NHS
National Patient Safety Agency
National Reporting and Learning Service

How do your patient safety incident reports compare with your peers'?

NHS organisation feedback report for

Any Town Trust

(PCO - No inpatient provision)

A feedback report for your organisation
on patient safety incidents reported to the
Reporting and Learning System within a cluster

Comprising incidents occurring between
October 2008 and March 2009

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For any queries, please contact:
nrlsxtranet@npsa.nhs.uk

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1 Your organisational feedback report

This feedback report provides a snapshot of the patient safety incidents occurring in your organisation, and your organisation's reporting culture, between 1 October 2008 and 31 March 2009, through individualised analysis of incidents reported from your organisation to the Reporting and Learning System (RLS).

The analyses presented in this report show you:

- what and where patient safety incidents occurred in your organisation between 1 October 2008 and 31 March 2009;
- how your organisation compared with other similar organisations (your cluster group, see page 2) in terms of rates of occurrence of incidents and reporting them to the RLS.

Key findings are presented in the main report, whilst detailed data (numbers, percentages, upper and lower quartiles, etc.) are given in Appendix 2.

The National Patient Safety Agency (NPSA) hopes that these analyses will stimulate your organisation's board, clinical governance or risk team, and clinical staff to have constructive discussions on how to:

- further improve the reporting of patient safety incidents in your organisation;
- provide safer care for your patients.

Improving reporting of patient safety incidents

Reporting of patient safety incidents can be improved by:

- implementing robust systems to send reports to the RLS at least monthly;
- developing an active reporting and learning culture;
- using the degrees of harm of severe or death correctly, including avoiding reporting deaths from natural causes as patient safety incidents;
- including medication name in reports of medication incidents;
- improving free text by avoiding the use of staff or patient identifiers and completing *'actions taken to prevent recurrence'*.

Note: As with all data, some analyses need to be interpreted with caution due to various reasons, for example, small numbers of incidents and incomplete reports. Throughout the report, boxes with the title *'! Interpret with care'* explain where and why caution is required while interpreting the data.

The RLS: every report helps

- Over 99 per cent of reports to the RLS are received via local risk management systems. Thus, for frontline staff, submitting a report to the RLS does not involve any additional time or effort. The NPSA is grateful to the staff in each NHS organisation who have developed and maintain their local risk management system and who regularly upload the locally reported incidents to the RLS.
- The information on patient safety incidents sent by your organisation to the RLS enables the NPSA to identify patterns and themes in patient safety, and provide feedback to the NHS on how this key component of healthcare can be improved, through a range of reports, alerts and other guidance (www.nrls.npsa.nhs.uk).
- If you have any problems with or questions regarding reporting to the RLS please call our helpdesk on 020 7927 9579 or visit the NPSA website for guidance and other sources of support (www.nrls.npsa.nhs.uk).

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Who should read the feedback report?

Patient safety is at the core of delivering high-quality care to patients. Therefore, it is important that the report is circulated as widely as possible, for example to your organisation's:

- group leading patient safety;
- department patient safety leads;
- patient safety champion.

Key findings should be shared with frontline staff. To aid with this the NPSA has designed a template for local staff newsletters, which you can use to share the findings from this report with frontline staff. This can be downloaded from www.nrls.npsa.nhs.uk

The medication section should be shared with your head of pharmacy or equivalent role.

How to use the feedback report?

Throughout this report we have identified areas where your organisation may wish to make changes to further improve patient safety. We have listed the relevant NPSA products, developed using learning from the RLS, along with other sources of information, which you can use to help implement changes.

However, every organisation is different. Therefore, the key findings of this report should be shared at a board-level meeting, so that your local knowledge of the services, patients and staff can help you ask the right questions and lead to ongoing improvements in incident reporting and patient safety at your organisation. We recommend that the full report is discussed and any further action planned by the group that leads on patient safety.

You could also use this report as part of your organisation's self-assessment against the Healthcare Standards for England and the Healthcare Standards for Wales.

Data included in this report

This report presents an analysis of all patient safety incidents successfully submitted by your organisation to the RLS by 30 June 2009, where the date that the patient safety incident occurred was between 1 October 2008 and 31 March 2009.

Note that reports uploaded via your local risk management system and reports uploaded by individual staff via the RLS eform are included in the analysis in this report.

Cluster group

Your organisation's cluster group is shown on the front cover of this report. The NPSA uses standard benchmark grouping, as used by other parts of the NHS. To see the names of all organisations within your group, please visit www.nrls.npsa.nhs.uk

Terms of use

Please see the privacy statement, usage rules and disclaimer in Appendix 1.

Do you have a query about your data?

If you cannot reconcile this report with the number of incidents you believe your organisation has sent to the RLS, please see the data query section in Appendix 3.

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2 Key findings

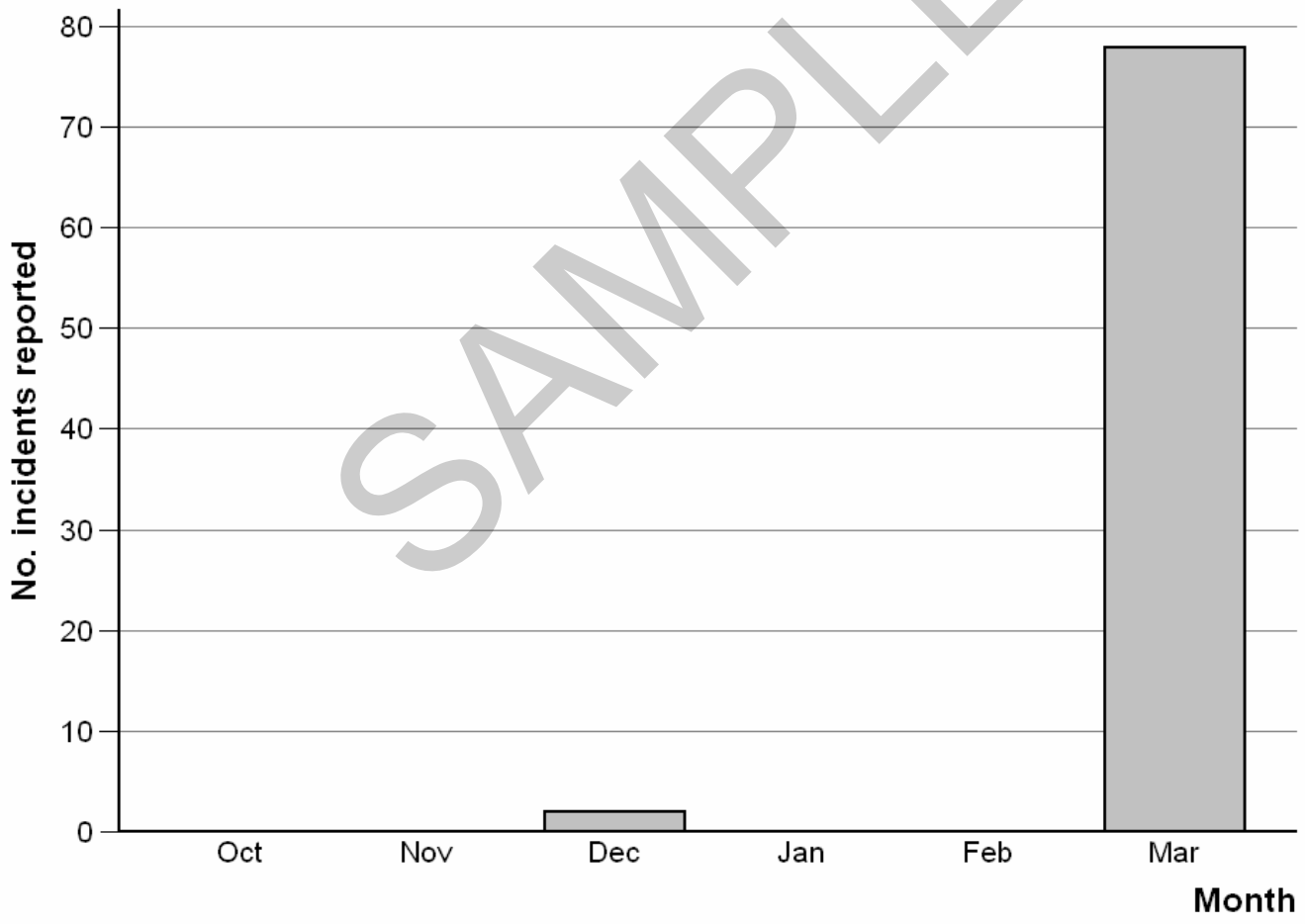
2.1 Your organisation's rate of reporting to the RLS

What we recommend:

- Each organisation should upload its latest data to the RLS at least monthly.
- If more than 50 patient safety incidents are reported in a week in your organisation then the data should be uploaded fortnightly.
- If more than 100 patient safety incidents are reported in a week in your organisation then the data should be uploaded weekly.

