Part A: Management of Patient Safety

Organisational structure and responsibility

A2 Who has lead board level executive responsibility for patient safety in your organisation?

Chief executive	11%
Medical director	31%
Director of nursing	45%
Director of human resources	1%
Other executive director	12%
Lead responsibility is not at executive board level	0%

A3 To which group does your organisation's Patient Safety Committee, or equivalent (a) report and (b) to which other groups do they provide information?

	(a) Report	(b) Provide information
Trust board	33%	48%
Risk management committee	40%	27%
Clinical governance committee	47%	35%
Governance committee	12%	
Health and Safety Committee	9%	
Combined risk management and governance	8%	
Other specific group	6%	
Executive Board	4%	
Trust Management Committee	1%	
Clinical Risk Forum	3%	
Quality Committee/ Quality Assurance Council	1%	
Audit Committee/ Group	3%	
Corporate Committee/ Group	2%	
Controls (Assurance) Committee/ Group	3%	
Other	9%	20%
This trust does not have a Patient Safety Committee	10%	
None of the above	18%	

A4 What were the three main issues for the patient safety committee (or equivalent) in the year April 2003 to March 2004?

Slips, trips and falls: 20%
Drug / medication errors and issues: 17%
Incident reporting: 14%
Infection control: 11%
Learning from incidents: 11%
Suicide 10%
Equipment management: 9%
Missing notes/ patient information issues: 9%
Risk register: 9%
Violence and aggression 8%
Meeting CNST standards: 8%
Consent: 5%
Trust structure: 5%
Trust policy: 5%
Training: 5%
Communication: 2%

Other: 36%

Patient Safety Resourcing

A5 How does your trust fund the management and administration of, and staff training for, patient safety? (Tick all that apply).

There is a separate designated budget for patient safety	5%
There is no separate budget for patient safety	44%
Patient safety is part of an integrated risk management budget	55%

A6 If there is a separate designated budget for patient safety, how much funding is the trust providing for patient safety in 2004-05?

Less than £50,000	8%
£50,000 - £100,000	39%
£100,000 - £250,000	23%
£250,000 - £500,000	31%
More than £500,000	0%

Patient Safety Culture

A7 Has the trust made a clear statement to its staff of its support for an "open and fair culture" (for example as defined in the NPSA's "Seven Steps to Patient Safety guidance")?

Yes	97%
No	3%

A8 How was that communicated?

Team meeting	41%
Through the management cascade	75%
Via letter, poster, newsletter, intranet	73%
Other	58%

A9 Has your trust evaluated its safety culture?

Yes	42%
No	58%

A10 How would your organisation describe its safety culture?

The trust has an open and fair safety culture operating throughout	23%
The trusts has a predominantly open and fair safety culture but there are some small pockets where there is a tendency towards a blaming and closed culture	72%
The trust is moving towards an open and fair safety culture but there are substantial areas where there is a tendency towards a blaming and closed culture	5%
The trust has a predominantly blaming and closed safety culture	0%

A11 **Key actions taken by organisations to improve patient safety culture**

▪ Forming of new teams / groups	34%
▪ Starting training (RCA, reporting etc)	32%
▪ Changes to / review of incident reporting system	26%
▪ New/ change of policy/ practice	26%
▪ Increased training (root cause analysis, reporting etc)	21%
▪ Analysis / follow up for incidents	20%
▪ More feedback	15%
▪ Raising awareness (reporting etc.)	12%
▪ Analysis / review of trust environment (ligature points etc.)	10%
▪ New software / data base	7%
▪ Risk register	7%
▪ Encourage an 'open'/ 'fair blame' culture	5%
▪ Develop an 'open'/ 'fair blame' culture	5%
▪ Achievement of standards (Clinical Negligence Scheme for Trusts, etc)	5%

Part B: Patient safety incident reporting

The Incident Reporting System

B1 **For how long has your organisation been operating a trust-wide patient safety incident reporting system?**

Less than a year	3%
1-2 years	7%
2-3 years	15%
3-4 years	10%
4-5 years	17%
5-7 years	20%
Over 7 years	29%
Not operating one	0%

