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The Health Foundation Healthcare Leaders Panel

Survey 1: Patient Safety

Report & Table of Results

Prepared for : The Health Foundation
Prepared by : YouGov Limited
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PATIENT SAFETY

YouGov survey

for

The Health Foundation

In July 2004 YouGov started recruiting a panel of senior healthcare managers and clinicians throughout the United Kingdom on behalf of The Health Foundation.

To create the Healthcare Leaders Panel, YouGov has so far recruited more than 900 healthcare professionals in senior managerial roles, both clinical and non-clinical, within the NHS. Members range from Chief Executives of NHS Trusts to Directors of Nursing, Health and Safety leads and Directors of Finance. The panel represents healthcare leaders across Great Britain and Northern Ireland and covers the full range of NHS healthcare bodies, from Primary Care Trusts and Local Health Boards to Foundation Trusts and Patient Forums. . The panel will later be expanded to include senior managers in both private and not-for-profit healthcare sectors. The quarterly surveys will ascertain the views of these key healthcare decision-makers on issues of current importance and track their opinions over time on the general condition of the health service within the UK.

This is a report of YouGov's first survey, conducted online between 11 and 23 August 2004 among 513 members of the panel.

YouGov also put one of the questions to a sample of the general public, to compare its view of the underlying condition of the UK's healthcare system with that of healthcare leaders.

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Summary of Key Findings

- Just over half of the UK's healthcare leaders think the quality of care that their organisation provides to patients has improved over the past year – but only one in ten think they will have sufficient funds to improve and/or expand the service they provide in the current financial year.

- 72% of healthcare leaders, and 68% of the general public, think that "there are some good things in our healthcare system, but fundamental changes are needed to make it work better".

- Patient safety is seen as a serious problem for the health service. A large majority of healthcare leaders correctly estimate that more than one in ten hospital inpatients suffer a preventable "adverse event".

- Healthcare leaders divide evenly as to whether human error or system error is the greater cause of patient safety incidents in their own organisations. However clinicians within the sample divide two-to-one in saying that system error is the main factor.

- Asked to say how patient safety can best be improved, the three most beneficial measures are considered to be:

    - An organisational culture that encourages reporting and avoids blame
    - More emphasis on infection control, including hand-washing
    - Better communication between staff and patients

- Most clinicians consider that records of patient safety incidents should be kept confidential within the community of health organisations. Non-clinical managers divide evenly between this view and the belief that the information should be shared in some form with the general public

- Most clinicians say that patients and their families should be told when there has been a breakdown of patient safety as part of their care, if they have suffered harm. Most non-clinical managers say patients should be told, even if they have suffered no harm.

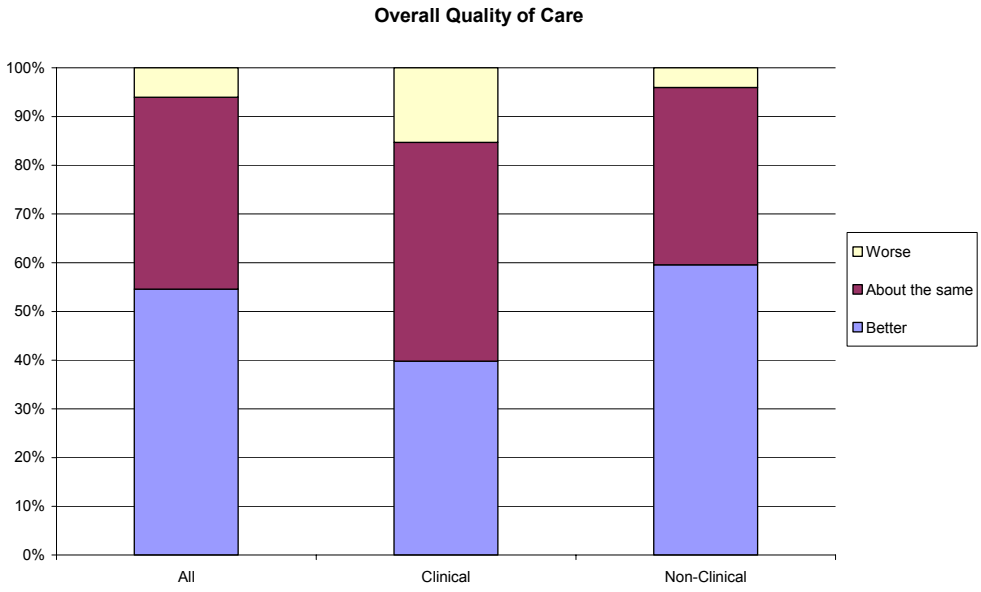
1. The state of healthcare in the UK today

The first section of the survey asked about healthcare leaders' views of the health service. The same questions will be asked on a quarterly basis to build a picture of how attitudes towards the state of healthcare in the UK are changing over time.

