

# The Safety of Services Provided by Health and Social Care Trusts



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## ***Reviews***

*It is just one of my personal favorite publication. It is among the most awesome publication i have read. It is extremely difficult to leave it before concluding, once you begin to read the book.*

***(Delia Rutherford)***

## THE SAFETY OF SERVICES PROVIDED BY HEALTH AND SOCIAL CARE TRUSTS



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TSO. Paperback. Book Condition: new. BRAND NEW, The Safety of Services Provided by Health and Social Care Trusts, Northern Ireland: Northern Ireland Audit Office, Approximately 83,000 adverse incidents are reported each year by HSC organisations. Apart from the distress caused to patients, relatives and front-line staff, these lapses in safety are a very expensive diversion of healthcare funds. In the past five years, the Department has paid out GBP116 million to settle claims for clinical and social care negligence - GBP77 million in compensation and GBP39 million in legal and administrative costs. In addition, the Department estimates that it could cost a further GBP136 million to meet the compensation costs of all the active negligence claims currently in the system. However, the true cost of adverse incidents remains unknown because the treatment costs of remedying the harm caused to patients or clients are not routinely measured. This report found considerable variation in the extent to which the skills and knowledge of HSC staff groups are appraised regularly. The report acknowledges the significant moves made by the Department to raise awareness among HSC Trusts of the need to ensure more openness and honesty when things go wrong. It is also important for the Department to periodically assess how the safety culture is improving. Currently there is no cohesive management information reporting system capable of delivering, at a regional level, high-quality, routinely available information on patterns, trends and underlying causes of harm to patients and clients. This limits the ability of HSC services to monitor performance and improve patient safety. The report considers that the Department needs to develop a means through which these resources are better targeted to meeting the needs of the harmed patient/client in smaller cases.



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