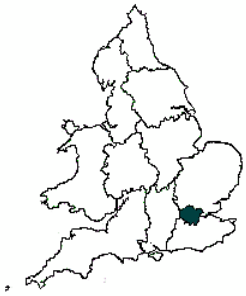


Queen Elizabeth Hospital NHS Trust

Organisation type: **Medium acute trust**

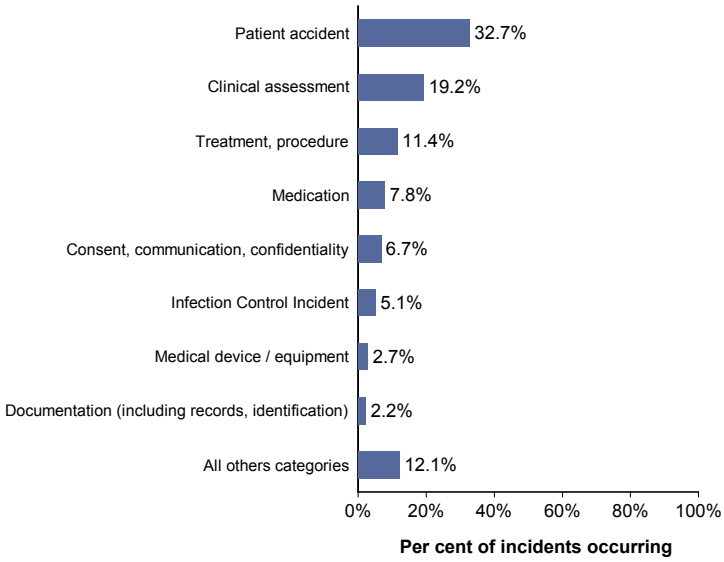
Region: **London SHA**

NHS
National Patient Safety Agency
National Reporting and Learning Service

Incident summary for the period April 2008 to September 2008

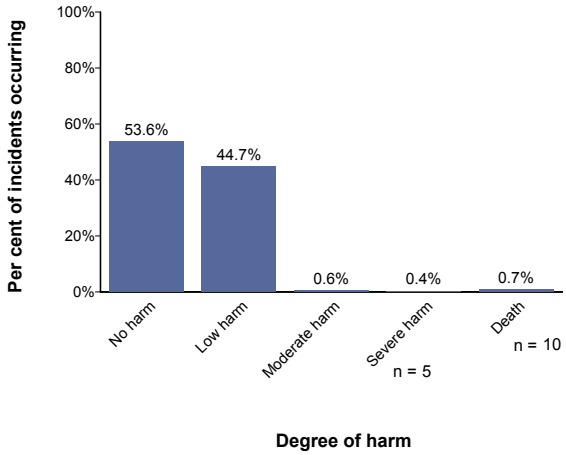
There were 1,346 incidents during the 6 month period between April 2008 to September 2008 submitted to the Reporting and Learning System (RLS) by the end of November 2008.

Incident type



The graph above shows the type of incidents reported from this organisation. A comparable national breakdown is available at http://www.npsa.nhs.uk/datareports/

Degree of harm



The graph above shows the degree of harm of incidents as reported by this organisation. Nationally, 66 per cent of incidents are reported as no harm, and just over 1 per cent as severe harm or death. However, not all organisations apply the national coding of degree of harm in a consistent way, which contributes to variations in the harm profile of each organisation (see action points overleaf).

Reporting level summary

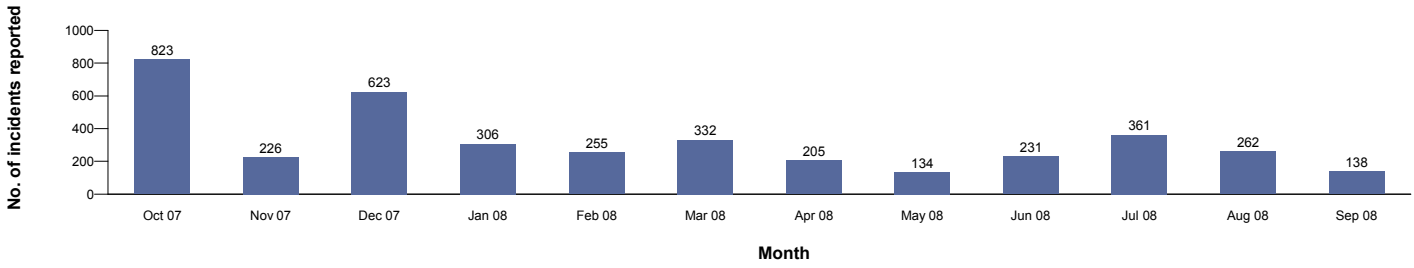
A high reporting rate indicates a stronger reporting and learning culture: experience from other industries shows that as an organisation's reporting culture matures, staff become more likely to report incidents.

The table to the right shows the rate of reporting (per 100 admissions) based on incidents occurring between April 2008 and September 2008 for this organisation, and the rate for organisations providing similar services in the same period (see www.npsa.nhs.uk/organisation-categories).