Figure 1 shows the pattern of uploading from your organisation from 1 October 2008 and 31 March 2009. This figure uses the date you successfully submitted incidents to the RLS rather than the date the patient safety incident occurred. We are going to be working with trusts to ensure that the most recent serious incidents are reported more quickly. Please see Section 3.8 for data on current timeliness on reporting from your trust.

Figure 1: Reports received by month from your organisation



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Source: patient safety incident reports successfully submitted to the RLS during the period 1 October 2008 to 31 March 2009

How to interpret Figure 1

If the graph shows broadly similar numbers of incidents for all six months, your organisation has well-established systems for regularly reporting to the RLS, and your local risk management or clinical governance team should be congratulated.

If the graph shows large differences in numbers of incidents reported over the six months, your organisation probably has not yet established reliable systems for reporting to the RLS.

Implications of Figure 1 for your organisation

If Figure 1 indicates that your organisation is not reporting regularly, you may wish to consider some of the reasons listed below.

- Only one member of staff has responsibility for your organisation's local risk management system. So when they are absent or if they leave the organisation, reporting to the RLS is interrupted.
- Data entry into the local risk management system is irregular or interrupted owing to local resource issues, for example, the responsible staff member is on long-term leave or there are recruitment problems.
- There are problems in the link between your local risk management system and the RLS. This should be reported to the NPSA, so we can provide advice and support to help resolve the problem.
- Following a pattern of monthly reporting around the first or last day of each calendar month can lead to the appearance of less frequent reporting, for example if reports are submitted on 1 and 31 October, 30 November, 3 and 31 January.

The NPSA expects that if your organisation had not been reporting regularly to the RLS, board-level staff would have been made aware of this through internal communication before your received this feedback report, and that a plan has been put in place to establish regular reporting.

! Interpret with care: Irregular reporters to note

If your organisation has not reported regularly to the RLS, or did not report all incidents that occurred between 1 October 2008 and 31 March 2009 by 30 June 2009, the remainder of this feedback report should be read bearing this in mind.

If your organisation 'caught up' with reporting after 31 March 2009 but before 30 June 2009, these data are not shown in Figure 1 but have been used in the rest of this feedback report.

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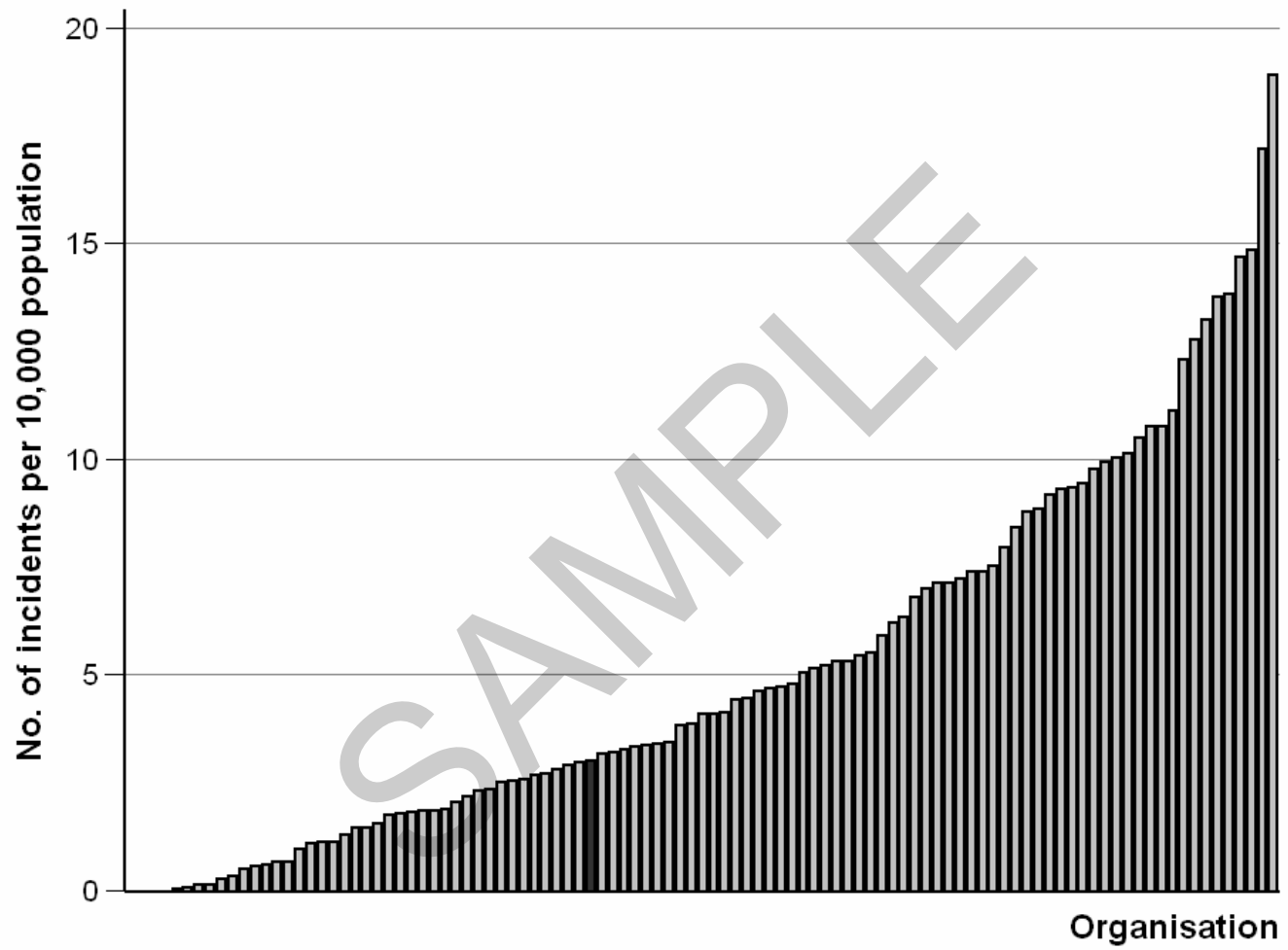
2.2 Your organisation's reporting culture compared with other organisations

In general, the higher rate of incidents, the stronger the reporting culture in that organisation.

We have shown your number of reported patient safety incidents in Figure 2 below. The data from your organisation has been highlighted in black, and is compared with other organisations in your cluster group. This figure uses the number of incidents per 10,000 population so that organisations of different sizes can make comparisons.

Figure 2: Incident rate per 10,000 population



Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

How to interpret Figure 2

Figure 2 shows the rates of patient safety incidents per 10,000 population occurring in the organisations in your cluster group during the period 1 October 2008 to 31 March 2009. The black bar represents the data from your organisation.

A direct comparison of the number of reports from various organisations can be misleading, as even organisations within the same cluster can vary considerably in size and activity.

Implications of Figure 2 for your organisation

- If your organisation is not among the high reporters according to Figure 2: Experience in other industries has shown that as an organisation's reporting culture matures, staff become more likely to report incidents.[1] Reports of patient safety incidents are predominantly made by frontline staff. Therefore to improve your organisation's rate of reporting, ensure that frontline staff are made aware that their reports are being used to improve their patients' safety and that the staff involved in patient safety incidents are treated fairly.

- If your organisation is among the high reporters according to Figure 2: Research suggests that even in high reporting organisations, many incidents do not get reported,[2] and that organisations need to remain proactive to maintain the level of reporting. This includes ensuring that frontline staff continue to see that their reports are being used to improve their patients' safety, that the staff involved in patient safety incidents are always treated fairly, and checking that good reporting cultures continue to be maintained in all departments and all staff groups.

If Figure 2 indicates that your organisation has a low reporting culture, you may wish to consider some of the reasons listed below.

