS body would choose to ignore them. In fact, I would go so far as to say that I find it personally deeply offensive that they would do so, especially in light of the fact that my father was killed by being administered a massive drug overdose of diamorphine, a potent analgesic, in a situation where the out of hours provider was not carrying the drug in line with National Patient Safety Agency guidelines.

It is only a matter of time before another death occurs because an NHS body chooses to ignore these alerts.

Procedures must be put in place by the Department of Health to ensure complete compliance with the National Patient Safety Agency alerts by NHS bodies. And I would consider any death that, God forbid, should occur through the failure to comply with a National Patient Safety Agency alert to be one of corporate manslaughter by the NHS body concerned."

6 FINDINGS

6.1 With respect to all patient safety alerts which were already past the deadline, there were

- 195 trusts who had not complied with at least one alert. This is almost 50% of all trusts.

- There were 455 instances of a patient safety alert not having been complied with by an NHS trust. This is an improvement on 654 in our February 2011 report.

- 22 trusts had not complied with 5 or more alerts. This was an improvement on the February 2011 figure of 45.

- Some of the outstanding alerts are over 5 years past the deadline.

For the detailed findings see Tables B and C below.

6.2 With respect to the extra-urgent "Rapid Response Report" alerts, there were

- 269 instances of these alerts not having been complied with.

- Of the nine "Rapid Response Reports" issued in 2010 which were already past the deadline, not a single alert had been complied with by every trust.

- The alert on "Transfusion of blood and blood components in an emergency" (deadline 26th April 2011) had not been complied with by 31 trusts. (See example below).

- The most recent "Rapid Response Report" on "Essential Care after an inpatient fall" (deadline 14th July 2011) had not been complied with by 101 trusts.

EXAMPLE:

The Rapid Response Report "The transfusion of blood and blood components in an emergency" was issued on 21st October 2010 with a deadline of 26th April 2011 for completion of all the required actions. It followed reports to the NPSA of 11 deaths and 83 incidents causing harm to patients as a result of delays in the provision of blood (there are usually more actual incidents than actually get reported). The Rapid Response Report sets out specific actions that need to be completed to reduce the risk of these incidents. To see this Rapid Response Report, see Appendix 3 on page 24.

See Table A below for a breakdown of all "Rapid Response Report" alerts.

6.3 Detailed findings

To interrogate the core data yourself, visit the NPSA website: http://www.nrls.npsa.nhs.uk/patient-safety-data/ . Select 'Central Alert System data – July 2011' to open spreadsheet. This enables you to analyse information in detail for each trust, individual alert etc.

Table A provides 'Rapid Response Report' alerts with number of Trusts which have not implemented them.

Table B provides Trusts who have not implemented 5 or more alerts (in descending order).

Table C provides Trusts in alphabetical order, with number of alerts not implemented for each trust. (Note: some trusts have changed names or merged).

TABLE A: 'Rapid Response Report' alerts with number of Trusts which have not implemented them

Reference Number	Title of Rapid Response Report Alert	No. of Trusts
NPSA/2008/RRR001	Risks of Incorrect Dosing of Oral Anti-Cancer Medicines	1
NPSA/2011/RRR001	Essential care after an inpatient fall	101
NPSA/2008/RRR003	Risks of Chest Drain Insertion	6
NPSA/2009/RRR004	Preventing delay to follow-up for patients with glaucoma	8
NPSA/2009/RRR005	Minimising risks of suprapubic catheter insertion (adults only)	4
NPSA/2009/RRR006	Oxygen safety in hospitals	7
NPSA/2009/RRR007	Reducing risks of tourniquets left on after finger and toe surgery	1
NPSA/2010/RRR008	Vaccine cold storage	2
NPSA/2010/RRR009	Reducing harm from omitted and delayed medicines in hospital	23
NPSA/2010/RRR010	Early detection of complications after gastrostomy	1
NPSA/2010/RRR011	Checking pregnancy before surgery	3
NPSA/2009/RRR012	Reducing risk of harm from oral bowel cleansing solutions	1
NPSA/2010/RRR013	Safer administration of insulin	14
NPSA/2010/RRR014	Reducing treatment dose errors with low molecular weight heparins	25
NPSA/2010/RRR015	Prevention of over infusion of intravenous fluid* and medicines in neonates	12
NPSA/2010/RRR016	Laparoscopic surgery: failure to recognise post-operative deterioration	29
NPSA/2010/RRR017	The transfusion of blood and blood components in an emergency	31

