IMPLEMENTATION OF

PATIENT SAFETY ALERTS

"TOO LITTLE TOO LATE?"

February 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 obtained as a result of a Freedom of Information Request to the Department of Health about information held on the 'Central Alert System' 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 asked for information on which NHS trusts 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 third report on this issue, updating on the situation revealed in its reports in February 2010 and August 2010.

The core information provided in response to AvMA's Freedom of Information request is now available on the National Patient Safety Agency's website at http://www.nrls.npsa.nhs.uk/patient-safety-data/

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 20th January 2011 (when the Department of Health collected the data) and relates to all patient safety alerts issued since 2004 for which the deadlines had already passed.

2 SUMMARY OF MAIN FINDINGS

- There were 654 instances of patient safety alerts which had not been complied with. Whilst this represents a decrease of 50% on the August 2010 figure, each alert not complied with means that lives are being put at unnecessary risk. All alerts are supposed to be complied with all trusts by the given deadline, and trusts have been reminded of this requirement by the Department of Health.

- 203 (50%) of trusts had failed to comply with at least one alert.

- 45 trusts had not complied with 5 or more alerts. 5 trusts had not complied with 10 or more alerts.

- Many of the alerts which had not been complied with were years past the deadline for completion. For example, "Safer use of Injectable medicines" (deadline for completion 31st March 2008) had not been complied with by 26 trusts. "Right Patient Right Blood" (deadline for completion 1st May 2009) had not been complied with by 36 trusts.

- Even extra urgent "Rapid Response Alerts" had not been complied with by many trusts. For example, rapid response alert "Oxygen Safety in Hospitals" (deadline for completion 29th March 2010) had not been complied with by 31 trusts.

- Some trusts which had been amongst the worst performers in our last two reports and to whom the Care Quality Commission had been moved to write to to remind them of the need to comply, still have over 10 alerts outstanding. For example, Stockport NHS Foundation Trust had 14 alerts outstanding (15 in February 2010); Manchester PCT had 13 outstanding (23 in February 2010);

Barts and the London NHS Trust had 11 alerts outstanding (20 in February 2010); and Aintree University Hospitals NHS Foundation Trust had 10 alerts outstanding (12 in February 2010).

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 report in August 2010, which showed that whilst there was some improvement, there was still widespread non-compliance and a failure on behalf of regulators to act.

3.2 What did we set out to find out this time?

We wanted to know whether the 'patient safety alerts' which are sent out to relevant NHS bodies by the National Patient Safety Agency are now being implemented on time by all trusts and, if not, who was responsible for checking and what is being done about it. The report is an update on the situation reflected in our August 2010 report.

3.3 How did we go about it?

We made a freedom of information request to the Department of Health to ascertain, in relation to every patient safety alert issued since 2004 for which the deadline for completion of the required actions had already passed:

- the number of NHS trusts who had or had not declared that they had completed the required actions in each alert.

- the names of the NHS trusts who had not completed the required action and those who had completed all the actions in all the alerts.

3.4 Possible limitations of the research data

The information supplied to us by the Department of Health relates to the data held on the Central Alert System as at 20th January 2011 In other words it is a snapshot in time. . Some trusts will have registered compliance with some of the patient safety alerts between then and publication of this report.

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 are 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 supplied by the Department of Health included 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. For the sake of clarity, the findings we have reported relate to *existing* NHS bodies unless stated. However, it should be noted that new NHS bodies, or those who have taken on previous NHS bodies, have the ability and are supposed to confirm whether the old body's record of not having complied should be removed. There are likely to be existing NHS bodies who have absorbed others where the alerts had not been implemented, whilst the Central Alert System does not list them as having those alerts outstanding.

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 them.

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 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 'action 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 4). 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 3).

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

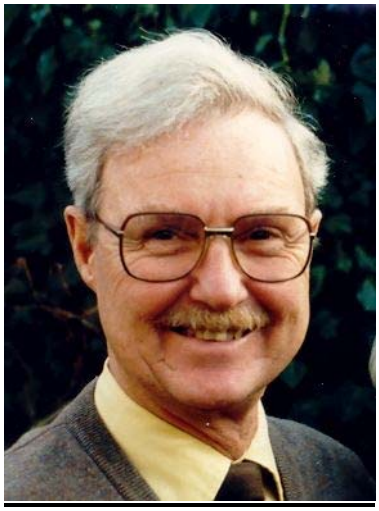
Paul Richards lost his life in July 2007 in Heartlands Hospital Birmingham as a result of confusion of two different types of the drug 'amphotericin', which led to him receiving a massive and fatal overdose. His widow, Lisa Richards-Everton, who is now looking after their three children alone, took some 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 Detailed findings

These are set out in the appendices.