- Half of all organisations will inevitably appear in the lower half of this figure, so consider whether your organisation is already working on improving reporting rates when you look at the figure.
- Data from your organisation may be missing in the RLS database if you have not uploaded patient safety incidents regularly, so the figure may not be accurate for your organisation.
- The population your organisation serves, or the specialties you provide, may mean patient safety incidents are less likely to occur (for example, younger adult patients are less likely to fall than older patients).
- Your organisation's policy regarding the kinds of patient safety incident that should be reported may be resulting in fewer incidents being reported. The NPSA defines a patient safety incident as 'any unintended or unexpected incident which could have, or did lead to harm for one or more persons receiving NHS funded healthcare'. We have found that most organisations have a similarly wide definition, usually with an additional 'if in doubt, report' proviso, but you may need to take a second look at your local policy.

If you believe your reporting rates are below average because you have made greater improvements in patient safety than most other organisations in your cluster, you need to carry out case note reviews or observational studies to confirm that your lower rates are due to improvements in safety rather than due to under-reporting.

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3 Further findings

! Interpret with care: Low reporters to note

If your organisation has reported few patient safety incidents, bear in mind that the rest of this feedback report may be affected. Small numbers of incidents can make detailed comparisons misleading, as each incident reported will then represent a greater proportion in the analysis (for example, if your organisation reported only 50 incidents, each incident will represent two per cent of the total, and make a visible difference to the figures).

3.1 How many patient safety incidents should be expected?

International studies help provide a picture of the numbers of patient safety incidents in primary care, although research is more difficult in primary care where the very high numbers of brief patient contacts makes scrutiny of records challenging, and where many employed and contracted staff work alone (which means research relies on individual staff recognising their own errors). Taken together,[3] these studies identified that general practitioners acknowledged between five and 80 errors per 100,000 consultations, with pharmacists identifying that around one per cent of prescriptions contained potentially harmful errors. Twenty-four per cent of staff employed by primary care organisations in the UK reported having seen a potentially harmful error in the past month.[4] In regularly reporting community hospitals, an average of eight patient falls per 100 occupied bed days was identified.[5]

Although all these figures sound modest, they need to be considered in the context of the very high levels of activity in primary care, with an average primary care organisation commissioning over a million consultations and generating a million and a half prescription items annually. Therefore, even in the better reporting primary care organisations, there is still scope to improve reporting and learning.

However, it is very unlikely a 'correct' level of reporting of patient safety incidents can ever be established. As more patients are treated in the community, new opportunities for error can arise, even if safety improvements are happening at the same time. As expectations and standards improve, minor delays in treatment or diagnosis that were previously accepted as normal practice will become perceived as preventable patient safety incidents.

Triangulating this report with other information on safety culture

Considering this feedback report in combination with other data sources on your organisation's safety culture can be helpful. For English organisations, the Care Quality Commission's staff survey at www.cqc.org.uk may be useful. Similar questions are included in the NHS Wales staff survey. A study found that organisations with better scores on items in the staff questionnaire (related to fair treatment of staff reporting errors, encouraging reporting, confidentiality and preventative action taken) also had higher reporting rates per admission.[6] However, the NPSA would suggest caution in interpreting responses to question 3.4.4 (England) or questions 16a-c (Wales) (for example, *'Have staff observed an error or near miss in the past working month?'*) as a higher than average response here could indicate an organisation with staff who are more alert to patient safety incidents, rather than an organisation where more patient safety incidents occur.

Additionally, only directly employed staff are included in the staff survey, whilst a key challenge for most primary care organisations is encouraging reporting from independent contractors. Does your organisation undertake local analysis of the proportion of reports made by independent contractors? Does your organisation have systems for reviewing reports of patient safety incidents from out-of-hours services?

It is also important to consider how your organisation's reporting changes over time: does your organisation undertake local analysis of year-on-year increases in reporting?

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Can the NPSA help your organisation improve your safety culture?

The NPSA has provided a variety of tools which can help you improve your local patient safety culture of reporting and learning. These include:

- Seven steps to patient safety in primary care – *advice on building a safety culture*
- MaPSaF – *a safety culture assessment tool for primary care organisations*
- The Incident Decision Tree – *to ensure fair treatment of staff involved in a patient safety incident*
- Engaging clinicians – *a resource pack to support local initiatives to increase reporting and learning*
- Medical error – *aimed particularly at encouraging reporting from junior doctors*
- Being Open – *managing communication with patients, relatives and staff when a patient safety incident has occurred*
- Chief Executives' checklist – *how leadership from the top can influence patient safety*
- Root Cause Analysis – *retrospective review of patient safety incident*
- Foresight training – *to help improve understanding of risk prone situations that could be considered as a "near miss"*
- Significant Event Audit – *sets out how to conduct an effective Significant Event Audit in seven simple stages*
- Risk Assessment – *guides to support commissioning practice-based and out-of-hours services*

Look at www.nrls.npsa.nhs.uk for links to all these and links to advice on safety culture from other patient safety organisations.

Would you like to contact a high reporting organisation?

Some high reporting primary care organisations are willing to be contacted by other primary care organisations who are seeking to improve their reporting rates, to discuss any differences in reporting systems, policy and practice. If you would like to contact any such organisations please email makingcontact@npsa.nhs.uk

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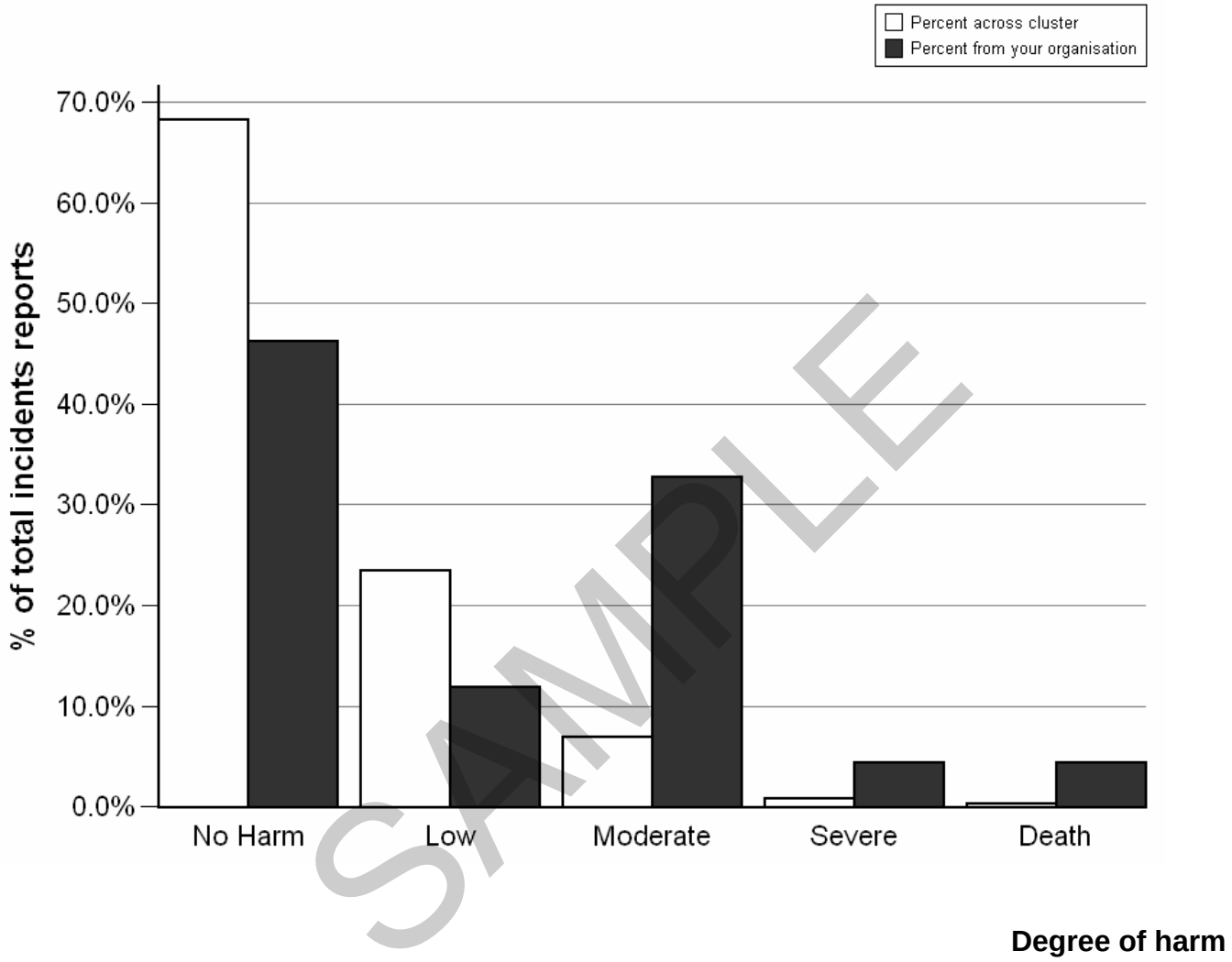
3.2 Analysis of the reported degree of harm*

Figure 3 shows how your organisation compares with other organisations in your cluster with regard to degree of harm incurred by patients in the incidents reported by your organisation.

