BRIEF UPDATE SURVEY FOR OUR NATIONAL REPORT ON PATIENT SAFETY

1. **Has your trust evaluated its safety culture since our first survey in August 2004?** Yes 51%
   No 46%
   (Blank 3%)

Tools/ methods used
- revision of risk management strategy 8%
- staff survey 16%
- trend analysis from local risk management system 1%
- Root Cause Analysis 3%
- assessment against standards of better health 10%
- via patient safety / clinical governance committee 1%
- on going review / development 8%
- external assessment tool / audit by external consultant 10%
- Seven Steps to Patient Safety 3%
- incident reporting 8%
- complaints 1%
- CNST / RPST Assessment 7%
- intranet / newsletters 0.5%
- patient surveys 0.5%
- other 2%

2. **Given the recent emphasis on developing a safety culture in the NHS, how would your organisation describe its safety culture?**

a) The trust has an open and fair safety culture operating throughout 31%

b) The trust has a predominantly open and fair safety culture BUT there are some small pockets where there is a tendency towards blame 65%

c) The trust is moving towards an open and fair safety culture BUT there are substantial areas where there is a tendency towards blame 1%

(Blank 3%)

3. **On a scale of 1-7** (where **1** is predominantly a blame culture; **4** is moving towards an open and fair culture but pockets of blame exist in some major areas of the trust and **7** is predominantly an open and fair safety culture throughout the trust) **where would you place your trust as at July 2005 and July 2004?**

	1	2	3	4	5	6	7	No answer
Position at July 2005	0	0	1%	8%	29%	42%	17%	3%
Position at July 2004	0	1%	9%	33%	30%	13%	8%	4%

Comparison between 2004 and 2005:
7 trusts (2%) had got worse; 145 (68%) had improved; 60 (28%) stayed the same

4. **Is your main local incident reporting system <u>in</u> the trust:**

a) Confidential (the identity of the reporter is known only to the person receiving the form) 34%
b) Anonymous (the identity of the reporter is not known to the person receiving the form) 0.5%
c) Open reporting system (where confidentiality is not guaranteed) 63%
(Blank 3%)

5. **Do you operate any anonymous incident reporting systems (do not include the NPSA e-Form)?**
   Yes 38%
   No 59%
   (Blank 3%)

Details of the type of incidents covered and the reasons for having it:
- reporting form has anonymous option 11%
- for when staff unable to use regular system 10%
- whistle blowing contact / policy 10%

▪ rarely used	6%
▪ voicemail / telephone	6%
▪ staff encouraged to put name on report	4%
▪ to raise any clinical concern	3%
▪ medication errors	2%
▪ to report poor conduct of medical colleague	2%
▪ report directly to risk manager	2%
▪ other	6%

How many incidents were reporting under this / these anonymous system(s) in 2004-05?
Mean: 192
Sum: 11,543
Range: 0 to 9,322
Median: 2
Mode: 0
(Only 60 out of 106 with anonymous system answered question, i.e. 46 blank)

6. How many patient safety incidents (those that impact on patients, including ones where no harm was caused) and near misses (where an incident was averted or avoided) were reported to the trust in 2004-05?

	Patient safety incidents	Near misses	Total
Mean	3,106	658	3,629
Sum	646,069	115,820	758,528
Range	0 – 11,142	0 – 4,960	0 – 13,056
Median	2,790	278	3,184
Mode	16	4	0
Blank	4	36	3

7. How many reported patient safety incidents in 2004-05 were categorised in the following NPSA definitions?

	No harm	Low	Moderate	Severe	Death
Mean	1,529	1,395	437	75	15
Sum	233,995	221,736	66,908	11,201	2,181
Range	0 – 8,294	0 – 8,977	0 – 2,666	0 – 2,383	0 – 214
Median	1,151	946	174	22	7
Mode	0	2	6	0	0
Blank	60	53	59	62	64

8. How many (if any) hospital acquired infections were recorded in your local risk management system in 2004-05?

Mean: 8
Sum: 1,511
Range: 0 to 281
Median: 0
Mode: 0
18 trusts (8%) reported hospital acquired infections via a different system so did not provide data
15 trusts (7%) said that the data was unavailable
6 trusts (3%) said that the question did not apply to them – these were all ambulance trusts
(Blank 19 (8%))

9. Between 2003-04 and 2004-05 have the number of patient safety incidents reported, both actual (those that have an impact on patients), and near misses:

	Increased	Decreased	Stayed the same	Don't know	Blank
Actual incidents	56%	21%	13%	6%	4%
Near misses	53%	15%	12%	13%	7%

10. What is your organisation's best estimate of the proportion of actual incidents which are NOT reported?

0-20% 49% **21-40%** 34% **41-60%** 10% **61-80%** 1% **81-100%** 0
Not possible to estimate 0.5%
Blank 5%

11. What is your organisation's best estimate of the proportion of near misses which are NOT reported?

0-20% 22% **21-40%** 28% **41-60%** 29% **61-80%** 13% **81-100%** 2%
Not possible to estimate 0.5%
Blank 6%

12. When did you start sending data from your local risk management system to the National Reporting and Learning System?

