Report by category:

Category:	2. National Patient Safty Agency (NSPSA) Internal
Organisation:	**National Patient Safety Agency**

Section: 1 << Questions Answers >>

A. Executive Summary - page 6

Action:

Comments:

B. Purpose, scope and responsibilities - page 7

Serious incidents occurring in Wales - I think this will cause confusion. Review date at the end of the document to be inserted.

Action: Accepted

Comments:

C. Purpose of the serious incident framework - page 7

Provide an overarching framework developed from good practice, along with signposting tools and resources that support good practice - not in exec. Summary

Action: Accepted

Comments:

D. Definition of a serious incident - pages 7-9

Action:

Comments:

E. Roles and Responsibilities pages 10-11

2.4 bullet point 3 "GP practices and community pharmacies". Definition of an organisation? There needs to bes omething about the responsibilties of individual practitioners to report incidents.

Action: Accepted

Comments:

F. Expectations of providers of NHS funded care, Commissioning PCTs and SHAs pages 11-17

Action:

Comments:

G. Management of a serious incident - page 17

Action:

Comments:

H. Identification and Response - pages 18-24

3.3. - under bullet point 2 - to add text below to flowchart. Grading of serious incidents - how is this fed into the NPSA? Reporting of serious incidents to the CQC - will this still be the case when individual practitioners are registered?

Action: Rejected

Comments: Will be addressed with SIMS implementation

I. Investigation - pages 24-26

Action:

Comments:

J. Action Plan Development & Implementation - page 27

3.5. - para 3 - (SHA/PCT) - so each organisation will do this independantly or together? Table 2 Grading monitoring - Grade 1 - monitoring to ensure the action plab is followed through? Grade 2 closure checklist - it has all been shared in the NPSA

Action: Accepted

Comments: Clarity of SHA/PCT roles to be clarified further

K. Monitoring and Closure - pages 27-28

Other bodies with a remit for serious incidents - SHA/PCTs should co-operate fully and investigations by these other bodies and provide documentation and information as required and within the remit of information governance arrangements

Action: Accepted

Comments:

L. Dissemination of Learning - pages 29-31

Action:

Comments:

M. Communication & the Media - pages 31-34

Something about making sure other organisations are an interest in the accident (e.g. PCTs, SHAs) should be kept in forwarding any proposed media activity

Action: Accepted

Comments:

Section: 2 << Questions Answers >>

Q1. Is the grading of 'Serious Incidents' clear? Please comment - Pages 20-21, Appendix A - page 36

Action:

Comments:

Q2. Does the Framework provide clarity regarding roles and responsibilities in reporting and learning from serious incidents? If not, how can this be improved?

Action:

Comments:

Q3. How should the framework be finally disseminated (e.g. via Central Alert System)?

Action:

Comments:

Q4. What are the main changes your organisation would need to make in order to comply with the Framework? What would be the risks of implementing or not?

Action:

Comments:

Q5. Please rate the overall ease of understanding/readability of the Framework (rate from 1-10 where 10 is easiest).

Action:

Comments:

Q6. Who has reviewed the framework in your organisation? (List of job titles and committees - personal names not needed)

Action:

Comments:

Q7. What would be the benefits of implementing the Framework?

Action:

Comments:

Q8. Is the Framework currently targeted at the correct level?

Action:

Comments:

Q9. Are there any bodies who should have been consulted on the Framework, but appear not to have been? *Appendix D - Page 41*

Action:

Comments:

Q10. Do you believe that national implementation of the Framework will improve reporting and learning from the most serious incidents? Please give reasons for your answers and any ideas how this can be further improved.

Action:

Comments:

Q11. Additional comments:

Action:

Comments:

Section: 1

<< Questions Answers >>

A. Executive Summary - page 6

Action:

Comments:

B. Purpose, scope and responsibilities - page 7

Action:

Comments:

C. Purpose of the serious incident framework - page 7

Action:

Comments:

D. Definition of a serious incident - pages 7-9

Action:

Comments:

E. Roles and Responsibilities pages 10-11

Action:

Comments:

F. Expectations of providers of NHS funded care, Commissioning PCTs and SHAs pages 11-17

Action:

Comments:

G. Management of a serious incident - page 17

Action:

Comments:

H. Identification and Response - pages 18-24

Action:

Comments:

I. Investigation - pages 24-26

Action:

Comments:

J. Action Plan Development & Implementation - page 27

Action:

Comments:

K. Monitoring and Closure - pages 27-28

Action:

Comments:

L. Dissemination of Learning - pages 29-31

Action:

Comments:

M. Communication & the Media - pages 31-34

Action:

Comments:

Section: 2

<< Questions Answers >>

Q1. Is the grading of 'Serious Incidents' clear? Please comment - Pages 20-21, Appendix A - page 36

Action:

Comments:

Q2. Does the Framework provide clarity regarding roles and responsibilities in reporting and learning from serious incidents? If not, how can this be improved?