Just over half of the UK's healthcare leaders think the quality of care that their organisation provides to patients has improved over the past year – but only one in ten think they will have sufficient funds to improve and/or expand the service they provide in the current financial year.

Clinicians have a bleaker view than non-clinical managers. Just 39% of clinicians, but 59% of non-clinical managers, say quality has improved over the past year. And only 20% of clinicians, compared with 33% of non-clinical managers, think their organisation will be able to maintain or improve the service their organisation provides this year.

Fig. 1 Compared to this time last year, do you think the overall quality of care provided to patients in your organisation is:



	All	Clinical	Non-Clinical
[Base]	*513*	*99*	*386*
	%	*%*	*%*
Compared to this time last year, do you think the overall quality of care provided to patients in your organisation is:			
Better	54	39	59
Worse	6	15	4
About the same	39	44	36
Not sure	1	1	2

	All	Clinical	Non-Clinical
[Base]	*513*	*99*	*386*
	%	*%*	*%*
This year, is the amount of funding available for your organisation…			
Sufficient for care to be improved and/or expanded	10	6	10
Sufficient for maintaining current levels of service	22	14	23
Not quite sufficient for maintaining current levels of service	43	41	44
So insufficient that patient care is compromised	23	36	20
Not sure	2	2	2

However, healthcare leaders do not think extra money is enough. Three out of four of them want fundamental changes in the system itself. The general public is even more hard-line. While only 2% of healthcare leaders think 'our healthcare system has so much wrong with it that we need to completely rebuild it', this view is held by 11% of the wider electorate.

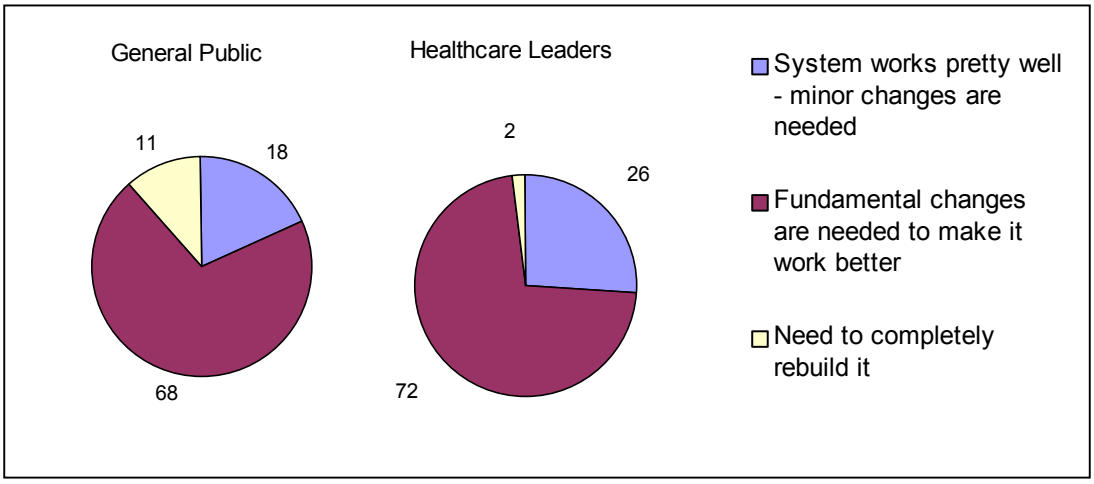


Fig. 2 Which of the following statements comes closest to describing your overall view of the healthcare system in the UK?

	Healthcare Leaders	General Public *
[Base]	*513*	*2,051*
	%	*%*
Which of the following statements comes closest to describing your overall view of the healthcare system in the UK?		
'On the whole the system works pretty well and only minor changes are needed to make it work better'	26	18
'There are some good things in our healthcare system, but fundamental changes are needed to make it work better'	72	68
'Our healthcare system has so much wrong with it that we need to completely rebuild it'	2	11
Not sure	1	3

*You Gov questioned a representative sample of 2,051 electors throughout Great Britain between 24 and 26 August 2004

Healthcare leaders were also asked the same question about 'the healthcare system for the part of the UK in which your organisation is based'. Their responses were very similar, largely refuting any suggestion that there might be a difference between perceptions of the healthcare system in the UK as a whole, and perceptions of the state of that system in the part of the UK respondents know best.

YouGov will track the views of healthcare leaders on these issues in subsequent surveys.