Figure 3: Degree of harm to patients



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Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

No harm	*e.g. wrong dose of medication prescribed, but no harm caused*
Low harm	*- requiring extra observation or minor treatment*
	e.g. accidentally bruised patient during physiotherapy session
Moderate harm	*- causing significant but not permanent harm*
	e.g. community nurse miscalculated syringe driver, hospital admission required to reverse opiate toxicity
Severe harm	*- causing permanent and significant harm*
	e.g. diagnosis of meningitis and septicaemia missed, patient critically ill with amputation of several digits
Death	*- directly attributable to the patient safety incident*
	e.g. patient in community hospital fell and fractured neck of femur, death directly attributable to fracture

* Figure 3 uses abbreviated definitions; see *Seven steps to patient safety* www.nrls.npsa.nhs.uk (page 100) for full definitions

How to interpret Figure 3

The black bars in Figure 3 show the proportions of no harm and more serious incidents reported in your organisation. The white bars show the average proportion of the same incidents that occurred in all the organisations in your cluster group.

We have used percentages rather than actual numbers for this figure as the organisations in your cluster group are of different sizes, which confounds comparison of actual numbers in a meaningful way. Also, we do not assign a degree of harm to some incidents – these are incidents in which many patients were involved together. However, there were only few such incidents.

Implications of Figure 3 for your organisation

If the proportion of incidents of different degrees of harm in your organisation differs noticeably from the average of the other organisations in your cluster, you may wish to consider some of the reasons listed below.

- The coding of degree of harm in your organisation may be flawed (see the quality section below).
- Have local initiatives affected the degree of harm reported? For example, initiatives to encourage the reporting of near misses may lead to an increased proportion of no harm incidents.
- Do the kinds of service provided by your organisation mean you would expect differences in degree of harm? For example, an organisation specialising in ophthalmology might expect fewer instances of incidents leading to death than an organisation specialising in cardiac conditions.

Experience in other industries suggests as reporting cultures mature, the proportion of reports of no harm incidents increases, and the number of reports of severe harm incidents decrease.[5] However, organisations should be very cautious in applying the findings to healthcare settings. For example, in the aviation industry, as reporting of near misses increased, the number of fatal incidents reduced.[6] But aviation, unlike healthcare, was starting from a baseline where all fatal aircraft crashes were known, whilst the issues for healthcare are much more complex. For example, a wrong diagnosis leading to a potentially preventable death may only be detected if the patient's family consented to a post-mortem examination.

An analysis of high reporting organisations found no significant correlation between the number of reports made per admission and the proportions of degrees of harm.[4] Because of this, the NPSA expects organisations to continue aiming to improve local reporting levels of patient safety incidents of all degrees of harm.

At a national level, all serious incidents are reviewed to extract any learning on risks and system weaknesses which need to be shared more widely. From this issues are identified and prioritised by the NPSA. Some of these may result in Rapid Response Reports and other guidance to drive safety improvements.

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Is your organisation coding incidents correctly with regard to degree of harm?

We sometimes find there is a discrepancy between the coding of degree of harm and other information in the report, such as incident type or the free text. You should be aware that inconsistent and incorrect coding of degree of harm will impact on the findings in this report and affect your ability to use your data to prioritise incidents for action.

It is important that incidents reports to the NPSA are only categorised as 'Death' if a patient died as a result of a patient safety incident. Deaths from natural causes or those that could not have been prevented are not patient safety incidents and should not be reported to the RLS.

We acknowledge that currently there are different definitions of a patient safety incident used across England and Wales, particularly in relation to serious untoward incidents. The NPSA is working to standardise these definitions. NHS organisations will be consulted in this work and the outcomes will be communicated to all organisations when the process is completed.

Some causes of incorrect coding of degree of harm:

- Confusing the potential degree of harm of an incident with actual degree of harm that occurred, for example coding near misses (where no harm resulted) as ‘severe’ harm. The NPSA requires the degree of harm to reflect the actual and not the potential degree of harm caused by the patient safety incident.

- Coding the degree of harm as ‘severe’ when the patient is expected to suffer severe but transient harm (for example severe bruising) instead of the required significant permanent harm (for example amputation, brain damage). Our recent analysis of free text suggests that only about 48 per cent of incidents reported as leading to severe harm were correctly coded by the reporting organisation.

- Coding the degree of harm as ‘death’ when a patient died but the death was unrelated to the patient safety incident they had suffered, or the patient did not die but could have died as a result of the incident (recording the potential rather than the actual harm that occurred). The NPSA defines ‘death’ as the degree of harm incurred ‘where death is directly attributable to a patient safety incident’. To illustrate the problem we conducted a detailed review of all incidents reported as death. For this we examined all the free text provided to identify whether the coding of death was supported by other information in the report. We have found that in a substantial proportion of incidents the free text and other information in the report do not appear to support the coding of harm.

- Other exclusions include some duplicate reports which only become apparent from the free text of incidents, cases where there is insufficient or inadequate information or detail provided; and cases which are not about patients receiving NHS funded care (for example visitor incidents).

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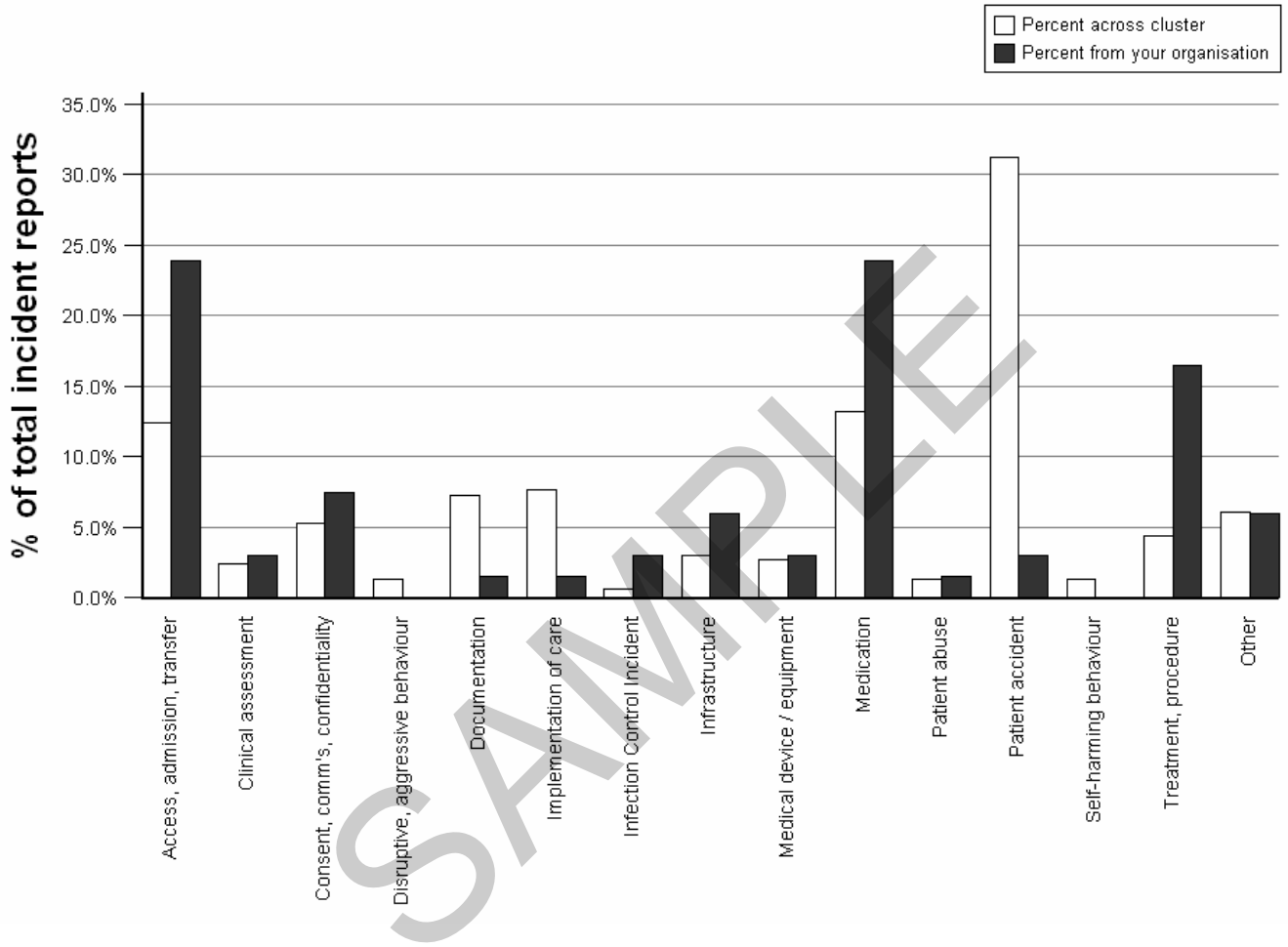
3.3 Comparison of the types of incident that occurred in your organisation and in other organisations in your cluster