TABLE B: Trusts who have not implemented 5 or more alerts (descending order)

Number of Alerts not implemented	Name of Trust
9	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST
9	WHIPPS CROSS UNIVERSITY HOSPITAL NHS TRUST
8	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
7	NORTH WEST LONDON HOSPITALS NHS TRUST
7	UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
6	IMPERIAL COLLEGE HEALTHCARE NHS TRUST
6	LUTON AND DUNSTABLE HOSPITAL NHS FOUNDATION TRUST
6	LUTON PCT
6	MID STAFFORDSHIRE NHS FOUNDATION TRUST
6	NORFOLK PCT
6	REDBRIDGE PCT
6	ROYAL FREE HAMPSTEAD NHS TRUST
6	SOUTH SEFTON PCT
6	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
6	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
6	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST
5	BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST
5	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
5	ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST
5	SOUTH LONDON HEALTHCARE NHS TRUST
5	SURREY HEATH & WOKING PCT
5	THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST

TABLE C: Trusts in alphabetical order, with number of alerts not implemented for each trust. (Note: some trusts have changed names or merged)

Name of Trust	Number of alerts Not implemented
2GETHER NHS FOUNDATION TRUST	0
5 BOROUGHS PARTNERSHIP NHS FOUNDATION TRUST	0
AINTREE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2
AIREDALE NHS FOUNDATION TRUST	0
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	4
ANGLIAN COMMUNITY ENTERPRISE COMMUNITY INTEREST COMPANY (ACE C/C)	0
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	2
ASHTON, LEIGH AND WIGAN PCT	0
AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	0
BARKING AND DAGENHAM PCT	2
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	0
BARNET AND CHASE FARM HOSPITALS NHS TRUST	2
BARNET PCT	2
BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	0
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	0
BARNSLEY PCT	0
BARTS AND THE LONDON NHS TRUST	2
BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2
BASINGSTOKE AND NORTH HAMPSHIRE NHS FOUNDATION TRUST	0
BASSETLAW PCT	0
BATH AND NORTH EAST SOMERSET PCT	1
BEDFORD HOSPITAL NHS TRUST	0
BEDFORSHIRE PCT	0
BERKSHIRE EAST PCT	0
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	0
BERKSHIRE WEST PCT	0
BEXLEY CARE TRUST	0
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	1
BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST	0
BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST	0
BIRMINGHAM EAST AND NORTH PCT	1
BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST	5
BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	0
BLACKBURN WITH DARWEN TEACHING CARE TRUST PLUS	0
BLACKPOOL PCT	0
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	0
BOLTON NHS FOUNDATION TRUST	1
BOLTON PCT	0
BOURNEMOUTH AND POOLE TEACHING PCT	0
BRADFORD AND AIREDALE TEACHING PCT	0
BRADFORD DISTRICT CARE TRUST	1
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	3
BRENT TEACHING PCT	0
BRIDGEWATER COMMUNITY HEALTHCARE NHS TRUST	0
BRIGHTON AND HOVE CITY PCT	0
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	0
BRISTOL PCT	0
BROMLEY PCT	0
BROMLEY HOSPITALS NHS TRUST	2
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	0

