

Reporting of patient safety incidents

Why this fact is important

All NHS organisations (acute trusts, ambulance trusts, learning disability trusts, care trusts, mental health trusts, and primary care trusts), are linked to the National Reporting and Learning System for reporting patient safety incidents. A patient safety incident is defined as any unintended or unexpected event that could have or did lead to harm for a patient receiving NHS healthcare.

This shows, for each trust, in how many months out of the last six they reported an incident. Research shows that organisations that have consistently high levels of reporting of patient incidents are more likely to have a stronger safety culture, as this shows that they are committed to learning from incidents to prevent them reoccurring.

Things to note

Data are taken from the National Reporting and Learning Service, a division of the National Patient Safety Agency which manages the national reporting and learning system.

Data source

National Reporting Learning Service

Time period

2008/2009