Figure 4 shows how your organisation compares with other organisations in your cluster group with regard to each category of patient safety incident reported by your organisation.

Figure 4: Incident type



(Note: for full data labels please refer to Appendix 2)
Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

How to interpret Figure 4

For each category of patient incident type, the black bars in Figure 4 show the proportions of incidents reported in your organisation. The white bars show the average proportion of the same incidents that occurred in all the organisations in your cluster group. We have used percentages rather than actual numbers for this figure as the organisations in your cluster group are of different sizes, which confounds comparison of actual numbers in a meaningful way.

Implications of Figure 4 for your organisation

The analysis of incident type can provide useful context for the earlier analysis of reporting culture: if your organisation is a high (or low) reporter, does that hold true over all incident types, or is your organisation's higher (or lower) reporting rate arising mainly from one or two incident types? Small variations between organisations are expected due to differences in categorisation and subcategorisation of incidents between your local risk management system and the others. However, if any incident types appear markedly more common or less common in your organisation than in other organisations of your type, you may find it useful to consider some of the reasons listed below.

- Differences in inpatient population: for example, a higher proportion of older patients may be reflected in an increased risk of patient accidents.
- Local risk management system is less successful at capturing some types of incident: for example, do the anaesthetists or pharmacists in your organisation maintain a separate reporting system that does not feed into your main local risk management system?
- A higher proportion of incidents coded as 'other': this may indicate problems with the incident categories that you use, or with the mapping of your local risk management system to the RLS.

Note: this comparison of incident types is intended to complement, not replace, the extensive local analysis carried out to prioritise and target efforts to improve patient safety, and understand trends.

Can the NPSA help with specific incident types?

A range of NPSA resources that can help you with specific incident types relevant to primary care organisations have been developed, including:

- Anticoagulant therapy
- Bedrail safety
- Cleaning safely
- Falls prevention
- Healthcare risk assessment made easy
- Infusion device safety
- Injectable medicines
- Latex allergy
- Methotrexate
- Morphine and diamorphine
- Nasogastric feeding
- Repevax and Revaxis
- Risks of omitting Hib when administering Infanrix-IPV+Hib
- Minimising risks of suprapubic catheter insertion (adults only)
- Female urinary catheters causing trauma to adult males
- WHO Surgical Safety Checklist

Many additional topics and good practice examples on medication safety relevant to primary care are included in the fourth report of the NPSA's patient safety observatory on medication safety 'Safety in doses'.

For links to all these please go to www.nrls.npsa.nhs.uk The site also links to useful advice from other organisations, including a range of resources around improving patient safety at the point of transfer of care, and the safety of patients missing from community hospitals, and additional resources for primary care organisations that provide mental health services.

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3.4 Where did the incidents that were reported from your organisation occur?

Some of the patient safety incidents reported by your organisation may not have occurred within the organisation. As patients move across healthcare services, patient safety incidents which occurred outside your organisation may be reported within your organisation.

For example, a patient safety incident that caused harm which needed acute hospital treatment, or because checks on transfer of care led to an earlier patient safety incident being detected: 'Patient admitted … drowsy and unresponsive with respiratory rate of 8 breaths per minute. Patient documented as having possible opioid toxicity … Accompanying GP letter stated patient takes 10mg Oramorph before removal of dressings … on investigation found prescription for 100mg had been written and dispensed.'

Table 1 compares the locations where incidents reported from your organisation and those reported from other organisations in your cluster occurred.

Table 1: Incident location

Incident location	Incidents across cluster	% Incidents across cluster	Incidents from your organisation	% Incidents from your organisation
Ambulance (including call / control centre)	9	<0.1%	0	0.0%
Community hospital	3,892	23.0%	0	0.0%
General / acute hospital	993	5.9%	1	1.5%
Mental health unit / facility	232	1.4%	0	0.0%
Not applicable	43	0.3%	0	0.0%
Primary care setting	3,969	23.4%	41	61.2%
Public place	140	0.8%	0	0.0%
Residence / home	4,923	29.0%	7	10.4%
Social care facility	2,016	11.9%	0	0.0%
Other	471	2.8%	18	26.9%
Unknown	267	1.6%	0	0.0%
Total	16,955	100.0%	67	100.0%

SAMPLE

Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

How to interpret Table 1

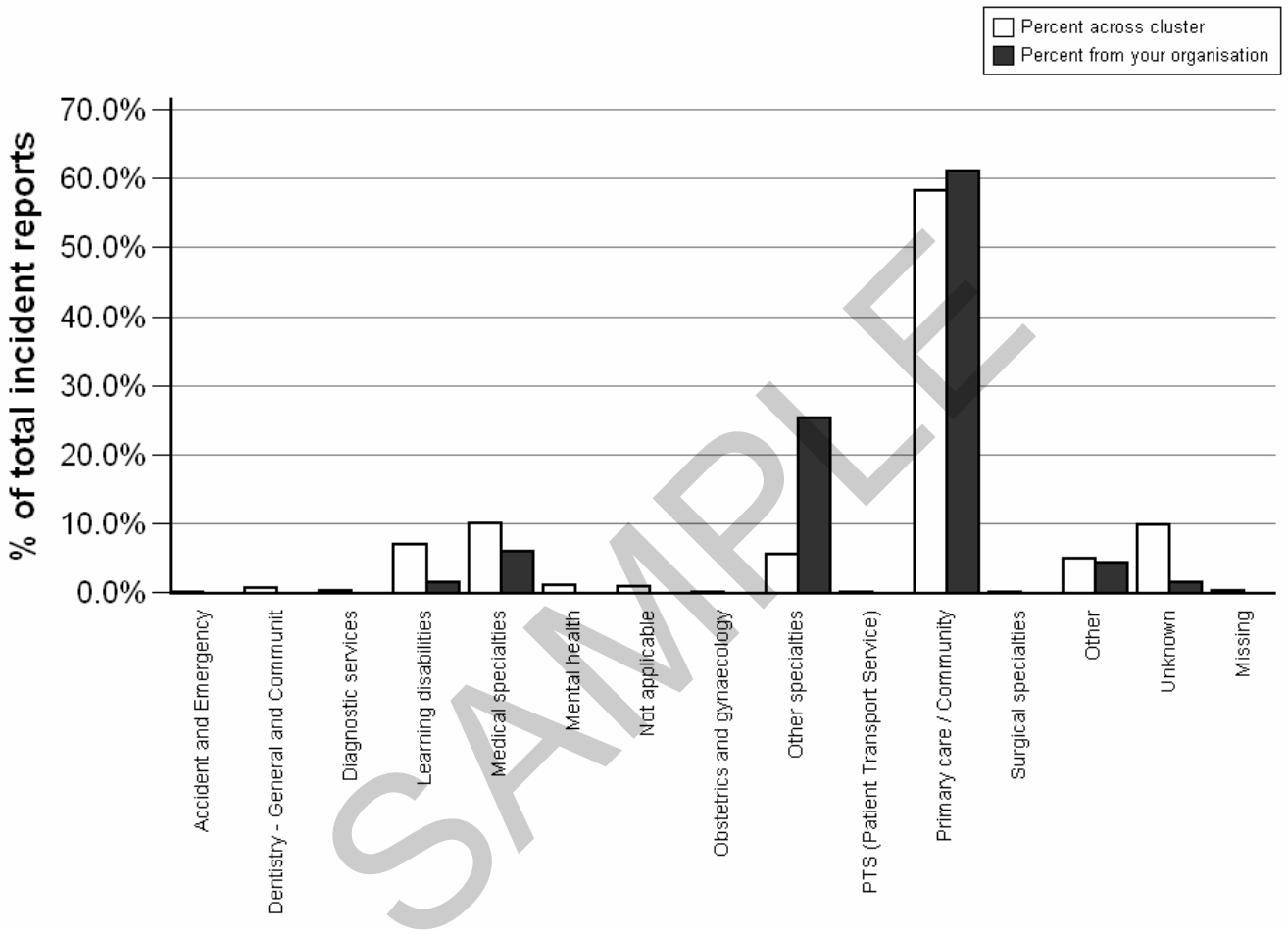
Cross-reporting happens in both directions, for example, a primary care organisation reporting a patient safety incident that occurred whilst the patient was admitted in an acute hospital but was detected after the patient had been discharged.