BUCKINGHAMSHIRE PCT	3
BURTON HOSPITALS NHS FOUNDATION TRUST	1
BURY PCT	0
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	0
CALDERDALE PCT	1
CALDERSTONES PARTNERSHIP NHS FOUNDATION TRUST	0
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	5
CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	0
CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST	0
CAMBRIDGESHIRE PCT	0
CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	0
CAMDEN PCT	0
CENTRAL AND EASTERN CHESHIRE PCT	0
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	0
CENTRAL LANCASHIRE PCT	2
CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST	0
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	3
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	1
CHESHIRE WEST PCT	2
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	0
CITY AND HACKNEY TEACHING PCT	1
CITY HEALTH CARE PARTNERSHIP	0
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	3
CLATTERBRIDGE CENTRE FOR ONCOLOGY NHS FOUNDATION TRUST	4
COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	0
COLCHESTER PCT	1
CORNWALL AND ISLES OF SCILLY PCT	0
CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	0
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	1
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	0
COUNTY DURHAM PCT	0
COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	1
COVENTRY TEACHING PCT	0
CRAWLEY PCT	1
CROYDON HEALTH SERVICES NHS TRUST	3
CROYDON PCT	0
CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	2
CUMBRIA TEACHING PCT	1
DARLINGTON PCT	0
DARTFORD AND GRAVESHAM NHS TRUST	0
DERBY CITY PCT	0
DERBY HOSPITALS NHS FOUNDATION TRUST	0
DERBYSHIRE COUNTY PCT	0
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	0
DERWENTSIDE PCT	2
DEVON PARTNERSHIP NHS TRUST	0
DEVON PCT	0
DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST	1
DONCASTER PCT	0
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	1
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	0
DORSET PCT	0
DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	0
DUDLEY PCT	0
EALING HOSPITAL NHS TRUST	2

EALING PCT	1
EASINGTON PCT	4
EAST AND NORTH HERTFORDSHIRE NHS TRUST	0
EAST CHESHIRE NHS TRUST	1
EAST ELMBRDIGE & MID-SURREY PCT	2
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	1
EAST LANCASHIRE HOSPITALS NHS TRUST	0
EAST LANCASHIRE TEACHING PCT	0
EAST LONDON NHS FOUNDATION TRUST	2
EAST MIDLANDS AMBULANCE SERVICE NHS TRUST	0
EAST OF ENGLAND AMBULANCE SERVICES NHS TRUST	0
EAST RIDING OF YORKSHIRE PCT	2
EAST SUSSEX DOWNS AND WEALD PCT	2
EAST SUSSEX HEALTHCARE NHS TRUST	2
EAST YORKSHIRE PCT	2
EASTERN AND COASTAL KENT PCT	0
EDEN VALLEY PCT	1
ELLESMERE PORT & NESTON PCT	3
ENFIELD PCT	1
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	0
ESSEX AMBULANCE SERVICE NHS TRUST	2
FRIMLEY PARK HOSPITAL NHS FOUNDATION TRUST	0
GATESHEAD HEALTH NHS FOUNDATION TRUST	2
GATESHEAD PCT	1
GEORGE ELIOT HOSPITAL NHS TRUST	0
GLOUCESTERSHIRE AMBULANCE SERVICES NHS TRUST	4
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	0
GLOUCESTERSHIRE PCT	0
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS TRUST	1
GREAT WESTERN AMBULANCE SERVICE NHS TRUST	0
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	2
GREAT YARMOUTH AND WAVENEY PCT	0
GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST	1
GREENWICH TEACHING PCT	0
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	0
HALTON AND ST HELENS PCT	1
HALTON PCT	1
HAMMERSMITH & FULHAM PCT	0
HAMMERSMITH HOSPITALS NHS TRUST	2
HAMPSHIRE PCT	2
HARINGEY TEACHING PCT	0
HARROGATE AND DISTRICT NHS FOUNDATION TRUST	1
HARROW PCT	1
HARTLEPOOL PCT	0
HASTINGS AND ROTHER PCT	2
HAVERING PCT	1
HEART OF BIRMINGHAM TEACHING PCT	0
HEART OF ENGLAND NHS FOUNDATION TRUST	1
HEATHERWOOD AND WEXHAM PARK HOSPITALS NHS FOUNDATION TRUST	2
HEREFORDSHIRE PCT	0
HERTFORDSHIRE COMMUNITY NHS TRUST	0
HERTFORDSHIRE PARTNERSHIP NHS FOUNDATION TRUST	0
HERTFORDSHIRE PCT	0
HEYWOOD, MIDDLETON AND ROCHDALE PCT	1
HILLINGDON PCT	0
HINCHINGBROOKE HEALTH CARE NHS TRUST	0

HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	0
HORSHAM & CHANCTONBURY PCT	3
HOUNSLOW PCT	0
HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	1
HULL TEACHING PCT	0
HUMBER NHS FOUNDATION TRUST	1
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	6
IPSWICH HOSPITAL NHS TRUST	1
ISLE OF WIGHT NHS PCT	2
ISLINGTON PCT	0
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0
KENSINGTON AND CHELSEA PCT	1
KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	1
KENT COMMUNITY HEALTH NHS TRUST	0
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	0
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	1
KINGSTON HOSPITAL NHS TRUST	0
KINGSTON PCT	0
KIRKLEES PCT	0
KNOWSLEY PCT	0
LAMBETH PCT	0
LANCASHIRE CARE NHS FOUNDATION TRUST	0
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	1
LANGBAURGH PCT	2
LEEDS PARTNERSHIPS NHS FOUNDATION TRUST	0
LEEDS PCT	0
LEEDS TEACHING HOSPITALS NHS TRUST	0
LEICESTER CITY PCT	0
LEICESTERSHIRE COUNTY AND RUTLAND PCT	0
LEICESTERSHIRE PARTNERSHIP NHS TRUST	0
LEWISHAM HEALTHCARE NHS TRUST	3
LEWISHAM PCT	0
LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	0
LINCOLNSHIRE TEACHING PCT	0
LIVERPOOL COMMUNITY HEALTH NHS TRUST	1
LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	2
LIVERPOOL PCT	1
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1
LONDON AMBULANCE SERVICES NHS TRUST	0
LUTON AND DUNSTABLE HOSPITAL NHS FOUNDATION TRUST	6
LUTON PCT	6
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	8
MAIDSTONE WEALD PCT	4
MANCHESTER MENTAL HEALTH AND SOCIAL CARE TRUST	0
MANCHESTER PCT	2
MEDWAY NHS FOUNDATION TRUST	2
MEDWAY PCT	0
MERSEY CARE NHS TRUST	0
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	0
MID ESSEX HOSPITAL SERVICES NHS TRUST	1
MID ESSEX PCT	0
MID STAFFORDSHIRE NHS FOUNDATION TRUST	6
MID YORKSHIRE HOSPITALS NHS TRUST	4
MIDDLESBROUGH PCT	0
MILTON KEYNES HOSPITAL NHS FOUNDATION TRUST	0
MILTON KEYNES PCT	0

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	2
NEWCASTLE PCT	0
NEWHAM PCT	2
NEWHAM UNIVERSITY HOSPITAL NHS TRUST	2
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1
NORFOLK AND WAVENEY MENTAL HEALTH NHS FOUNDATION TRUST	0
NORFOLK COMMUNITY HEALTH AND CARE NHS TRUST	0
NORFOLK PCT	6
NORTH BRISTOL NHS TRUST	4
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	0
NORTH EAST AMBULANCE SERVICES NHS TRUST	0
NORTH EAST ESSEX PCT	3
NORTH EAST LINCOLNSHIRE CARE TRUST PLUS	0
NORTH EAST LONDON NHS FOUNDATION TRUST	2
NORTH ESSEX PARTNERSHIP NHS FOUNDATION TRUST	1
NORTH LANCASHIRE TEACHING PCT	1
NORTH LINCOLNSHIRE PCT	0
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	4
NORTH SOMERSET PCT	1
NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	0
NORTH STAFFORDSHIRE PCT	2
NORTH SURREY PCT	3
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	0
NORTH TYNESIDE PCT	0
NORTH WEST AMBULANCE SERVICES NHS TRUST	0
NORTH WEST LONDON HOSPITALS NHS TRUST	7
NORTH WEST SURREY MENTAL HEALTH NHS PARTNERSHIP TRUST	3
NORTH YORKSHIRE AND YORK PCT	4
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	0
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	1
NORTHAMPMTONSHIRE TEACHING PCT	0
NORTHERN DEVON HEALTHCARE NHS TRUST	0
NORTHERN LINCOLNSHIRE AND GOOLE HOSPITALS NHS FOUNDATION TRUST	1
NORTHUMBERLAND CARE TRUST	0
NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	0
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	0
NOTTINGHAM CITY PCT	1
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	0
NOTTINGHAMSHIRE COUNTY TEACHING PCT	0
NOTTINGHAMSHIRE HEALTHCARE NHS TRUST	1
NUFFIELD ORTHOPAEDIC CENTRE NHS TRUST	0
OLDHAM PCT	0
OXFORD RADCLIFFE HOSPITALS NHS TRUST	0
OXFORDSHIRE AND BUCKINGHAMSHIRE MENTAL HEALTH NHS FOUNDATION TRUST	0
OXFORDSHIRE LEARNING DISABILITY NHS TRUST	0
OXFORDSHIRE PCT	0
OXLEAS NHS FOUNDATION TRUST	0
PAPWORTH HOSPITAL NHS FOUNDATION TRUST	0
PENNINE ACUTE HOSPITALS NHS TRUST	0
PENNINE CARE NHS FOUNDATION TRUST	1
PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST	0
PETERBOROUGH PCT	0
PLYMOUTH HOSPITALS NHS TRUST	0
PLYMOUTH TEACHING PCT	0
POOLE HOSPITAL NHS FOUNDATION TRUST	1

PORTSMOUTH CITY TEACHING PCT	0
PORTSMOUTH HOSPITALS NHS TRUST	4
PRESTON PCT	2
QUEEN ELIZABETH HOSPITAL NHS TRUST	1
QUEEN MARY'S SIDCUP NHS TRUST	1
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	0
REDBRIDGE PCT	6
REDCAR AND CLEVELAND PCT	0
RICHMOND AND TWICKENHAM PCT	4
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC AND DISTRICT HOSPITAL NHS TRUST	0
ROTHERHAM PCT	0
ROTHERHAM, DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	0
ROYAL BERKSHIRE NHS FOUNDATION TRUST	0
ROYAL BROMPTON AND HAREFIELD NHS FOUNDATION TRUST	2
ROYAL CORNWALL HOSPITALS NHS TRUST	2
ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	1
ROYAL FREE HAMPSTEAD NHS TRUST	6
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	2
ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES NHS FOUNDATION TRUST	0
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	0
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	5
ROYAL UNITED HOSPITAL BATH NHS TRUST	2
SALFORD PCT	3
SALFORD ROYAL NHS FOUNDATION TRUST	0
SALISBURY NHS FOUNDATION TRUST	0
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	2
SANDWELL PCT	0
SCARBOROUGH AND NORTH EAST YORKSHIRE HEALTH CARE NHS TRUST	1
SEFTON PCT	0
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	0
SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST	0
SHEFFIELD PCT	0
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	0
SHEPWAY PCT	1
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	1
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	3
SHROPSHIRE COUNTY PCT	1
SOLIHULL CARE TRUST	2
SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	0
SOMERSET PCT	1
SOUTH BIRMINGHAM PCT	0
SOUTH CENTRAL AMBULANCE SERVICES NHS TRUST	0
SOUTH DEVON HEALTHCARE NHS FOUNDATION TRUST	0
SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST	4
SOUTH EAST ESSEX PCT	0
SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	0
SOUTH GLOUCESTERSHIRE PCT	0
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	0
SOUTH LONDON HEALTHCARE NHS TRUST	5
SOUTH SEFTON PCT	6
SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST	0
SOUTH STAFFORDSHIRE PCT	0
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	1
SOUTH TYNESIDE NHS FOUNDATION TRUST	0

SOUTH TYNESIDE PCT	1
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	1
SOUTH WEST ESSEX PCT	0
SOUTH WEST KENT PCT	3
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	2
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	0
SOUTH WESTERN AMBULANCE SERVICE NHS FOUNDATION TRUST	0
SOUTHAMPTON CITY PCT	1
SOUTHAMPTON UNIVERSITY HOSPITALS NHS TRUST	1
SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	6
SOUTHERN HEALTH NHS FOUNDATION TRUST	0
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	3
SOUTHWARK PCT	0
ST GEORGE'S HEALTHCARE NHS TRUST	2
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	4
STOCKPORT NHS FOUNDATION TRUST	0
STOCKPORT PCT	0
STOCKTON-ON-TEES TEACHING PCT	0
STOKE ON TRENT PCT	0
SUFFOLK MENTAL HEALTH PARTNERSHIP NHS TRUST	1
SUFFOLK PCT	0
SUNDERLAND TEACHING PCT	1
SURREY AMBULANCE SERVICE NHS TRUST	1
SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	1
SURREY AND SUSSEX HEALTHCARE NHS TRUST	3
SURREY HEATH & WOKING PCT	5
SURREY PCT	2
SUSSEX AMBULANCE SERVICES NHS TRUST	1
SUSSEX COMMUNITY NHS TRUST	1
SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	0
SUTTON AND MERTON PCT	1
SWINDON PCT	0
TAMESIDE AND GLOSSOP PCT	2
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	3
TAUNTON AND SOMERSET NHS FOUNDATION TRUST	0
TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	0
TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	0
TELFORD AND WREKIN PCT	0
TENDRING PCT	1
THE CHRISTIE NHS FOUNDATION TRUST	0
THE DUDLEY GROUP OF HOSPITALS NHS FOUNDATION TRUST	0
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	5
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	0
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	0
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN. NHS FOUNDATION TRUST	1
THE ROTHERHAM NHS FOUNDATION TRUST	0
THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	0
THE ROYAL MARSDEN NHS FOUNDATION TRUST	0
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	6
THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST	3
THE WALTON CENTRE NHS FOUNDATION TRUST	4
THE WHITTINGTON HOSPITAL NHS TRUST	1
TORBAY CARE TRUST	0
TOWER HAMLETS PCT	1
TRAFFORD HEALTHCARE NHS TRUST	0
TRAFFORD PCT	0