▪ December 2002: 0.5%	▪ November 2003: 0.5% ▪ December 2003: 0.5%	▪ February 2004: 0.5% ▪ April 2004: 1% ▪ June 2004: 2% ▪ August 2004: 0.5% ▪ September 2004: 3% ▪ October 2004: 5% ▪ November 2004: 6% ▪ December 2004: 17%	▪ February 2005: 2% ▪ March 2005: 3% ▪ April 2004: 7% ▪ May 2005: 4% ▪ July 2005: 5% ▪ August 2005: 6% ▪ September 2005: 2% ▪ October 2005: 1%
▪ Not sending data to NRLS yet: 16%			

13. What type of local risk management data base to you use?

Datix	52%	Vantage	1%
Ulyses	18%	Savant (Medirisk)	1%
Safecode (IRIS)	8%	Respond	1%
Sentinel	6%	CAMS	0.5%
Prism	5%	Chimera	0.5%
Trust's in house	4%	Formic	0.5%
Blank	3%	HIRS	0.5%

14. Have you kept your own incident classification (taxonomy)? Yes 68%
No 26%
(Blank 6%)

15. How easy was it to integrate your trust's local risk management system into the National Reporting and Learning system:

	Not a problem at all	Difficult but not insurmountable	Caused major difficulties
Mapping the data has been	12%	65%	17%

(Blank 6%)

Why was this the case?	Not a problem at a (%)	Difficult but not insurmountable (%	Caused major Difficulties (%)
Time	16	79	64
Resources	8	54	61
Software issues	4	45	56
Local IT issues		21	44
Relationship with the NPSA	32	7	28
Relationship with the software lender	20	14	25
Conflicting codes		5	19
Knowledge of the data base		2	3
Lack of clear information / training		2	3
Other		3	17

16. What is you trust's approach to the National Reporting and Learning System's anonymous e-Form?

a) We encourage the use of the e-Form in our trust 14%

b) We neither encourage nor discourage its use 77%

c) We discourage its use 2%

(Not adopted it yet: 0.5%)
(Blank 6%)

Why?	We encourage the use of the e-Form in our trust (%)	We neither encourage nor discourage its use (%)	We discourage its use (%)
Prefer staff to report incidents to the trust	10	22	60
Reporting to the trust allows action to be taken		12	40
Focused on implementing trust reporting system		7	20
Anonymous reporting doesn't encourage open and fair culture		1	20
Staff unaware of e-Form		7	
Many staff trained/aware of e-Form	21	6	
Not implemented / used e-Form yet		5	
Staff satisfied with current reporting routes		5	
Trust offers range of reporting routes	7	4	
Mapping process (for NRLS) done via e-Form	7	2	
e-Form only available if staff really need it		2	
No requests for e-Form		2	
Too many incident reporting systems		1	
In appropriate to prevent use of e-Form		1	
e-Form used corporately to accurately grade incidents	7		

17. Which of the following have the NPSA's local Patient Safety Manager provided for your trust:

all that apply

Specialist Root Cause Analysis training to selected staff 88%
Expertise, support and co-ordination to help develop and introduce the NRLS 66%
Raised the awareness of the patient safety agenda 62%
Support and advice on developing training in patient safety 55%
Leadership and advice on patient safety to NHS organisations in your area 51%
Support for risk managers in the identification, management, investigation and reporting of patient safety incidents and risks; 48%
Bring patient safety concerns and solution ideas to the attention of the NPSA and help develop solutions; 41%
Support and advice on developing an open and fair culture 28%

How useful were these? (1 is the most useful and 5 the least)

