

Appendix B

Q.6 National reporting systems : England and Wales response

6a) Is there a national incident reporting system? Yes If yes, please answer points b) to i)
b) Please provide contact details: National Patient Safety Agency 4-8 Maple Street London W1T 5HD General enquiries tel:020 7927 9500 http://www.npsa.nhs.uk
c) Does the system collect information on near misses? Yes
d) Is the data protected from legal inquiry? Yes
e) Is the system connected in any way to litigation? No
f) How is the data collected used? The data is held anonymously and is used to identify patterns and trends. It is hoped that by analysing the data they will be able to find solutions to specific issues. It is also fed back to the Health Service.
g) Is there a system for analysing reported events? Yes

h) what systematic approaches are used? (eg, root cause analysis, process mapping).

A National Reporting and Learning System (NRLS) is currently being evaluated by the NPSA and will use standard definitions of adverse events and near misses to determine the causes behind them. Evaluations have been aimed at testing the new centralised system for recording, coding, classifying, analysing and providing feedback on adverse events.

The information on incidents received by the NPSA, through the national reporting system, will already have been managed by the relevant NHS trust, organisation or accountability body. Through the national reporting the NPSA will be able to develop an accurate picture of the extent of adverse incidents taking place in healthcare and have a baseline against which to measure improvements in patient safety. By working with the organisations involved, NPSA will also be able to understand and tackle the "root causes" behind incidents and by sharing that learning help prevent the same incidents and errors occurring again. Through their work they will also be able to identify trends in the occurrence of, and reasons for, incidents and will produce guidance and patient safety alerts where needed to improve patient safety. Recognising the scale of the problems and the key fact that as many as half the adverse events and errors that occur are preventable, it is hoped that improvements and changes can be identified and delivered across the NHS in order to achieve better quality and ultimately safer journey for patients using the service. It has been implemented in stages since the end of 2003.

i) Can patients report incidents directly to the national reporting system? **Yes**

This is possible through the NPSA website via the Please ask system
<http://www.npsa.nhs.uk/pleaseask>