TWO SHIRES AMBULANCE NHS TRUST	3
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	6
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	0
UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST	0
UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST	2
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	0
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	7
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	1
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	4
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	9
WAKEFIELD DISTRICT PCT	0
WALSALL HEALTHCARE NHS TRUST	0
WALSALL TEACHING PCT	0
WALTHAM FOREST PCT	2
WANDSWORTH PCT	0
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	0
WARRINGTON PCT	1
WARWICKSHIRE PCT	0
WEST ESSEX PCT	1
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	2
WEST KENT PCT	0
WEST LONDON MENTAL HEALTH NHS TRUST	1
WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	1
WEST MIDLANDS AMBULANCE SERVICES NHS TRUST	0
WEST SUFFOLK HOSPITALS NHS TRUST	2
WEST SUSSEX PCT	0
WESTERN CHEESHIRE PCT	0
WESTERN SUSSEX HOSPITALS NHS TRUST	4
WESTERN SUSSEX PCT	4
WESTMINSTER PCT	0
WESTON AREA HEALTH NHS TRUST	0
WHIPPS CROSS UNIVERSITY HOSPITAL NHS TRUST	9
WILTSHIRE PCT	0
WINCHESTER AND EASTLEIGH HEALTHCARE NHS TRUST	0
WIRRAL PCT	0
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	0
WOLVERHAMPTON CITY PCT	3
WORCESTERSHIRE ACTUE HOSPITALS NHS TRUST	0
WORCESTERSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	0
WORCESTERSHIRE PCT	2
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	0
WYE VALLEY NHS TRUST	0
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	0
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	0
YORKSHIRE AMBULANCE SERVICE NHS TRUST	0
YORKSHIRE WOLDS & COAST PCT	3
YOUR HEALTHCARE	1

7 CONCLUSIONS AND RECOMMENDATIONS

Whilst there has been some improvement since our report six months' ago, and even more since the shocking situation we revealed in our first report in February 2010, there is still widespread non-compliance with patient safety alerts. Patients are being left at unnecessary risk, and it is probable that some patients have been needlessly harmed or even killed as a result of non-compliance with patient safety alerts. This situation can not be allowed to continue.

It is our clear impression that without the pressure that we, a small independent charity, and concerned patients have brought to bear with the help of the media, the improvement that has been achieved would not have happened. The fact that 50% of trusts have been able to declare compliance with all of the alerts shows that with hard work, determination and a genuine commitment to patient safety it can be done.

The raw data on compliance with patient safety alerts is now being posted on the NPSA website on a monthly basis. Whilst this is a step in the right direction (previously, we were required to make a Freedom of Information request to get the information) this is not being done in a fully transparent way. It takes considerable knowledge and patience to find it, let alone interpret it. If patients and the public had easy-to-access and easy-to-understand information on compliance with patient safety alerts, it would provide a powerful incentive for trusts to improve.