Appendix 1 provides a 'league table' of trusts who failed to comply with 10 or more alerts in descending order.

Appendix 2 provides an alphabetical list of trusts with the number of alerts which they had failed to comply with (including trusts with "0" not complied with).

7 CONCLUSIONS AND RECOMMENDATIONS

Whilst there has been substantial 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 inevitable that some patients have been needlessly harmed or even killed as a result of non-compliance with patient safety alerts.

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 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 at all for a co-ordinated approach to patient safety in the interim period.

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.

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.

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.

Appendix 1: Trusts in order of number of alerts outstanding

Number of Alerts not implemented	Name of Trust
14	STOCKPORT NHS FOUNDATION TRUST
13	MANCHESTER PCT
11	BARTS AND THE LONDON NHS TRUST
11	BEDFORD HOSPITAL NHS TRUST
10	AINTREE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
9	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST
9	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST
9	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST
9	ST GEORGE'S HEALTHCARE NHS TRUST
8	LEWISHAM HEALTHCARE NHS TRUST
8	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
8	MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
8	NORTH WEST LONDON HOSPITALS NHS TRUST
7	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
7	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
7	MID YORKSHIRE HOSPITALS NHS TRUST
7	ROYAL WEST SUSSEX NHS TRUST
7	THE HILLINGDON HOSPITAL NHS TRUST
7	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
6	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST
6	CITY AND HACKNEY TEACHING PCT
6	GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS TRUST
6	IMPERIAL COLLEGE HEALTHCARE NHS TRUST
6	LUTON PCT
6	NEWHAM UNIVERSITY HOSPITAL NHS TRUST
6	NORFOLK PCT
6	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST
6	ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST
6	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST
6	ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST
6	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST
6	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST
5	MID STAFFORDSHIRE NHS FOUNDATION TRUST
5	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST
5	ROYAL CORNWALL HOSPITALS NHS TRUST
5	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST
5	SOUTH LONDON HEALTHCARE NHS TRUST
5	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST
5	SURREY AND SUSSEX HEALTHCARE NHS TRUST
5	THE DUDLEY GROUP OF HOSPITALS NHS FOUNDATION TRUST
5	TRAFFORD HEALTHCARE NHS TRUST
5	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
5	WALSALL HOSPITALS NHS TRUST
5	WHIPPS CROSS UNIVERSITY HOSPITALS NHS TRUST
5	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST
4	BATH AND NORTH EAST SOMERSET PCT
4	BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST
4	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
4	CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST
4	GLOUCESTERSHIRE AMBULANCE SERVICES NHS TRUST

4	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
4	LEWISHAM PCT
4	LIVERPOOL PCT
4	MANCHESTER MENTAL HEALTH AND SOCIAL CARE TRUST
4	MEDWAY NHS FOUNDATION TRUST
4	NORTHERN DEVON HEALTHCARE NHS TRUST
4	ROYAL BROMPTON AND HAREFIELD NHS FOUNDATION TRUST
4	SOUTH EAST COAST AMBULANCE SERVICE NHS TRUST
4	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
4	STOKE ON TRENT PCT
4	TAMESIDE HOSPITAL NHS FOUNDATION TRUST
4	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
4	THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST
4	UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST
4	WEST LONDON MENTAL HEALTH NHS TRUST
4	WEST SUFFOLK HOSPITALS NHS TRUST
4	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
3	BEDFORDSHIRE PCT
3	BRADFORD DISTRICT CARE TRUST
3	BROMLEY HOSPITALS NHS TRUST
3	CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST
3	CLATTERBRIDGE CENTRE FOR ONCOLOGY NHS FOUNDATION TRUST
3	EALING HOSPITAL NHS TRUST
3	EAST CHESHIRE NHS TRUST
3	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
3	EST SUSSEX HOSPITALS NHS TRUST
3	ENFIELD PCT
3	GATESHEAD PCT
3	GREAT WESSTERN HOSPITALS NHS FOUNDATION TRUST
3	HARROGATE AND DISTRICT NHS FOUNDATION TRUST
3	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
3	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
3	LUTON AND DUNSTABLE HOSPITAL NHS FOUNDATION TRUST
3	MID ESSEX HOSPITAL SERVICES NHS TRUST
3	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
3	NORTH EAST LONDON NHS FOUNDATION TRUST
3	PORTSMOUTH HOSPITALS NHS TRUST
3	REDBRIDGE PCT
3	SALFORD PCT
3	SOUTH TYNESIDE PCT
3	SUNDERLAND TEACHING PCT
3	SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST
3	THE WALTON CENTRE NHS FOUNDATION TRUST
3	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
3	WEST SUSSEX PCT
3	WILTSHIRE AMBULANCE SERVICE NHS TRUST
2	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST
2	BARNSLEY HOSPITAL NHS FOUNDATION TRUST
2	BASINGSTOKE AND NORTH HAMPSHIRE NHS FOUNDATIONT RUST
2	BEDFORDSHIRE AND LUTON MENTAL HEALTH AND SOCIAL CARE PARTNERSHIP NHS TRUST
2	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION

	TRUST
2	BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST
2	BRISTOL PCT
2	BURTON HOSPITALS NHS FOUNDATION TRUST
2	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST
2	CENTRAL LANCASHIRE PCT
2	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST
2	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
2	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST
2	COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST
2	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST
2	DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST
2	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST
2	EAST LONDON NHS FOUNDATION TRUST
2	ESSEX AMBULANCE SERVICE NHS TRUST
2	GATESHEAD HEALTH NHS FOUNDATION TRUST
2	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
2	GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST
2	HARROW PCT
2	KINGSTON HOSIPTAL NHS TRUST
2	LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST
2	NORTH BRISTOL NHS TRUST
2	NORTH EAST ESSEX PCT
2	NORTH ESSEX PARTNERSHIP NHS FOUNDATION TRUST
2	NORTH LANCASHIRE TEACHING PCT
2	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST
2	NORTHAMPTONSHIRE TEACHING PCT
2	OXFORDSHIRE AND BUCKINGHAMSHIRE MENTAL HEALTH NHS FOUNDATION TRUST
2	POOLE HOSPITAL NHS FOUNDATION TRUST
2	QUEEN ELIZABETH HOSPITAL NHS TRUST
2	QUEEN MARY'S SIDCUP NHS TRUST
2	RICHMOND AND TWICKENHAM PCT
2	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
2	SOUTH CENTRAL AMBULANCE SERVICE NHS TRUST
2	SOUTH STAFFORDSHIRE PCT
2	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST
2	THE ROTHERHAM NHS FOUNDATION TRUST
2	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST
2	WEST KENT PCT
2	WILTSHIRE PCT
2	WORCESTERSHIRE PCT
1	5 BOROUGHS PARTNERSHIP NHS FOUNDATION TRUST
1	AVON AMBULANCE SERVICE NHS TRUST
1	BARKING AND DAGENHAM PCT
1	BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST
1	BARNET AND CHASE FARM HOSPITALS NHS TRUST
1	BASILDON AND THURRODCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
1	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST
1	BROMLEY PCT
1	CAMDEN AND ISLINGTON NHS FOUNDATION TRUST

1	CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST
1	CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
1	DORSET PCT
1	EAST AND NORTH HERTFORDSHIRE PCT
1	EAST LANCASHIRE TEACHING PCT
1	EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST
1	EAST RIDING OF YORKSHIRE PCT
1	GEORGE ELIOT HOSPITAL NHS TRUST
1	GREENWICH TEACHING PCT
1	HALTON AND ST HELENS PCT
1	HAMMERSMITH AND FULHAM PCT
1	HEATHERWOOD AND WEXHAM PARK HOSPITALS NHS FOUNDATION TRUST
1	HINKLEY AND BOSWORTH PCT
1	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
1	ISLE OF WIGHT NHS PCT
1	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST
1	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST
1	MERSEY CARE NHS TRUST
1	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST
1	NORTH STAFFORDSHIRE PCT
1	NORTH YORKSHIRE AND YORK PCT
1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST
1	OLDHAM PCT
1	PENNINE ACUTE HOSPITALS NHS TRUST
1	PENNINE CARE NHS FOUNDATION TRUST
1	PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION
1	PLYMOUTH TEACHING PCT
1	REDBRIDGE PCT
1	REDCAR AND CLEVELAND PCT
1	ROYAL BERKSHIRE NHS FOUNDATION TRUST
1	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST
1	ROYAL FREE HAMPSTEAD NHS TRUST
1	ROYAL UNITED HOSPITAL BATH NHS TRUST
1	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST
1	SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST
1	SHEFFIELD PCT
1	SHROPSHIRE COUNTY PCT
1	SOLIHULL CARE TRUST
1	SOUTH TYNESIDE NHS FOUNDATION TRUST
1	SOUTH WESTERN AMBULANCE SERVICE NHS TRUST
1	SOUTHAMPTON UNIVERSITY HOSPITALS NHS TRUST
1	SURREY PCT
1	SWINDON PCT
1	TAMESIDE AND GLOSSOP PCT
1	TELFORD AND WRKIN PCT
1	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST
1	THE WHITTINGTON HOSPITAL NHS TRUST
1	TOWER HAMLETS PCT
1	WEST ESSEX PCT
1	WEST HERTFORDSHIRE PCT
1	WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST
1	WOLVERHAMPTON CITY PCT
1	WORTHING AND SOUTHLANDS HOSPITALS NHS TRUST