From this table you can also find out how the services offered by your organisation compare with the services in other organisations in your cluster: any differences here will make a difference to the comparison and also to the type and number of patient safety incidents reported.

3.5 Breakdown of incidents by specialty

Figure 5 shows how the specialties in your organisation compare with those in other organisations in your cluster group with regard to the proportion of incidents occurring in each specialty.

Figure 5: Top level specialties within the cluster



Specialties

(Note: for full data labels please refer to Appendix 2)
Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

How to interpret Figure 5

The black bars in Figure 5 show in which specialties the patient safety incidents reported in your organisation occurred. The white bars show the average proportion of incidents that occurred in the same specialties across all the organisations in your cluster group. We have used percentages rather than actual numbers for this figure as the organisations in your cluster group are of different sizes which confounds comparison of actual numbers in a meaningful way.

For organisations providing a range of different specialties and sub-specialties: this figure shows top-level specialties offered by organisations within your cluster. For more detailed sub-group breakdowns please see Appendix 2 (Tables 7a and 7b).

Implications of Figure 5 for your organisation

A degree of variation between your organisation and other organisations in your cluster in the proportion of incidents reported by specialty is expected due to differences in local service provision. However, if there is a marked difference in the proportion of incidents occurring in a specialty in your organisation and the cluster average, you may wish to consider some of the reasons listed below.

- Are there differences in service provision that explain differences in reporting?
- Does the reporting from any specialty in your organisation appear to be lower than in other organisations?
- If so, do they have a specialty reporting system that is not connected to your local risk management system, or do they need support to improve reporting and learning?

The comparison of specialties' reporting patterns from your organisation with reporting patterns from specialties in other organisations in your cluster is intended to complement, not replace, the extensive local analysis carried out to understand and act on the particular patient safety challenges within different specialties.

SAMPLE

3.6 Reporting information that could identify individuals

The NPSA screens free text fields to find information that may potentially identify individuals. This information is then removed. Table 2 shows the proportion of incidents reported by your organisation that had person identifiable data removed by the NPSA. The table shows the proportions of incidents that contain patient information (address, name, patient number or date of birth), proportions of incidents that contained staff information and the proportion of incidents that contain other identifiable information (third-party information or information we cannot determine the nature of).

Note: no screening process is totally accurate, so the number of incidents below may be an under-estimation of the actual number of incidents that contain person-identifiable information sent by your organisation.

Table 2: Percentage of reports from your organisation that included person identifiable data

Type of person identifiable data	Oct-08 to Mar-09	Apr-08 to Sep-08
Incidents including patient identifiable information	5.0%	18.9%
Incidents including staff identifiable information	17.5%	22.2%
Incidents including other identifiable information	3.8%	0.0%
Total incidents with identifiable information	21.3%	35.6%

(Note: an incident can contain patient, staff and other identifiable information. Therefore, the total number of incidents with person identifiable data is unlikely to equal the sum of the other figures in the table, in most cases it will be lower.)

Source: patient safety incident reports successfully submitted to the RLS during the period 1 October 2008 to 31 March 2009

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Implications of Table 2 for your organisation

Every organisation, including NHS organisations, is required by common law duty of confidentiality and the Data Protection Act[9] not to send any person identifiable data to third parties, including the NPSA, without the consent of the individual concerned.

The NPSA can only hold person identifiable information with that person's consent. The reporting mechanism does not include a facility to obtain patient consent. Therefore, the RLS is designed not to capture patient identifiable data in its reporting dataset.

However, as shown in Table 2, your organisation, among others, has been including person identifiable information in the free text fields of the RLS. Although we make every effort to remove person identifiable information from incident records, this cannot be guaranteed. Therefore, we request that your organisation should avoid including person identifiable data in all fields where free text can be entered, such as the description of the incident, minimising actions and actions taken to prevent reoccurrence. This can be successfully avoided by using descriptors rather than names (for example the patient, staff nurse A) at the point of data entry, even if staff used real names in an original handwritten report.

The majority of person identifiable information is found in the free text variable 'Actions preventing reoccurance' (IN10). If you have high percentages in Table 2 you should check that the text in this field is being anonymised.

3.7 Can your organisation improve the quality of the data submitted to the RLS?

We recognise that all organisations have to seek a balance between the amount of information they request when a patient safety incident has occurred, and making reporting as easy and straightforward as possible for frontline staff. Because of this, only a limited number of fields are mandatory when submitting information to the RLS (failure to complete these fields means the report cannot be successfully uploaded). However, further information adds considerably to the value of reports both for your local learning and for the effectiveness of the RLS. We would suggest the highest priorities for improvements in data quality are:

- Including a correctly spelt medication name in reports of medication incidents;
- Using the degrees of harm of severe or death correctly, including avoiding reporting deaths from natural causes as patient safety incidents and reporting the actual not potential degree of harm;
- Avoiding the use of staff or patient identifiers within the free text;
- Increasing the proportion of reports where the free text section of *'actions taken to prevent recurrence'* is completed.