Looking to the future, the NHS reforms which are currently being debated in Parliament may have a number of benefits for patients in the long term. However, they have not been designed with patient safety as the main criteria. There is a worrying lack of clarity about how patient safety will be promoted and regulated in the new regime, and there appears to be no plan for a co-ordinated approach to patient safety in the interim period. The NPSA is to be abolished and has already lost most of its staff. Its responsibility for patient safety alerts is meant to transfer to a new NHS Commissioning Board, but the legislation to create it has not even been passed yet. Meanwhile, Strategic Health Authorities and Primary Care Trusts, who are also to be abolished, have been haemorrhaging staff and are unlikely to be in a position to monitor patient safety alerts.

Lastly, we congratulate those 50% of trusts who have succeeded in becoming compliant with all patient safety alerts. However, we know from our own case work that even where compliance has been declared, the alerts are not necessarily being followed in practice. This was also the finding when the Healthcare Commission looked at this. More work is needed to quality assure declared compliance.

We recommend the following urgent actions:

1 The Care Quality Commission should be more proactive in insisting with compliance with patient safety alerts, and taking action with trusts who continue not to comply. Starting with the trusts with multiple alerts outstanding, and those who are more than a year overdue with complying with an alert, trusts should be made to produce an action plan for complying within a short timescale or face sanctions. The action plan should be publicly available.

2 The Department of Health should produce a business plan for the co-ordination of patient safety work, including the generation of and monitoring compliance with patient safety alerts. This should include detail on how this work will be co-ordinated when the new system is up and running and in the immediate short-term period of transition.

3 Information on compliance with patient safety alerts should be made available in a far more prominent and user-friendly way than is the case presently. If patients and the public could readily see if trusts were complying or not on the trust's own website and through NHS Choices, this would provide a powerful incentive for trusts to improve compliance.

4 There needs to be a concerted programme of training for NHS staff drawing on the best practice that has allowed 50% of trusts to comply with patient safety alerts and real patient stories demonstrating how vitally important this is.

5 There should be routine audits of NHS trusts' work on implementing patient safety alerts to establish whether those that are declared 'complete' are actually being implemented and followed in practice.

6 Detailed consideration should be given to how implementation of relevant patient safety alerts in primary care can be more rigorously promoted and regulated.

APPENDIX 1

22 June 2010

Dear [NAME],

Implementation of NPSA patient safety alerts

I am writing to you with regard to implementation of patient safety alerts issued by the National Patient Safety Agency (NPSA) via the NHS Central Alerting System (CAS).

Compliance with these alerts was core standard C1 (b) of 'standards for better health'. Under CQC's guidance about compliance with our new essential standards, the importance of implementing these alerts is covered by the following outcomes:

4: care and welfare of people who use services
9: management of medicines
10: safety and suitability of premises
11: safety, availability and suitability of equipment

The legal force behind these essential standards came into force on 1 April at the point at which your trust was registered with CQC.

We have contacted you because the latest data we have from the CAS system (from 7 June 2010) indicates that your trust has failed to implement 10 or more of the alerts issued by the NPSA since 2004 where the completion date is prior to 7 June. We are writing to every trust in England where this is the case.

Please could you reply to this letter by 30 July setting out why you have not confirmed with the CAS system that you have implemented these alerts, and explaining what action you have in place to address this?

While we appreciate that the CAS data needs to be treated with some caution, these alerts are a vital part of patient safety. A comprehensive report issued by Action against Medical Accidents in February of this year sets out exactly why implementing these alerts is important. Failure to put these alerts into action can have extremely serious consequences for patient care.

You can find a full list of the alerts, including those issued by the Department of Health and the Medicines and Healthcare Products Regulatory Agency, here www.cas.dh.gov.uk/Home.aspx. You can find CQC's guidance about compliance on our website www.cqcguidanceaboutcompliance.org.uk, or order a printed copy by calling 0870 240 7535. Please contact me if you have any further questions. I look forward to your response.

theweek. Issue 133 12 February – 18 February 2010

NHS

select a section...

Published every Thursday, **the week** provides need-to-know news, consultations and events for chief executives and their teams. It provides links to more information and resources, highlighting areas for action.

Policy news

1. Ensuring safety alerts are implemented and completed on CAS (Gateway Reference Number: 13640)

Safety alerts are issued to all trusts in England, who must report receipt and confirm completion of actions on the Central Alerting System (CAS). Trusts are responsible for ensuring that their reporting systems are robust, that reporting is timely and accurate, and that all actions are completed satisfactorily and by the due dates.

Link:
https://www.cas.dh.gov.uk

Action:

- NHS chief executives are reminded of their responsibility to ensure that actions arising from safety alerts are implemented within deadline, and that CAS is regularly updated by trusts to reflect the current status of alert implementation.

2. Legal duties – NICE technology appraisal guidance (Gateway Reference Number: 7521)

PCTs are legally required to make funding available for treatments recommended by NICE's technology appraisal guidance within three months of final guidance being published, as set out in the directions in the link below. The Department of Health expects each PCT as best practice to endeavour to ensure that any new treatments recommended by NICE technology appraisals are available as soon as possible after NICE issues final guidance.

Link:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4083088

Action:

- PCT chief executives are reminded of their legal duties under the three month funding direction.

APPENDIX 3

NHS
National Patient Safety Agency

Rapid Response Report

NPSA/2010/RRR017

From reporting to learning — 21 October 2010

The transfusion of blood and blood components in an emergency

Issue

The urgent provision of blood for life threatening haemorrhages requires a rapid, focused approach as excessive blood loss can jeopardise the survival of patients. Early recognition of major blood loss and immediate effective interventions are vital to avoid hypovolaemic shock and its consequences. One such action is the rapid provision of blood and blood components, for which effective communication between all personnel involved in the provision and transportation of blood is key.

Evidence of harm

During the period October 2006 to September 2010, the National Patient Safety Agency (NPSA) received reports of 11 deaths and 83 incidents in which a patient was harmed as a result of delays in the provision of blood in an acute situation.

Reducing the risk of harm

This Rapid Response Report (RRR) is intended to focus the attention of hospitals on the systems in place and the human factors that impact on the efficient provision of blood in emergencies. Other guidance available that should be considered alongside this RRR includes guidance issued by the British Committee for Standards in Haematology (2006); the recommendations of the Confidential Enquiries into Maternal and Child Health (CEMACH) (2007) for a protocol for the management of massive obstetric haemorrhage; and the Royal College of Obstetricians and Gynaecologists guidance *Blood transfusion in obstetrics* (2008).

For IMMEDIATE ACTION by the NHS and independent (acute) sector. Actions should be led by an executive director nominated by the Chief Executive, working with the Chair of the Hospital Transfusion Committee. Deadline for ACTION COMPLETE is 26 April 2011.

Local organisations should ensure that:

1. The hospital transfusion committee reviews the local protocols and practices for requesting and obtaining blood in an emergency (including out of hours), ensuring that they include all the actions required by clinical teams, laboratories and support services, e.g. portering and transport staff/drivers and any specific actions pertinent to sites without an on-site transfusion laboratory.
2. Local protocols enable the release of blood and blood components without the initial approval of a haematologist although they should be advised of the situation at the earliest opportunity.
3. Staff (clinical, laboratory and support staff) know where to find the massive blood loss protocol in all relevant clinical and laboratory areas and are familiar with it, supported by training and regular drills.
4. The blood transfusion laboratory staff are informed of patients with a massive haemorrhage at the earliest opportunity.
5. Clinical teams dealing with patients with massive haemorrhage nominate a specific member of the team to co-ordinate communication with the laboratory staff and support services for the duration of the incident.
6. There is a clear and well understood trigger phrase to activate the massive blood loss protocol, for example *"I want to trigger the massive blood loss protocol [*and state location e.g. *delivery suite]"* and all subsequent communications between clinical areas and laboratory staff should be preceded by the use of a locally agreed trigger phrase such as *"This call relates to the massive blood loss protocol [and location]"*.
7. All incidents where there are delays or problems in the provision of blood in an emergency are reported and investigated locally, and reported to the NPSA and the Serious Hazards of Transfusion (SHOT) scheme (www.shotuk.org).
8. Each event triggering the massive blood loss protocol is recorded and reviewed by the hospital transfusion committee to ensure local protocols are applied appropriately and effectively.

Supporting information on this RRR is available at www.nrls.npsa.nhs.uk/alerts. Further queries should be directed to rrr@npsa.nhs.uk; telephone 020 7927 9890.

The NPSA has informed NHS organisations, the independent sector, commissioners, regulators and relevant professional bodies in England and Wales.

Gateway ref: 14960