B2 **Is the patient safety reporting system part of an integrated reporting system for all incidents – clinical and non-clinical, and those affecting patients, staff and visitors?**

There is a separate system specifically for incidents affecting patients	2%
Patient safety reporting is part of an integrated reporting system for incidents affecting staff, patients and visitors	97%
Other	1%

B3 **Are patients informed when an incident they are involved in is reported?**

Yes	24%
No	6%
Dependent on severity of the incident	52%
Dependent on other criteria	17%
Don't know	2%

B4 **Is the incident reporting system in your trust confidential?** (i.e. the reporter's identity known to the person receiving the report, but not disclosed to others)

Yes	63%
No	37%

B5 **Is the incident reporting system in your trust anonymous?** (i.e. the reporter's identity not known to the person receiving the report)

Yes	5%
No	95%

B6 **Although the system is anonymous are there any mechanisms for the Patient Safety team to identify staff that knowingly depart from agreed protocols or safe procedures?**

Yes	79%
No	21%

B7 **Do staff members have the opportunity to provide additional information about error producing conditions/contributory factors (such as communication failures or lack of protocols) and systems weaknesses on the trust incident forms?**

Yes	98.5%
No	1.5%

B8 **(a) How can patients, or the public, report their concerns about patient safety issues?**
(b) And which are the three most effective routes for trusts to obtain such reports?

	(a) all that apply	*(b) the most **effective***
By reporting incidents in the same way as hospital staff	26%	12/210
By completing patient complaints forms	87%	63/197
By informing staff members who then complete incident forms	94%	57/214
Through the PALS system	97%	86/218
No route through which they can raise patient safety issues	0%	
Other	3%	3/52
Letters/ oral complaints	9%	
Patient forums/ groups/ meetings	8%	
Comment cards	6%	
Phone line	4%	
Patient survey	2%	
Website/ on-line reporting	2%	

B9 **What steps does the trust take to inform patients of the ways in which they can raise their concerns about patient safety?**

	all that apply
Provides written information (such as a booklet or leaflet) as a matter of course	66%
Provides oral information as a matter of course	41%
Posters displayed in public areas of the hospital	50%
Provides information to patients only if they are the subject of a patient safety incident	8%
Other methods are used to inform patients	29%
Patients are not provided with information about how they might raise patient safety concerns	9%

Coverage and effectiveness of the reporting system

B10 **To what extent does your organisation perceive underreporting of patient safety incidents, both actual (those that have an impact on patients), and near misses to be a problem?**

	Actual	**Near misses**
Under reporting of incidents is a major problem within our trust	2%	15%
Under reporting of incidents is a moderate problem within our trust	35%	52%

Under reporting of incidents is only a minor problem within our trust	52%	22%
Under reporting of incidents is not a problem within our trust	8%	3%
Don't know	3%	8%

B11 (a) Has your organisation attempted to estimate the proportion of patient safety incidents occurring in your trust that are actually reported?

Yes	20%
No	80%

(b) What percentage of those incidents are reported?

0% – 10%	9%	50% – 60%	15%
10% – 20%	4%	60% – 70%	11%
20% – 30%	6%	70% – 80%	13%
30% - 40%	11%	80% – 90%	9%
40% - 50%	7%	90% – 100%	6%
	Don't know	11%	

B12 What, if any, have been, or are, the main barriers in the trust to full and effective patient safety incident reporting? And what action has your organisation taken to overcome them?

Barriers	Action
▪ Staff awareness of what/ how/ when to report 50%	▪ training 87 ▪ new processes/ tools 29 ▪ raising profile 20 ▪ new policies/ guidelines 19 ▪ triggers list 16 ▪ regular feedback on incidents 10 ▪ review/ assessment 10 ▪ staff advisors 5
▪ Blame culture prevailing 42%	▪ promotion of fair culture 63 ▪ training 38 ▪ new tools/ procedures 33 ▪ awareness campaign 21 ▪ using evidence 8 ▪ anonymous reporting 4 ▪ leadership 4 ▪ staff support 4 ▪ special staff 2
▪ Time pressure on staff 32%	▪ revised format / form for reporting 19 ▪ online reporting 16 ▪ training 13 ▪ campaign stressing importance of reporting 10 ▪ nothing 5 ▪ new structures 4 ▪ designated reporting staff 3 ▪ review/ assessment 3
▪ Form poorly designed 31%	▪ electronic system developed 39 ▪ revised form 31 ▪ reduced number of forms 16 ▪ review / assessment 15 ▪ new policies 12 ▪ training 9 ▪ shorter form 5

B13 To what extent has the action your organisation has taken been successful in overcoming the barriers to patient safety incident reporting in your trust?

Incident reporting rates have increased greatly as a result of the action we have undertaken	25%
Incident reporting rates have increased as a result of the action we have undertaken	52%
Incident reporting rates have not increased as a result of the action we have undertaken	4%
We have not taken any action	0%
Too early to tell	15%

B14 (a) Is under-reporting a problem with any of the following staff groups?

(i) Medical staff	Yes	87%	No	13%
(ii) Nursing staff	Yes	12%	No	88%
(iii) Allied health professionals	Yes	26%	No	74%
(iv) Ancillary staff	Yes	37%	No	63%
(v) Other staff	Yes	29%	No	71%

Action taken	
▪ Training/ education	37%
▪ Induction training	33%
▪ Raising awareness of importance/ how to report	23%
▪ Feedback to staff	11%

Training in Incident Reporting

B15 Do all new employees receive training on:

(i) What to report	Yes	97%	No	3%
(ii) How to report	Yes	97%	No	3%
(iii) When to report	Yes	97%	No	3%

B16 How does your organisation ensure existing staff are continually made aware of the trust's Patient Safety reporting requirements?

	all that apply
Continuing training	84%
Reinforcement through appraisals	30%
Reinforcement through staff communications (e.g. newsletters)	87%
Other methods	52%
None of the above	2%

B17 How does your organisation ensure that your temporary staff (such as locums and agency nurses) are aware of the trust's patient safety reporting requirements?

	all that apply
Training	44%
Briefings	34%
Communications	40%
Management cascade	52%
Other methods	36%
None of the above	4%

B18 How does your organisation ensure that contractor staff working within your trust are aware of the trusts' patient safety incident reporting requirements?

	all that apply
Training	20%
Briefings	40%
Communications	40%
Management cascade	37%
Other methods	35%
None of the above	8%

B19 What, if any, are the main barriers preventing effective training of staff in your organisation? And what action has your organisation taken to overcome them?

Barriers	Action
▪ Releasing staff 60%	▪ review of training timing, requirements & delivery 42 ▪ CD-ROM/ e-learning/ DVD/ video 26 ▪ statutory/mandatory training day or annual training day 25 ▪ local level/ ward level training 24 ▪ recruitment/ increase in resources 8 ▪ evidence of attendance/ monitoring by managers 5 ▪ cascade training 4 ▪ integrated training 3 ▪ budget to cover agency/bank staff 2
▪ Not enough trainers 24%	▪ review of training capacity, capability & delivery 16 ▪ additional resources/ trainers employed 7 ▪ business case for resources 6 ▪ appointment of manager/ director 5 ▪ e-learning 4 ▪ working with external groups 4 ▪ restructuring 3 ▪ review by committees 3 ▪ risk management strategy/ action plan 2 ▪ root cause analysis training 2 ▪ funding 2
▪ Time 23%	▪ review of training requirements/shift patterns/delivery 22 ▪ CD-Rom/intranet/e-learning 13 ▪ mandatory training days 12 ▪ training at ward/departmental level 11 ▪ emphasising importance of training 6 ▪ flexible training programme 6 ▪ increase time of planned training days 4 ▪ information in handbooks 4 ▪ managers/risk management teams 4 ▪ monitoring 4 ▪ short training sessions 4 ▪ time allocated on induction 2 ▪ refresher updates 2 ▪ management cascade 2

Other:

- Budget / financial constraints 18%
- Sceptical of the value of training 10%
- Attendance is low 9%
- Capacity 8%
- Dispersed nature of trust 7%

National Reporting and Support

B20 **(a) How readily has the trust integrated the NPSA's reporting system into the trust's own reporting system?**

No problems at all	11%
Some difficulty met but surmountable	34%
Major difficulties met	5%
Too early to tell	50%

Difficulties	
▪ Incompatibility with NPSA system	17%
▪ Incident reporting differs from NPSA system, i.e. information collated different	11%
▪ Time difficulties	6%

B21 **(a) Has your organisation disseminated the NPSA full 188 page guidance "Seven Steps to patient safety" (NPSA, 2004) within your trust?**

Yes	46%
No	54%

(b) If "yes", how have you disseminated it?

	Tick one only
Distributed it in full to all staff	4%
Distributed in full to selected staff (e.g. managers)	56%
Distributed it in summary form to staff	21%
Highlighted its existence	19%

B22 **Has your organisation contacted the NPSA Patient Safety Manager responsible for your Strategic Health Authority area in relation to any of the following:**

	all that apply
To seek advice or expertise in the investigation of patient safety incidents	49%
To bring to their attention local patient safety concerns or effective solutions	38%
To seek support and advice about the National Reporting and Learning System	92%
To seek advice on **other** wider patient safety issues	49%
No contact with them	2%

B23 **Has the local NPSA Patient Safety Manager contacted your organisation in relation to any of the following:**

	all that apply
To introduce themselves and explain their role	97%
To provide advice and expertise in the investigation of patient safety incidents	49%
To seek information about local patient safety concerns or effective solutions	38%
To provide support and advice about the National Reporting and Learning System	89%
To provide advice on **other** wider patient safety issues	45%
No, they have not contacted me	2%

B24 As far as your trust is concerned what would your organisation like to see the NPSA do MORE of?

▪ Feedback on incident reporting (trends, benchmarking etc)	26%
▪ Give more advice	18%
▪ Closer discussion with trusts / individuals	16%
▪ Solutions / resolution for patient safety issues	14%
▪ More integrated approach	10%
▪ Feedback/ progress reports on NPSA achievements	9%

B25 As far as your trust is concerned what things would your organisation like to see the NPSA do LESS of?

▪ Duplication of ideas / information already produced by another system	6%
▪ None/ Don't know	76%

B26 (a) As far as your trust is concerned, what would you like to see the CNST do MORE of in relation to patient safety?

▪ More sharing of best practice	36%
▪ Work with/ integrate with other agencies more	24%
▪ More advice/ guidance on patient safety	15%
▪ More consistency in assessments	10%
▪ More feedback of national data, including trends	10%
▪ More consolidation on standards/ assessment	9%
▪ None/ Don't know	16%

(b) As far as your trust is concerned, what would you like to see the CNST do LESS of in relation to patient safety?

▪ Less duplication with other organisations	13%
▪ Less prescriptive/ pedantic assessments	13%
▪ Don't change standards so often	7%
▪ Less 'paper evidence only' assessments – look at practice	7%
▪ None/ Don't know	59%

Part C: Analysis

Incident Classification

C1 How many patient safety incidents (those that had an impact on patients) and near misses were reported to the trust in the following years?

NOT ALL TRUSTS PROVIDED DATA FOR ALL YEARS AND MANY TRUSTS WERE UNABLE TO SEPARATE NEAR MISSES AND INCIDENTS BUT INCLUDED A TOTAL UNDER 'INCIDENTS'

Incident reporting Year	Number of reported patient safety incidents	Number of reported near misses	TOTAL (NOT ON ORIGINAL SURVEY)
2003-2004	76,2243	120,167	882,410
2002-2003	61,1720	90,560	702,280
2001-2002	39,3256	54,562	447,728

C2 Does your organisation grade patient safety incidents in relation to

(i) Severity of outcome for patient	Yes	90%	Sometimes	7%	No	2%
(ii) Likelihood of recurrence	Yes	75%	Sometimes	17%	No	5%
(iii) Likely consequences of recurrence	Yes	60%	Sometimes	24%	No	10%

C3 How many patient safety incidents were reported to the trust for the following patient safety incident classifications?

NOT ALL TRUSTS PROVIDED DATA FOR ALL YEARS AND MANY TRUSTS WERE UNABLE TO PROVIDE DATA BY SEVERITY, BUT ONLY PROVIDED THE TOTAL NUMBER OF INCIDENTS. SOME TRUSTS INCLUDED NEAR MISSES IN THE TOTAL, OTHERS DID NOT

NPSA Incident reporting by Year	Total number of incidents reported:	Number of reported patient safety incidents by impact of incident on patient				
		None/ Insignificant	Low/ Minor	Moderate	Severe/ Major	Death/ Catastrophic
2003-2004	854,771	188,090	190,478	6,1294	10,806	2,660
2002-2003	682,365	123,079	115,079	4,1988	6,630	2,242
2001-2002	416,794	41,754	56,277	2,2164	3,407	949

C4 The percentage of all incidents that each of the following primary classifications represented in your organisation in 2003-2004.

NOT ALL TRUSTS PROVIDED DATA (total percentages worked out as percentage of total figure at C3)
ONLY TOP 4 'OTHER' CATEGORIES OF INCIDENTS SHOWN

Primary Incident Classification	Percentage of all incidents
Medication errors	7.1
Adverse Drug Reaction	0.6
Equipment errors	4.1
Patient Injury (e.g. trips slips and falls)	31.5
Other:	
1. Records/documentation	1.8
2. Communication	1.6
3. Diagnostic tests	1.1
4. Lack of dedicated / permanent staff	1.1
TOTAL (This should be equal to, or less than, 100)	48.9

Incident costing

C5 Has your organisation attempted to estimate the cost to the NHS, including additional bed days, litigation etc, of patient safety incidents across your trust for a defined time period?

Yes	1%
No	98%

C6 **Has your organisation undertaken any research into the cost to the NHS of specific types of patient safety incidents (for example medication errors) in your trust?**

Yes	4%
No	94%

EXAMPLES ARE GIVEN IN THE REPORT AND OTHER WEB PAGES CONTAIN FURTHER ILLUSTRATIONS OF TRUSTS' WORK

In depth analysis of incidents

Although the NPSA introduced their root cause analysis tool in 2003, we recognise that many trusts were undertaking in depth analysis of underlying causes of incidents before then. In this section, and elsewhere in the questionnaire, we have used the generic description "in depth analysis" to include all forms of analysis of underlying causes, including root cause analysis.

C7 **For how long has your organisation been undertaking in depth analysis of incidents?**

Less than one year	16%
1-2 years	25%
2-3 years	22%
3-4 years	13%
4-5 years	9%
5-7 years	7%
Over 7 years	8%
Not used	0%

C8 **How many members of staff in your trust have received training (including from the NPSA) in in-depth analysis of incidents?**

Mean = 29 Total = 7,082

C9 **What criteria does your organisation use to decide which patient safety incidents to investigate?**

	All that apply
Severity of impact on patient	94%
Frequency of particular incident type	83%
Potential risk to the trust or patient	86%
Other	18%

C10 **For how many patient safety incidents did your organisation undertake in depth analysis in the 12 months April 2003 to March 2004?**

Mean = 52 Total = 11,530

C11 **Who normally participates in in-depth analysis in your trust?**

	ALL that apply
Senior trust staff	94%
Member/s of the patient safety team	69%
Staff local to the area where the incident occurred	91%
Staff from another area of the trust	60%
The trust's health and safety advisor / manager	67%
Staff from another trust	28%
A patient involved in the incident, or their representative	19%
Other	18%

C12 Has your trust calculated the average cost of each in-depth analysis it undertakes?

Yes	2%
No	98%

C13 What barriers, if any, have prevented your organisation from undertaking more in-depth analyses of incidents within your trust?

Barrier	
▪ Staff untrained	44%
▪ Time constraints	37%
▪ Not enough staff	21%
▪ None/ Don't know	17%

C14 Does your trust actively encourage the use of the NPSA root cause analysis toolkit?

Yes	76%
No	24%

C15 (a) Has publication of the NPSA toolkit changed your trust's approach to in-depth analyses of incidents?

Yes	60%
No	40%

Changes:	
▪ Better quality of investigations	14%
▪ More structured approach to investigations	11%
▪ More consistent approach to investigations	8%
▪ More trained staff	7%
▪ None / Don't know	15%

C16 How many members of the trust's staff have received training in root cause analysis from the NPSA?

Mean = 9 Total = 2,025

Feedback

C17 When staff, patients, or the public report patient safety incidents or near misses, is it the trust's practice to provide... *all that apply*

	(a) Staff	*(b) Patients*
An acknowledgement thanking them for reporting the incident	33%	51%
Feedback on how the report will be dealt with (i.e. investigated, or recorded)	52%	50%
Feedback on the outcome of the investigation (if one is undertaken)	84%	67%
Don't know	4%	16%
Other feedback	32%	16%

Other:	
Presented at meetings	8%
Published in newsletters	6%
Dependent on severity and other variables	6%
Summarised in reports or other regular documents	6%
Via reports	6%
Posted on intranet	1%

C18 Are patients invited to your organisation's Patient Safety Committee meetings (or equivalent).

Always	20%
Usually	3%
Sometimes	11%
Never	59%

C19 Does your organisation provide information for patients to help them maintain their own safety?

Yes	73%
No	27%

Provides written information (such as a booklet or leaflet) as a matter of course	66%
Provides oral information as a matter of course	57%
Posters displayed in public areas of the hospital	51%
Other methods are used to inform patients	33%

Reporting on Analyses

C20 How often does your organisation produce formal summarised patient safety incident reports for review and action?

	ALL that apply
Summarised reports not produced	1%
On an annual basis (as part of the Trust's Clinical Governance Annual Report)	59%
On a six month basis (internally)	17%
Every Quarter (internally)	75%
Monthly(internally)	54%
Other	23%

C21 What information is contained in these reports?

	all that apply
Analysis of trends	88%
Analysis by category	91%
Frequency analysis	63%
Analysis by staff group	39%
Analysis by directorate	81%
Analysis by specialty	52%
Analysis by Ward	57%
Outcome of underlying cause analyses	34%
Action taken/ recommended	6%
Depends for who the report is for	2%
Analysis by severity	4%
Other	16%
Don't know	1%

C22 To what extent does patient safety learning in the trust draw on the following sources?

	To a large Extent	To some extent	Not at all	Not Relevant
Complaints from patients against the trust	52%	48%		
Clinical negligence claims against the trust	41%	54%	3%	2%
The trust's in depth analyses of incidents	64%	35%	1%	
The trust's reports to the MHRA	21%	57%	9%	5%
The trust's reports to the Health and Safety Executive	39%	54%	3%	2%
Outcomes from clinical audit	32%	63%	3%	
Problems identified by other trusts	11%	78%	9%	
National Confidential Enquiries	34%	56%	4%	3%
Experience in healthcare systems in other countries	2%	45%	43%	3%
Relevant experience in other industries	3%	51%	37%	2%
Other	3%	8%	8%	6%

Part D: Organisational Learning from Incidents and Other Sources

Identifying areas for improvement

D1 At what forum are patient safety reports discussed and actions prioritised?

Tick all that apply

	Reports presented but not discussed	Reports discussed	Actions prioritised
Trust Management Board	20%	68%	22%
Health and Safety Committee	3%	67%	51%
Patient Safety Committee	0%	2%	36%
Clinical Governance Committee	0%	11%	55%
Risk Management/ Clinical Risk Management Committee	3%	81%	67%
Other trust forum	5%	45%	33%

D2 Do all relevant staff groups play a role in the identification of patient safety priorities for action within your trust?

Yes	93%
No	7%

D3 Do patients and the public play any role in the identification of patient safety priorities for action within your trust?

Yes	68%
No	32%

Method:

▪ Complaints / claims	19%
▪ Representation on other forums / groups / boards	18%
▪ Patient forum	17%
▪ Patient Advisory and Liaison Service	13%
▪ Member/ representative on clinical governance committee	9%

D4 **Do all relevant staff groups play a role in the design and development of patient safety solutions within the trust?**

Yes	93%
No	7%

D5 **Do patients and the public play any role in the design and development of any patient safety solutions within your trust?**

Yes	58%
No	42%

Method:	
▪ Patient forum/ council	17%
▪ Consulted about certain initiatives / issues	12%
▪ Representation on boards, committees etc	12%
▪ None / don't know	17%

Disseminating lessons learnt

D6 **How does your organisation disseminate lessons learnt across the trust?**

	all that apply
Discussion at relevant hospital wide meeting groups (e.g. Clinical Governance Committee)	97%
Discussion by local meeting groups responsible for local patient safety issues	86%
Mail/ email to local managers (e.g. ward sisters) who cascade to other staff	80%
Trust's Intranet	59%
Newsletters	77%

Other:	
Local meeting/ group	9%
Training	5%
Bulletins	5%
Reports	5%
Alerts	3%
Notice board	2%
Workshops	2%
Team briefs	2%

D7 **Does your organisation share lessons learnt with any of the following external organisations?**

	Tick all that apply
Local trusts	63%
Strategic Health Authority	91%
National Patient Safety Agency	34%
Primary Care Trusts	68%
Medicines and Healthcare products Regulatory Agency	51%
Health and Safety Executive	60%
Local Authority	5%
Ambulance group	4%
Other NHS body	3%
Coroner	3%
Other	20%

D8 **Does your organisation have plans to increase the extent to which it shares lessons learnt with other organisations?**

Yes	77%
No	23%

Implementation

D9 **Please list the mechanisms that the trust uses to monitor whether lessons learnt and solutions devised are being implemented across the trust.**

▪ Audit / assessment	34%
▪ Monitoring/ review of action plan by committee/ group	26%
▪ Incident recurrence/ trends	9%
▪ Report of progress from group implementing	9%

D10 **Please list the main barriers in the trust to implementing lessons learnt or solutions devised.**

Barriers	
▪ Financial difficulty	15%
▪ Difficulty in communication	15%
▪ Size of the trust	9%
▪ Cultural problems, including blame	7%
▪ Time problems	6%
▪ Management structure	6%
▪ Difficulty in analysing incidents	5%

D11 **What action has the trust taken where lessons learnt or solutions devised were not implemented?**

▪ Reviewed/ monitored by specific committee/ group	28%
▪ Discussion with manager/ staff as to why	14%
▪ Reported upwards	9%
▪ Placed on risk register	8%
▪ Further awareness, training etc.	7%
▪ None / don't know	26%

D12 **How does the trust know whether lessons learnt or solutions devised have been successful?**

▪ Incident data – trends/ recurrence/ amount of reporting	44%
▪ Audit	35%
▪ Monitoring/ review by board/ group/ committee	25%
▪ Staff feedback	11%
▪ Fewer complaints/ claims	10%
▪ Reports to the board/ committee etc.	9%
▪ Review of practice	9%

Achievements

D13 How effective are the trust's systems for learning from patient safety incidents, investigations and other patient safety based initiatives, in bringing about changes in clinical practice?

Not at all effective	0%
Not very effective	6%
Fairly effective	72%
Very effective	20%
Extremely effective	2%

Evidence:	
▪ Changes in practice (clinical)	18%
▪ Lessons learned/ plans implemented	17%
▪ Changes in structure (policy/ guidelines etc)	17%
▪ Demonstrated by audit	16%
▪ Number of incidents	14%
▪ Level of training	9%
▪ Level of reporting	8%
▪ Changes in investigative practice	7%
▪ Better communication	7%

D14 Solutions devised by weakness identified:

Equipment problem – 87 examples

review and/or implementation of equipment policy/ guidelines	20%
training	16%
appropriate equipment provided	8%
standardisation of devices	6%
evaluation of equipment	6%
central equipment stores/ library/ department	5%
medical device co-ordinator	5%
removal of device/equipment	4%
audit/ monitoring/ investigation	4%
restraints/secured equipment	4%
communication with supplier	4%
increase staff awareness	4%
report to Medicines and Healthcare products Regulatory Agency	3%
competency assessment	3%
disposable equipment	2%
funding	2%
communication with strategic health authority/ NPSA/ Estates	2%
maintenance programme	2%