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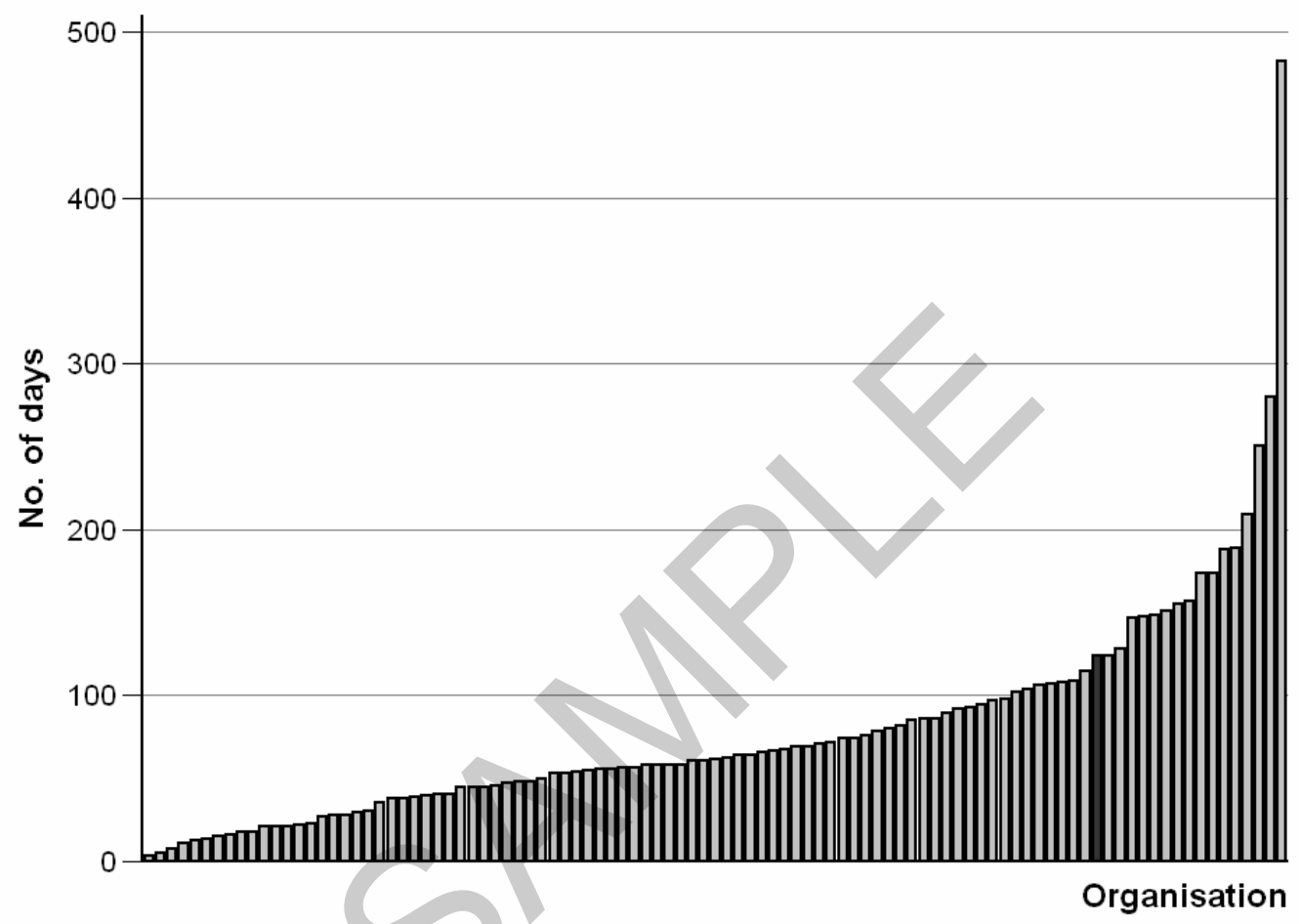
Timeliness of reporting

The time between an incident occurring and being reported to the RLS is important for the information to be useful for identifying and acting on patient safety incidents quickly.

Figure 6: Median time difference between incidents occurring and being reported to the NPSA



SAMPLE

Source: Incidents reported to the NPSA between 1 October 2008 to 31 March 2009

How to interpret Figure 6

Figure 6 shows the median number of days between an incident occurring and the incident being reported to the RLS in the organisations in your cluster group. Your organisation is represented by the black bar.

Note: The median is used because the data distributions used in the above figure are skewed (that is, they have some incidents with very large values, but the majority are much smaller); a small number of incidents with a long time-delay would make the average much higher.

Implications of Figure 6 for your organisation

At present the median time taken for incidents to reach the NPSA is 57 days, with reports of deaths and severe harm taking 51 days. Timeliness of reports to the NPSA affects how quickly we can provide you with benchmarking reports and also how quickly we can review and respond to the most serious incidents.

In response to requests from trusts, we base these reports on incidents occurring within a given time period, but with a two-month delay in incidents being sent to the NPSA, there is a corresponding time lag before we can start the analysis to provide these reports.

One of the key benefits of a national system is to be able to spot new issues and trends quickly, so that information about risks and remedial actions can be disseminated quickly to prevent further incidents.

In accordance with *Safety first* the NPSA has established a new response unit to ensure the most serious of incidents can be reported and addressed quickly and has been piloting new ways of working with 38 trusts. The pilot has been evaluated and findings will be published in the Autumn on the NPSA website. At this time we will also begin to roll out rapid reporting nationally and will be requesting all trusts to upload their most serious incidents much more quickly (within 2 working days of local notification). Details on how to send update reports following initial reports will be provided.

For more details on how your organisation can rapidly report more serious incidents see http://www.nrls.npsa.nhs.uk.

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4 Next steps: reviewing the learning, taking action

The NPSA hopes that these analyses will stimulate your organisation's board, clinical governance or risk team, and clinical staff to have constructive discussions on how to:

- further improve the reporting of patient safety incidents in your organisation;
- provide safer care for your patients.

Reporting of patient safety incidents can be improved by:

- implementing robust systems to send reports to the RLS at least monthly;
- developing an active reporting and learning culture;
- using the degrees of severe harm or death correctly, including avoiding reporting deaths from natural causes as patient safety incidents.

SAMPLE

5 Contact us

We hope this feedback report will stimulate your board, risk and integrated governance team, and clinical staff to have constructive discussions on whether local reporting of patient safety incidents could be further improved, and that you will be able to use the resources this report signposts to help your organisation improve patient safety.

Feedback on previous reports had requested help with the interpretation of some of the data. We have expanded on the explanation of the data, and also added prompts for interpretation. If you need further help to interpret the data, you can contact your SHA's Patient Safety Action Team (England), Patient Safety Manager (Wales), or use the feedback link and send an email to the NPSA on NRLSxtranet@npsa.nhs.uk. If you send an email, please ensure that you include details of your query in addition to your own contact details. This will help us to make sure that the most appropriate person in the team at the NPSA responds to you.

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Appendices

APPENDIX 1: Terms of use

The extranet information service website is hosted by the NPSA. It enables you to access aggregated data on patient safety incident reports that have been submitted to the RLS. Your use of this information is governed by the following privacy statement, usage rules and disclaimer.

Privacy statement

The RLS does not seek to collect information on the names of patients or staff involved in an incident, and takes steps to remove person identifiable data that are inadvertently included in descriptions of the incident as far as possible. The data presented in this and future reports will not contain any information that could directly identify an individual patient or staff member involved in an incident.

The NPSA will regularly publish statistics and analyses of patient safety incident data to promote a learning culture and the development of patient safety improvements in the NHS. The NPSA operates under the principle that it will share information with partner organisations where this is beneficial to patient safety, but will inform your chief executive first of its intention, and ensure your organisation has first sight of any data.

Usage rules

Our aim is to provide you with a report focused on your organisation. We will provide notes on interpretation, including where organisations should interpret with caution. Your organisation is responsible for the use of the data and the communication of the information to your staff.

The data are made available to you through a secure website with password protection. It is the responsibility of your organisation to ensure that login details and passwords are restricted to authorised users only. You are responsible for authorising the appropriate people within your organisation to access the site.

Disclaimer

The incidents summarised in this report have been drawn from the RLS, which supports the goal of the NPSA to make patient care safer. These incidents have been reported to the RLS by NHS organisations across England and Wales, and are reported through a variety of routes by individual NHS staff through local risk management systems and web-based eforms (including an open access eform). The individual reports are not investigated or verified by the NPSA. These incidents are self-reported and so are not necessarily representative of the NHS across England and Wales and therefore should be interpreted with care.

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APPENDIX 2: Detailed data

The following tables provide back-up detail for the figures and tables in the main report. All the caveats and cautions which apply to the figures apply to these tables, and they should be read in conjunction with the text supplied within the main report.

Table 3 provides summary statistics on the number of safety incident reports. The cluster information relates to incidents that occurred during the period between 1 October 2008 and 31 March 2009.

Table 3: Summary statistics for the number and rate of incidents reported

From your organisation	**Incidents occurring (1Oct2008 - 31Mar2009)**	67
	Incidents reported (1Oct2008 - 31Mar2009)	80
	Population (Mid 2007 estimates)	222,861
Across your cluster	**Minimum number of reports**	0
	Lower quartile	30
	Median	95
	Upper quartile	201
	Maximum	1,139
	Total number of reports	16,955

SAMPLE

Table 4: Incident type

Incident type	Incidents across cluster	% incidents across cluster	Incidents from your organisation	% incidents from your organisation
Access, admission, transfer, discharge (including missing patient)	2,103	12.4%	16	23.9%
Clinical assessment (including diagnosis, scans, tests, assessments)	399	2.4%	2	3.0%
Consent, communication, confidentiality	890	5.2%	5	7.5%
Disruptive, aggressive behaviour	225	1.3%	0	0.0%
Documentation (including records, identification)	1,228	7.2%	1	1.5%
Implementation of care and ongoing monitoring / review	1,298	7.7%	1	1.5%
Infection Control Incident	109	0.6%	2	3.0%
Infrastructure (including staffing, facilities, environment)	504	3.0%	4	6.0%
Medical device / equipment	452	2.7%	2	3.0%
Medication	2,230	13.2%	16	23.9%
Patient abuse (by staff / third party)	229	1.4%	1	1.5%
Patient accident	5,301	31.3%	2	3.0%
Self-harming behaviour	223	1.3%	0	0.0%
Treatment, procedure	739	4.4%	11	16.4%
Other	1,025	6.0%	4	6.0%
Total	16,955	100.0%	67	100.0%

Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

SAMPLE

Table 5: Incident location

Incident Location	Incident Location	Incidents across cluster	% Incidents across cluster	Incidents from your organisation	% Incidents from your organisation
Ambulance (including call / control centre)	**In vehicle / in transit**	6	<0.1%	0	0.0%
	Other	2	<0.1%	0	0.0%
	Missing	1	<0.1%	0	0.0%
Community hospital	**Day care services**	149	0.9%	0	0.0%
	General areas	417	2.5%	0	0.0%
	Inpatient areas	2,330	13.7%	0	0.0%
	Outpatient department	113	0.7%	0	0.0%
	Support Services	175	1.0%	0	0.0%
	Other	707	4.2%	0	0.0%
	Missing	1	<0.1%	0	0.0%
General / acute hospital	**Accident (A) / minor injury unit / medical assessment unit**	80	0.5%	0	0.0%
	Day care services	8	<0.1%	0	0.0%
	General areas	39	0.2%	1	1.5%
	Inpatient areas	591	3.5%	0	0.0%
	Outpatient department	107	0.6%	0	0.0%
	Support Services	59	0.3%	0	0.0%
	Other	108	0.6%	0	0.0%
	Missing	1	<0.1%	0	0.0%
Mental health unit / facility	**Community mental health facility**	7	<0.1%	0	0.0%
	Day care services	22	0.1%	0	0.0%
	General areas	35	0.2%	0	0.0%
	Inpatient areas	101	0.6%	0	0.0%
	Outpatient department	16	<0.1%	0	0.0%
	Support Services	13	<0.1%	0	0.0%
	Other	38	0.2%	0	0.0%

SAMPLE

Table 5: Incident location (Continued)

Incident Location	Incident Location	Incidents across cluster	% Incidents across cluster	Incidents from your organisation	% Incidents from your organisation
Not applicable		43	0.3%	0	0.0%
Primary care setting	**Ambulatory care treatment centre**	24	0.1%	0	0.0%
	Community pharmacy	211	1.2%	1	1.5%
	Dental surgery	92	0.5%	0	0.0%
	GP Surgery	932	5.5%	6	9.0%
	Health centre / out-of-hours centre	1,989	11.7%	34	50.7%
	Optician / optometrist	2	<0.1%	0	0.0%
	Rehabilitation centre	206	1.2%	0	0.0%
	Other	512	3.0%	0	0.0%
	Missing	1	<0.1%	0	0.0%
Public place	**Missing**	140	0.8%	0	0.0%
Residence / home	**Hospice**	28	0.2%	0	0.0%
	Intermediate care setting	562	3.3%	7	10.4%
	Nursing home	576	3.4%	0	0.0%
	Prison / remand centre	442	2.6%	0	0.0%
	Private house / flat etc.	3,277	19.3%	0	0.0%
	Other	38	0.2%	0	0.0%
Social care facility	**Day care services**	20	0.1%	0	0.0%
	Local Authority (non-residential)	7	<0.1%	0	0.0%
	Residential care home	1,948	11.5%	0	0.0%
	Other	41	0.2%	0	0.0%
Other		471	2.8%	18	26.9%
Unknown		267	1.6%	0	0.0%
Total		16,955	100.0%	67	100.0%

Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

SAMPLE

Table 6: Degree of harm to patients

Degree of harm	Incidents across cluster	% Incidents across cluster	Incidents from your organisation	% Incidents from your organisation
No Harm	11,567	68.2%	31	46.3%
Low	3,994	23.6%	8	11.9%
Moderate	1,184	7.0%	22	32.8%
Severe	138	0.8%	3	4.5%
Death	72	0.4%	3	4.5%
Total	16,955	100.0%	67	100.0%

Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

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Table 7a: Top level specialties within the cluster

Specialty Level 1	Incidents across cluster	% Incidents across cluster	Incidents From your Organisation	% Incidents From your Organisation
Accident and Emergency	26	0.2%	0	0.0%
Dentistry - General and Community	128	0.8%	0	0.0%
Diagnostic services	48	0.3%	0	0.0%
Learning disabilities	1194	7.0%	1	1.5%
Medical specialties	1728	10.2%	4	6.0%
Mental health	184	1.1%	0	0.0%
Not applicable	164	1.0%	0	0.0%
Obstetrics and gynaecology	3	<0.1%	0	0.0%
Other specialties	962	5.7%	17	25.4%
PTS (Patient Transport Service)	5	<0.1%	0	0.0%
Primary care / Community	9906	58.4%	41	61.2%
Surgical specialties	25	0.1%	0	0.0%
Other	834	4.9%	3	4.5%
Unknown	1680	9.9%	1	1.5%
Missing	68	0.4%	0	0.0%
Total	16955	100.0%	67	100.0%

Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

SAMPLE

Table 7b: Level 1 and 2 specialty split by paediatric/adult

Specialty levels 1 and 2		Total clust	Total Org	Adult / Paediatrics Specialty					
				Adult		Missing		Paediatrics	
				N Cluster	N Org	N Cluster	N Org	N Cluster	N Org
Learning disabilities	**Inpatient assessment and treatment**	270	0			270	0		
	Residential care	93	0			93	0		
	Supported living	270	0			270	0		
	Other	388	0			388	0		
	Remainder grouped	173	1	56	1	117	0		
Medical specialties	**Care of older people**	933	0	397	0	536	0		
	Rehabilitation	612	2	213	2	399	0		
	Remainder grouped	183	2	29	2	153	0	1	0
Mental health	**Child and adolescent mental health**	87	0			87	0		
	Drug and alcohol service	60	0			60	0		
	Remainder grouped	37	0	10	0	26	0	1	0
Other specialties	**Occupational therapy**	88	0			88	0		
	Pharmacy (inpatient)	113	0			113	0		
	Physiotherapy	315	1	104	1	211	0		
	Other	162	0			162	0		
	Remainder grouped	284	16	175	16	90	0	19	0

SAMPLE

Table 7b: Level 1 and 2 specialty split by paediatric/adult (Continued)

Specialty levels 1 and 2		Total clust	Total Org	Adult / Paediatrics Specialty					
				Adult		Missing		Paediatrics	
				N Cluster	N Org	N Cluster	N Org	N Cluster	N Org
Primary care / Community	**Chiropody / podiatry**	150	0			150	0		
	Community medicine	167	0			167	0		
	Community midwifery	164	0			164	0		
	Community nursing	5,002	4	1,556	4	3,446	0		
	Community paediatrics	84	0			84	0		
	General practice - no specialism	788	13	110	13	678	0		
	Health visiting / school nursing	637	0	70	0	567	0		
	Intermediate care	1,579	8	222	8	1,357	0		
	Sexual health / family planning	257	1	94	1	163	0		
	Other	898	10	416	10	482	0		
	Remainder grouped	180	5	78	0	35	0	67	5
Other		834	3	164	3	657	0	13	0
Unknown		1,680	1	263	1	1,415	0	2	0
Other low frequency specialties	**Other low frequency specialties**	467	0	73	0	393	0	1	0

Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

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APPENDIX 3: Queries about your data?

Figure 1 and Table 2 refer to the month in which you submitted reports to the RLS. All other figures and tables in this feedback report use patient safety incidents successfully reported to the RLS by 30 June 2009, where the date that the patient safety incident occurred falls between 1 October 2008 and 31 March 2009. Details of how we calculate rates can be found at www.nrls.npsa.nhs.uk

The numbers of reports here might not exactly match the number you believe you have submitted. Differences occur because reports where essential data fields are missing are automatically rejected, and we seek to delete reports affecting staff or visitors, and multiple reports of the same incident. For more information, including how to make a query if you cannot reconcile the number of reports we received with the number of reports you believe you have sent, go to www.nrls.npsa.nhs.uk

The NPSA no longer manually recodes incidents reported as 'other' categories by organisations where possible. Because of this process change you may find your proportion of incidents or specialties coded as 'other' has increased between this and previous feedback reports.

SAMPLE

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