% based on all answering – i.e. all that used service

	1	**2**	**3**	**4**	**5**
Specialist Root Cause Analysis training to selected staff	43	26	14	11	4
Expertise, support and co-ordination to help develop and introduce the NRLS	40	21	21	14	4
Raised the awareness of the patient safety agenda	29	27	22	17	6
Support and advice on developing training in patient safety	23	33	34	4	6
Leadership and advice on patient safety to NHS organisations in your area	25	29	36	7	3
Support for risk managers in the identification, management, investigation and reporting of patient safety incidents and risks	27	30	28	12	4
Bring patient safety concerns and solution ideas to the attention of the NPSA and help develop solutions	31	31	27	10	2
Support and advice on developing an open and fair culture	23	28	41	9	

18. The Safety Alert Broadcast System:

	To a large extent	To some extent	Not at all	Not applicable
Has it improved your system for acting upon advice on patient safety issues (Blank 3%)	31%	62%	4%	-
Has it added any significant new administrative burdens (Blank 2%)	23%	60%	17%	0.5%
Is it clear what rationale has been used to categorise the alerts (Blank 3%)	34%	48%	13%	1%
If funding was needed to implement the alert, were you able to access the funding required (Blank 4%)	11%	31%	14%	40%
Required resulted in other patient safety solutions being put on hold (Blank 7%)	0.5%	16%	51%	26%
The system is easy use (Blank 2%)	60%	35%	1%	0.5%

19. What progress has your trust made to achieve the four specific aims outlined in *An organisation with a memory* (2000):

	Achieved (%)	Not yet achieved (%)	Not applicable to the organisation (%)	No answer (%)
No patients dying or being paralysed by maladministered spinal injections	51	1	41	7
Reduce by 25 per cent the number of instances of negligent harm in obstetrics and gynaecology which result in litigation	14	27	41	19
Reduce by 40 per cent the number of serious errors in the use of prescribed drugs	14	54	10	22
Reduce to zero the number of suicides by mental health in-patients as a result of hanging from non-collapsible rails on wards	37	4	53	6

20. What is the main driver for the Trust Board to improve Patient Safety?

To create a safe environment for patients

	%
Ranked 1st	73
Ranked 2nd	12
Ranked 3rd	5
Ranked 4th	3
Ranked 5th	1
Ranked 6th	1
Ranked 7th	0.5
Blank	6

To comply with the 'duty of quality' in Clinical Governance'

	%
Ranked 1st	10
Ranked 2nd	14
Ranked 3rd	37
Ranked 4th	21
Ranked 5th	7
Ranked 6th	4
Ranked 7th	0.5
Blank	8

To learn from serious incidents and minimise future harm

	%
Ranked 1st	10
Ranked 2nd	53
Ranked 3rd	14
Ranked 4th	9
Ranked 5th	3
Ranked 6th	4
Ranked 7th	0.5
Blank	6

To provide assurance for the statement on internal control

	%
Ranked 1st	8
Ranked 2nd	6
Ranked 3rd	16
Ranked 4th	17
Ranked 5th	27
Ranked 6th	20
Blank	6

To meet NHS Litigation Authority standards and assessments

	%
Ranked 1st	6
Ranked 2nd	6
Ranked 3rd	14
Ranked 4th	27
Ranked 5th	26
Ranked 6th	15
Blank	7

To manage complaints and claims

	%
Ranked 1st	5
Ranked 2nd	1
Ranked 3rd	7
Ranked 4th	12
Ranked 5th	23
Ranked 6th	43
Ranked 7th	1
Blank	8

Personal values and principles of the staff

	%
Ranked 1st	1
Ranked 2nd	0.5
Ranked 5th	0.5
Ranked 7th	0.5
Blank	98

Financial savings from reduced NHS Litigation Authority contributions

	%
Ranked 1st	0.5
Blank	99.5

Healthcare standards / Healthcare Commission annual heath check

	%
Ranked 4th	0.5
Ranked 7th	0.5
Blank	99

Other

	%
Ranked 1st	2
Blank	98

21. What evidence does the Trust Board expect to use to demonstrate that the Trust is meeting the first core standard C1 of the new *Standards for Better Healthcare*?

	%
procedure for Safety Alert Broadcast System	56
CNST/RPST compliance achieved	52
incident reporting policy/ process	49
Trust Reports	28
action taken following incidents / investigations	27
minutes of meetings	26
training	22
incident investigation guidelines	21
incident trend analysis	21
risk management strategy	20
risk management committee structure and reports	21
communication of patient safety messages	19
National Reporting and Learning System set up/ reporting	18
risk management policies	17
Clinical Audit	11
risk register	11
job roles / descriptions	10
Self Assessment (Balanced Scorecards)	7
Healthcare Commission prompts	5
Local Risk Management Software	5
Patient Involvement	4
Other	20