Medication errors – 65 examples

new or revised procedures/ policies/ guidelines	24%
training	24%
audit/ monitoring	8%
medicine safety group/ working group/ committee	8%
review of drug storage	8%
increase awareness	7%
review criteria for prescribing, documentation and administration of drugs	5%
competency assessment	4%

revised charts	3%
review of suppliers	2%
system for transmitting orders to pharmacy/dispensing drugs	2%
lessons shared	2%

Slips trips and falls – 48 examples

falls assessment	28%
review of policy/policy introduced	11%
identification of high risk falls patients	10%
falls group/co-ordinator established	9%
training	7%
identification of new equipment, e.g. hip protectors, non-slip slippers	6%
bed/chair alarms	5%
review of bed rails	3%
increase staff awareness	2%
links with other health agencies	2%
mattresses on floors	2%
piloting of new strategy	2%
purchase or modifications on ambulances with special lifts etc	2%

Suicide and self-harm – 34 examples

review of ligature points	27%
risk assessment/ root cause analysis/ audit	22%
capital programme for ligature risks	9%
secured windows	7%
raise staff awareness	5%
specialist group	5%
training	4%
collapsible rails	4%
joint working	4%
NHME suicide audit toolkit	4%
prioritisation regarding level of risk	4%
review/audit of toilet doors	2%
self-harm pts treated on ground floor	2%
low risk bedrooms	2%

FURTHER EXAMPLES ARE DESCRIBED ON OTHER WEB PAGES

D15 Has your organisation undertaken any cost benefit analysis of any changes made to improve patient safety?

Yes	5%
No	94%

Part E: For Completion by the Trust Chief Executive

E1 **What actions have you taken as chief executive to improve patient safety in your trust?**

▪ Strengthen structural process	40%
▪ Giving patient safety higher priority in the trust	29%
▪ Improve reporting system	27%
▪ Personal involvement in an issue	25%
▪ Personnel appointment	24%
▪ Training	19%
▪ Committee/ group established	18%
▪ Review of old system	15%
▪ Forming of a learning environment	12%
▪ Integration of committees / groups	11%
▪ Head /lead /chair committee /group	11%
▪ Development of long term plan	10%
▪ Achieved Clinical Negligence Scheme for Trusts accreditation	10%
▪ Supported 'open and fair' culture	9%

E2 **For the Trust board, what have been the main drivers encouraging them to improve patient safety?**

	ALL that Apply	***the main driver***
Self Assessment again Controls Assurance Standards	94%	21/217
Clinical Negligence Scheme for Trust standards/ evaluations	96%	58/226
Clinical governance reviews	91%	89/214
Need to provide statement on internal control	88%	17/202
National Patient Safety Agency reporting requirements	71%	4/157
All	6%	
Other:		48/84
Other assessments/ performance indicator	19%	
To create a safe environment for patients	14%	
Complaints and claims	5%	
Governance system	4%	

E3 **Has your organisation introduced any personal incentives for senior managers or clinical staff in your trust to improve patient safety?**

(i) Senior Managers	Yes	16%	No	80%
(ii) Clinical Staff	Yes	15%	No	79%

E4 One of the Health care standards for services under the NHS, published for consultation in February 2004 by the Department of Health, is that:

"Health care organisations have systems in place to identify and learn from all patient safety incidents and other reportable incidents, and demonstrate improvements in practice based on local and national experience and information derived from the analysis of incidents".

To what extent does the system your trust currently has in place enable it to meet this standard?

System enables us to meet this standard	55%	
System enables us to meet this standard in part		41%
Not able to meet this standard with the system currently in place		1%
Don't know	3%	

E5 **If you do not fully meet this standard now, do you think you be able to meet it in the near future?**

Yes	88%
No	12%

E6 **To what extent does the board lead the trust in improving patient safety?**

Tick all that apply

The trust board regularly identifies potential systems modifications after discussing patient safety issues and trends in incidents	30%
The trust board regularly discusses patient safety issues and trends in patient safety incidents	54%
The trust board discusses patient safety issues and trends when formal reports are produced	72%
The trust board discusses patient safety when major incidents occur within the trust	57%

E7 **What are the key priorities the board has identified to improve patient safety in your trust?**

- Training 25%
- Communication 25%
- Learning from incidents 13%