Appendix 2: Trusts in alphabetical order, with number of alerts outstanding

Name of Trust	Number of alerts Not implemented
5 BOROUGHS PARTNERSHIP NHS FOUNDATION TRUST	1
AINTREE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	10
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	6
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	2
AVON AMBULANCE SERVICE NHS TRUST	1
BARKING AND DAGENHAM PCT	1
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	1
BARNET AND CHASE FARM HOSPITALS NHS TRUST	1
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	2
BARTS AND THE LONDON NHS TRUST	11
BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1
BASINGSTOKE AND NORTH HAMPSHIRE NHS FOUNDATION TRUST	2
BATH AND NORTH EAST SOMERSET PCT	4
BEDFORD HOSPITAL NHS TRUST	11
BEDFORDSHIRE AND LUTON MENTAL HEALTH AND SOCIAL CARE PARTNERSHIP NHS TRUST	2
BEDFORDSHIRE PCT	3
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	1
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	2
BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST	2
BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST	4
BRADFORD DISTRICT CARE TRUST	3
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	4
BRISTOL PCT	2
BROMLEY HOSPITALS NHS TRUST	3
BROMLEY PCT	1
BURTON HOSPITALS NHS FOUNDATION TRUST	2
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	2
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	7
CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	1
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	1
CENTRAL LANCASHIRE PCT	2
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	2
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	4
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	2
CITY AND HACKNEY TEACHING PCT	6
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	3
CLATTERBRIDGE CENTRE FOR ONCOLOGY NHS FOUNDATION TRUST	3
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	7
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	2
COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	2
CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	2
DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST	2

DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	2
DORSET PCT	1
EALING HOSPITAL NHS TRUST	3
EAST AND NORTH HERTFORDSHIRE PCT	1
EAST CHESHIRE NHS TRUST	3
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	3
EAST LANCASHIRE TEACHING PCT	1
EAST LONDON NHS FOUNDATION TRUST	2
EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST	1
EAST RIDING OF YORKSHIRE PCT	1
EAST SUSSEX HOSPITALS NHS TRUST	3
ENFIELD PCT	3
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	9
ESSEX AMBULANCE SERVICE NHS TRUST	2
GATESHEAD HEALTH NHS FOUNDATION TRUST	2
GATESHEAD PCT	3
GEORGE ELIOT HOSPITAL NHS TRUST	1
GLOUCESTERSHIRE AMBULANCE SERVICES NHS TRUST	4
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	2
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS TRUST	6
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	3
GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST	2
GREENWICH TEACHING PCT	1
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	4
HALTON AND ST HELENS PCT	1
HAMMERSMITH AND FULHAM PCT	1
HARROGATE AND DISTRICT NHS FOUNDATION TRUST	3
HARROW PCT	2
HEATHERWOOD AND WEXHAM PARK HOSPITALS NHS FOUNDATION TRUST	1
HINKLEY AND BOSWORTH PCT	1
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	3
HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	1
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	6
ISLE OF WIGHT NHS PCT	1
KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	1
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	1
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	9
KINGSTON HOSPITAL NHS TRUST	2
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	9
LEWISHAM HEALTHCARE NHS TRUST	8
LEWISHAM PCT	4
LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	2
LIVERPOOL PCT	4
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	3
LUTON AND DUNSTABLE HOSPITAL NHS FOUNDATION TRUST	3
LUTON PCT	6
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	8
MANCHESTER MENTAL HEALTH AND SOCIAL CARE TRUST	4
MANCHESTER PCT	13
MEDWAY NHS FOUNDATION TRUST	4
MERSEY CARE NHS TRUST	1
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	1
MID ESSEX HOSPITAL SERVICES NHS TRUST	3
MID STAFFORDSHIRE NHS FOUNDATION TRUST	5

MID YORKSHIRE HOSPITALS NHS TRUST	7
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	8
NEWHAM UNIVERSITY HOSPITAL NHS TRUST	6
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	3
NORFOLK PCT	6
NORTH BRISTOL NHS TRUST	2
NORTH EAST ESSEX PCT	2
NORTH EAST LONDON NHS FOUNDATION TRUST	3
NORTH ESSEX PARTNERSHIP NHS FOUNDATION TRUST	2
NORTH LANCASHIRE TEACHING PCT	2
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	5
NORTH STAFFORDSHIRE PCT	1
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	2
NORTH WEST LONDON HOSPITALS NHS TRUST	8
NORTH YORKSHIRE AND YORK PCT	1
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	6
NORTHAMPTONSHIRE TEACHING PCT	2
NORTHERN DEVON HEALTHCARE NHS TRUST	4
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	1
OLDHAM PCT	1
OXFORDSHIRE AND BUCKINGHAMSHIRE MENTAL HEALTH NHS FOUNDATION TRUST	2
PENNINE ACUTE HOSPITALS NHS TRUST	1
PENNINE CARE NHS FOUNDATION TRUST	1
PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION	1
PLYMOUTH TEACHING PCT	1
POOLE HOSPITAL NHS FOUNDATION TRUST	2
PORTSMOUTH HOSPITALS NHS TRUST	3
QUEEN ELIZABETH HOSPITAL NHS TRUST	2
QUEEN MARY'S SIDCUP NHS TRUST	2
REDBRIDGE PCT	3
REDCAR AND CLEVELAND PCT	1
RICHMOND AND TWICKENHAM PCT	2
ROYAL BERKSHIRE NHS FOUNDATION TRUST	1
ROYAL BROMPTON AND HAREFIELD NHS FOUNDATION TRUST	4
ROYAL CORNWALL HOSPITALS NHS TRUST	5
ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	1
ROYAL FREE HAMPSTEAD NHS TRUST	1
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	5
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	6
ROYAL UNITED HOSPITAL BATH NHS TRUST	1
ROYAL WEST SUSSEX NHS TRUST	7
SALFORD PCT	3
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	1
SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST	1
SHEFFIELD PCT	1
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	6
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	2
SHROPSHIRE COUNTY PCT	1
SOLIHULL CARE TRUST	1
SOUTH CENTRAL AMBULANCE SERVICE NHS TRUST	2
SOUTH EAST COAST AMBULANCE SERVICE NHS TRUST	4
SOUTH LONDON HEALTHCARE NHS TRUST	5
SOUTH STAFFORDSHIRE PCT	2
SOUTH TYNESIDE NHS FOUNDATION TRUST	1

SOUTH TYNESIDE PCT	3
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	5
SOUTH WESTERN AMBULANCE SERVICE NHS TRUST	1
SOUTHAMPTON UNIVERSITY HOSPITALS NHS TRUST	1
SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	4
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	2
ST GEORGE'S HEALTHCARE NHS TRUST	9
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	6
STOCKPORT NHS FOUNDATION TRUST	14
STOKE ON TRENT PCT	4
SUNDERLAND TEACHING PCT	3
SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	3
SURREY AND SUSSEX HEALTHCARE NHS TRUST	5
SURREY PCT	1
SWINDON PCT	1
TAMESIDE AND GLOSSOP PCT	1
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	4
TELFORD AND WREKIN PCT	1
THE DUDLEY GROUP OF HOSPITALS NHS FOUNDATION TRUST	5
THE HILLINGDON HOSPITAL NHS TRUST	7
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	4
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	1
THE ROTHERHAM NHS FOUNDATION TRUST	2
THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	4
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	7
THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST	9
THE WALTON CENTRE NHS FOUNDATION TRUST	3
THE WHITTINGTON HOSPITAL NHS TRUST	1
TOWER HAMLETS PCT	1
TRAFFORD HEALTHCARE NHS TRUST	5
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	6
UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST	4
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	5
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	3
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	2
WALSALL HOSPITALS NHS TRUST	5
WEST ESSEX PCT	1
WEST HERTFORDSHIRE PCT	1
WEST KENT PCT	2
WEST LONDON MENTAL HEALTH NHS TRUST	4
WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	1
WEST SUFFOLK HOSPITALS NHS TRUST	4
WEST SUSSEX PCT	3
WHIPPS CROSS UNIVERSITY HOSPITAL NHS TRUST	5
WILTSHIRE AMBULANCE SERVICE NHS TRUST	3
WILTSHIRE PCT	2
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	6
WOLVERHAMPTON CITY PCT	1
WORCESTERSHIRE PCT	2
WORTHING AND SOUTHLANDS HOSPITALS NHS TRUST	1
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	5
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	4

Appendix 3

Care Quality Commission

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.