Reporting rate per 100 admissions
(April 2008 to September 2008)

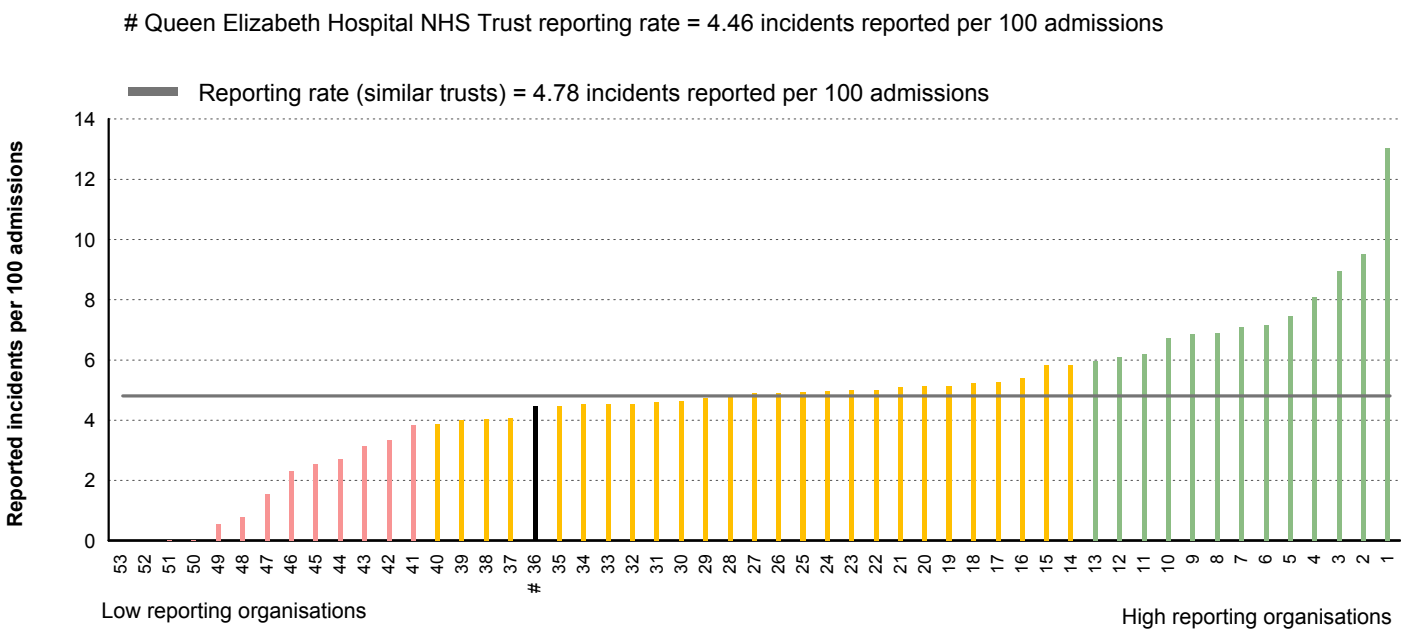
Reporting rate (similar trusts)	4.78
This organisation	4.46

Reports submitted by month



The graph above shows the number of incidents submitted in each of the last 12 months. Consistent or increasing numbers of reports each month indicate that an organisation has a robust process for submitting data. Organisations should submit incidents to the RLS at least monthly, to allow timely national action to be taken. The median days between an incident occurring and being submitted to the RLS for the period April 2008 to September 2008 is 57 days: the time lag for this organisation over the same period was 17 days.

Reporting rate: number of reports occurring between April 2008 to September 2008, per 100 admissions, in medium acute trusts



The graph above shows the rates of reported patient safety incidents per 100 admissions for each organisation during the period 1 April 2008 to 30 September 2008. The black bar represents the data from this organisation. There are 53 organisations in this group (see www.npsa.nhs.uk/organisation-categories for a list of organisations).

Acting on this report

- **Engage frontline staff and management.** To stimulate reporting within your organisation, and demonstrate the importance of reporting, share this report with the Board, risk and integrated governance team, and clinical staff.
- **Report regularly.** Trusts that report incidents regularly suggest a stronger organisational culture of safety. They take all incidents seriously and link reporting with learning. Incident reports should be submitted to the RLS at least monthly.
- **Report serious incidents quickly.** It is vital that healthcare staff report serious safety risks promptly so that lessons can be learned and action taken to protect harm to others. Submit incident reports to the RLS within 36 hours when the degree of harm is severe (permanent harm) or death.
- **Make reporting matter.** Review steps your organisation can take to increase reporting. Read: *Act on reporting: five actions to improve reporting* at: www.npsa.nhs.uk/nrls/reporting/.
- **Ensure consistency.** A consistent approach to coding of degree of harm ensures that the NPSA can compare and analyse data nationally in order to take action to improve patient safety. National definitions can be found on page 100 of *Seven steps to patient safety*: www.npsa.nhs.uk/sevensteps/.

For help and advice on improving reporting, see: www.npsa.nhs.uk/nrls/reporting/contact-the-npsa/

To comment on this report, or to make suggestions for future reports, email: yourdata@npsa.nhs.uk

Further information about the RLS

The RLS enables the NHS to understand why, what and how patient safety incidents happen, learn from these experiences and take action to prevent future harm to patients. For the latest alerts and directives based on the RLS, see: www.npsa.nhs.uk/nrls/alerts-and-directives. National data from the RLS can be found at: www.npsa.nhs.uk/datareports/.