Action:

Comments:

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Comments:

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Comments:

Q7. What would be the benefits of implementing the Framework?

Action:

Comments:

Q8. Is the Framework currently targeted at the correct level?

Action:

Comments:

Q9. Are there any bodies who should have been consulted on the Framework, but appear not to have been? *Appendix D - Page 41*

Action:

Comments:

Q10. Do you believe that national implementation of the Framework will improve reporting and learning from the most serious incidents? Please give reasons for your answers and any ideas how this can be further improved.

Action:

Comments:

Q11. Additional comments:

My only comments at this stage are it might be useful to forward this to DH Estates for their comments as we are exploring ways that our system and their system can be of more use to each other.

Action: Accepted

Comments:

Organisation: **NPSA2**

Section: 1 << Questions Answers >>

A. Executive Summary - page 6

Page 4 – format of different levels of numbering. Page 5 – the diagram – this is important as people will use this as representative of everything they need to know about the rest of the document – if it is in the text but not clear in the diagram, it may not be fully digested. I was concerned that based on the diagram, local and organisational notification only end up in a media focus – surely there is more they do than that? Is there any responsibility for reviewing local policies and procedures beyond the clinical practice? This should encourage local learning beyond reacting to the incident in question through the RCA and its results. Thus, as they learn, we can used this learning to feed national learning – I am sure they don't wait for us to make decisions on what needs to be done before they learn and implement changes for themselves - so how do we encourage this learning and thus allow us to exploit it on a national level –

Action: Rejected

Comments:

B. Purpose, scope and responsibilities - page 7

Action:

Comments:

C. Purpose of the serious incident framework - page 7

Action:

Comments:

D. Definition of a serious incident - pages 7-9

Action:

Comments:

E. Roles and Responsibilities pages 10-11

Action:

Comments:

F. Expectations of providers of NHS funded care, Commissioning PCTs and SHAs pages 11-17

Action:

Comments:

G. Management of a serious incident - page 17

Action:

Comments:

H. Identification and Response - pages 18-24

Page 21 ? Grade 2 examples - surely it is ?failures in child protection? rather than ?child protection???? ÿ

Action: Accepted

Comments: Examples to be changed

I. Investigation - pages 24-26

Action:

Comments:

J. Action Plan Development & Implementation - page 27

Action:

Comments:

K. Monitoring and Closure - pages 27-28

Action:

Comments:

L. Dissemination of Learning - pages 29-31

Page 29 covers it quite neatly but this should somehow be captured in the diagram?? That is, the learning can involve local policies that are beyond clinical practice or the investigation – for example, ensuring IT support for 24 hours not simply 9-5; thus reducing delays caused by failed technology and the change in behaviour that may result, leading to errors. ?Then I recognised that this process diagram assumes these events "occur" but does not state who takes responsibility for them - if this is the responsibility of one person within the organisation, this should be stated within the document as this diagram becomes their checklist that they are doing all that is required - again just a diagram thing. ?

Action: Accepted

Comments:

M. Communication & the Media - pages 31-34

Action:

Comments:

Section: 2 << Questions Answers >>

Report by category:

Q1. Is the grading of 'Serious Incidents' clear? Please comment - Pages 20-21, Appendix A - page 36

Action:

Comments:

Q2. Does the Framework provide clarity regarding roles and responsibilities in reporting and learning from serious incidents? If not, how can this be improved?

Action:

Comments:

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Action:

Comments:

Q4. What are the main changes your organisation would need to make in order to comply with the Framework? What would be the risks of implementing or not?

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Comments:

Q5. Please rate the overall ease of understanding/readability of the Framework (rate from 1-10 where 10 is easiest).

Action:

Comments:

Q6. Who has reviewed the framework in your organisation? (List of job titles and committees - personal names not needed)

Action:

Comments:

Q7. What would be the benefits of implementing the Framework?

Action:

Comments:

Q8. Is the Framework currently targeted at the correct level?

Action:

Comments:

Q9. Are there any bodies who should have been consulted on the Framework, but appear not to have been? *Appendix D - Page 41*

Action:

Comments:

Q10. Do you believe that national implementation of the Framework will improve reporting and learning from the most serious incidents? Please give reasons for your answers and any ideas how this can be further improved.

Action:

Comments:

Q11. Additional comments:

Action:

Comments: