Patient safety performance scoring

As part of our fieldwork for *A Safer Place for Patients: Learning to improve patient safety*, we conducted a census of all NHS acute, ambulance and mental health trusts. The survey addressed how organisations managed patient safety, what incident reporting systems were in place, how information on patient safety was analysed and how information from reported incidents was used to prevent similar errors recurring.

In addition to presenting the headline figures to specific questions we wanted to use this information to gain an overall picture of how well the NHS is improving reporting and learning from patient safety incidents. Based on key processes as defined by *An organisation with a memory,* we developed a model to compare and assess trust performance. The performance indicators were:

- the issue was given a high profile lead;
- an open culture, in which errors or service failures can be admitted, reported and discussed without fear of reprisal, had been developed;
- a well-established incident reporting system;
- patient and service users are involved to encourage learning;
- the incident reporting system focused on near misses as well as actual incidents;
- specific training was provided;
- feedback was given to front-line staff and patients to allow people to see what has changed as a result of incident or near miss reporting;
- staff and patients identified learning priorities and the developed sound solutions to patient safety problems; and
- systems facilitated dissemination of learning internally and NHS-wide.

Scores were given based on trusts' responses to 17 questions identified from our census. The scoring system and the specific questions we selected for the purposes of comparison are set out below.

A2: Who has lead board level executive responsibility for patient safety in your organisation?	
Response	**Score**
Chief Executive	1
Other executive board member	1
Lead responsibility is not at executive board level	0
Maximum score:	1

A10: How would your organisation describe its safety culture?	
Response	**Score**
The trust has an open and fair safety culture throughout	3
The trust has a predominantly open and fair safety culture	2
The trust is moving towards an open and fair safety culture	1
The trust has predominantly blaming and closed safety culture	0
Maximum score:	3

B1: For how long has your organisation been operating a trust-wide patient safety incident reporting system?	
Response	**Score**
Less than a year	1
1 – 2 years	1
2 – 3 years	2
3 – 4 years	2
4 – 5 years	3
5 – 7 years	3
Over 7 years	3
Not operating one	0
Maximum Score:	3

B9:What steps does the trust take to inform patients of the ways in which they can raise their concerns about patient safety?	
Response	**Score**
Response 6 or no responses	0
Response 4	1
1 or 2 from responses 1,2,3 or 5	2
3 + from responses 1,2,3 or 5	3
Maximum score:	3

B10: To what extent does your organisation perceive under-reporting of patient safety incidents, both actual (those that have an impact on patients), and near-misses to be a problem?		
	(a) Actual	(b) Near-misses
Response	**Score**	**Score**
Under-reporting is a major problem within our trust	0	0
Under-reporting is a moderate problem within our trust	1	1
Under-reporting is only a minor problem within our trust	2	2
Under-reporting is not a problem within our trust	3	3
Don't Know	0	0
Maximum score:	3	3

B16/ 17/ 18: How does your organisation ensure existing/ temporary and contractor staff are aware of the trust's patient safety reporting requirements?			
	Existing	Temporary	Contractor
Response	**Score**	**Score**	**Score**
No responses selected	0	0	0
1 response selected	1	1	1
2 responses selected	2	2	2
3 or more responses selected	3	3	3
None of the above selected	0	0	0
Maximum score:	3	3	3

C17: When staff, patients or the public report patient safety incidents or near misses, is it the trust's practice to provide the following?		
	(a) Staff	(b) Patients
Response	**Score**	**Score**
No responses selected	0	0
1 response selected	1	1
2 responses selected	2	2
All responses selected or responses a, b and c selected	3	3
Maximum score:	3	3

D2/ D3: Do all relevant staff and patient groups play a role in the identification of patient safety priorities for action within the trust?		
	D2 Staff	D3 Patients
Response	**Score**	**Score**
Yes	1	1
No	0	0
Maximum score:	1	1

D4/ D5: Do all relevant staff and patient groups play a role in the design and development of patient safety solutions within the trust?		
	D4 Staff	D5 Patients
Response	**Score**	**Score**
Yes	1	1
No	0	0
Maximum score:	1	1

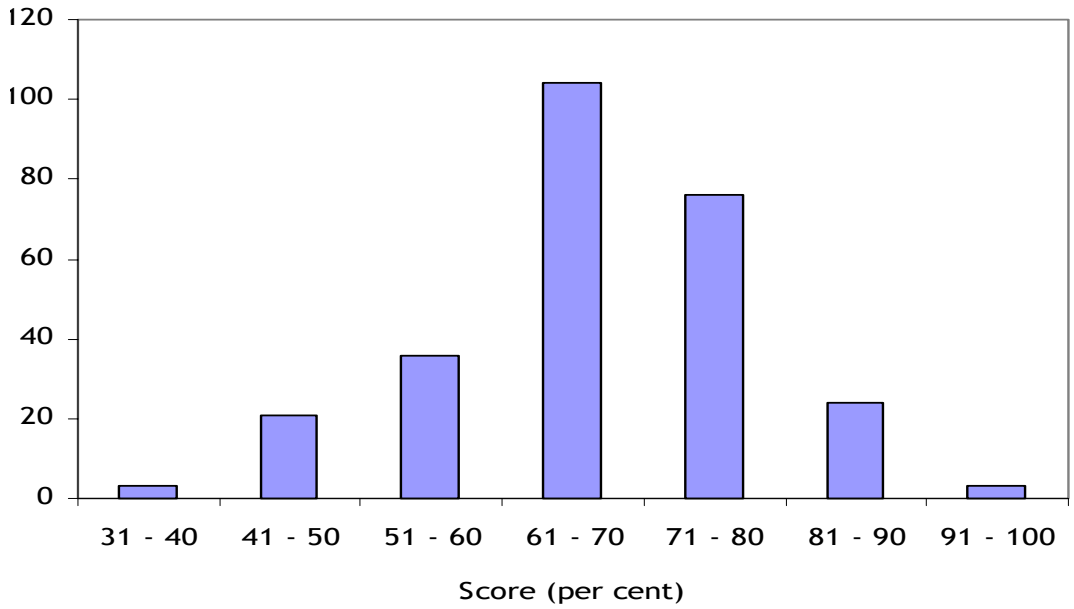
D6/ D7: How does your organisation disseminate lessons learnt across the trust, and with what other organisations do you share lessons learnt?		
	D6 Disseminate across the trust	**D7 Sharing lessons with other organisations**
Response	**Score**	**Score**
None or one response selected	0	0
2 – 3 responses selected	1	1
4 - 5 responses selected	2	2
6 or more responses selected	3	3
Maximum score:	3	3

E1: What actions have you taken as chief executive to improve patient safety in your trust?	
Response	**Score**
Any response	1
No response or Don't Know	0
Maximum score:	1

E4: To what extent does the system your trust currently has in place enable it to meet this standard?	
Response	**Score**
System enables them fully	2
System enables them in part	1
System does not enable them	0
Maximum score:	2

Figure: Over three-quarters of trusts have made good progress in establishing key processes to improve performance in patient safety

Note: The percentage scores are a relative indicator of performance and not an attempt to assign an absolute score to trusts.



Score (per cent)	Number of trusts
31 - 40	3
41 - 50	21
51 - 60	36
61 - 70	104
71 - 80	76
81 - 90	24
91 - 100	3
	267