

Organisation patient safety incident data

Briefing for boards of NHS healthcare organisations

September 2011

The [Organisation Patient Safety Incident Reports](#) data are published by the [National Patient Safety Agency](#) (NPSA). These data cover patient safety incidents occurring in a six month period and reported to the [National Reporting and Learning System](#). In publishing the data the NPSA aims to provide tools to support NHS organisations to analyse and learn from safety incidents to prevent patient harm in the future. Below are key actions for board members of NHS healthcare providers to use these reports.

1. Use your organisation's data to analyse the trends in your reporting with other similar organisations. Read the [Frequently Asked Questions](#) for information on how to interpret these data.
2. If your reporting profile looks different from similar organisations this could reflect differences in reporting culture and practices, the type of services provided or your patient group. It could also indicate high risk areas. Incidents should be investigated thoroughly using [Root Cause Analysis](#). Ensure you receive regular reports of actions taken as a result of investigations.
3. Reporting patient safety incidents provides an opportunity for learning. Step six of [Seven steps to patient safety](#) provides information on how your organisation can learn and share safety lessons.
4. Continue to ensure that NPSA's [safer practice recommendations](#) are implemented and maintained.
5. Review the steps you can take to improve reporting and learning as set out in [Act on reporting: five actions to improve reporting](#) and [Questions are the answer! Seven questions every board member should ask about patient safety](#)
6. Building a safer culture needs strong board leadership. Step two of [Seven steps to patient safety](#) explains how good leadership can help establish a strong focus on patient safety throughout an organisation. Review the interventions which aim to ensure a leadership culture at board level, to promote patient safety, from the [Patient Safety First](#) and [1000 Lives Plus](#) campaigns.
7. Encourage openness and transparency in communications about patient safety incidents. Communicating effectively with patients and their carers is a vital part of the process of dealing with errors or problems in a patient's treatment. See the NPSA's [Being Open](#) guidance.