2. Awareness of adverse events in UK hospitals

In order to understand the level of awareness amongst healthcare leaders of patient safety incidents, respondents were asked two questions about the numbers of patient incidents in UK hospitals – what proportion of inpatients experience an adverse incident and how many patients die each year as a result of breakdowns in patient safety. (Respondents to the survey were asked to consider 'adverse event' and 'breakdowns in patient safety' as referring only to '*preventable* events that harm or narrowly avoid harming patients'.)

A clear majority said that fewer than 15% of hospital inpatients experience such an 'adverse event'. Excluding those who said 'don't know', a clear majority also replied that fewer than 10,000 patients die each year as a result of preventable breakdowns in patient safety.

How accurate are these estimates? There is no aggregate national data. The nearest we have is an analysis by Vincent et al[1], based on detailed records kept by two hospitals. This suggests that around 10% of inpatients suffer an 'adverse event' – or 800,000 out of 8.5 million inpatients per year – of which around half are thought to be preventable. Of these 400,000 preventable adverse events, 1 in 10 are estimated to result in the death of a patient, meaning that 40,000 patients die each year as a result of breakdowns in patient safety. If these extrapolated figures are accurate, then it would seem that healthcare leaders are fairly accurate in estimating the number of patients who experience preventable adverse events, but tend to underestimate the number who die as a result.

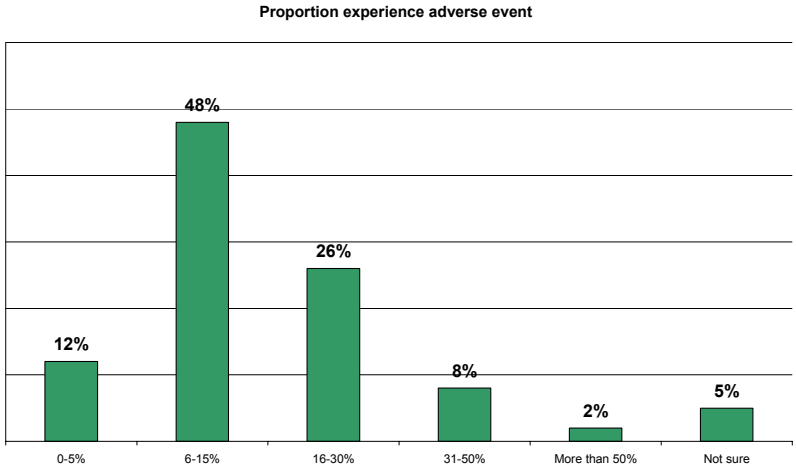


Fig. 3 From what you know, what proportion of the UK's hospital in-patients do you think experience an adverse event?

[1] *Vincent, Neale and Woloshynowych. Adverse events in British hospitals: Preliminary retrospective record review. British Medical Journal/ Vol 322. 3 March 2001*.

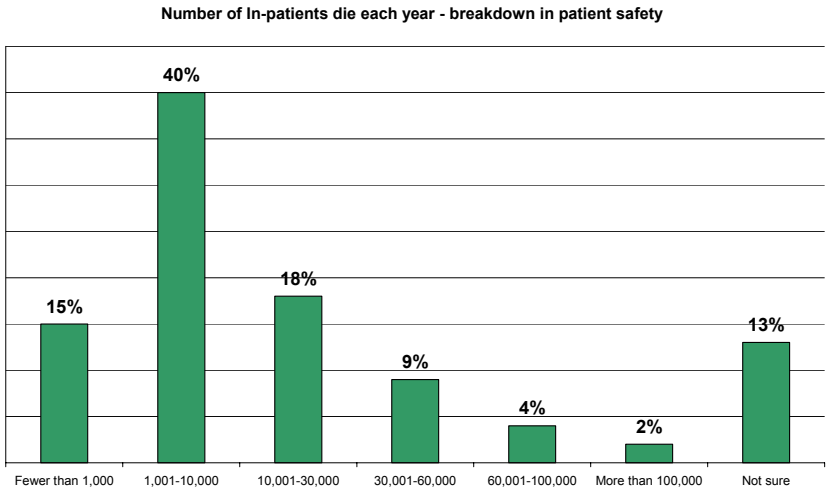


Fig. 4 For the UK as a whole, how many hospital in-patients do you think die each year as result of a breakdown in patient safety?

3. Patient safety – current practices

Most healthcare leaders say that improving patient safety is a high, but not top, priority for their organisation. Asked to give marks out of ten, from 0 = very low priority, to 10 = single most important priority, half the sample awarded their own organisation 7 or 8. The mean score was 7.1.

	Healthcare Leaders	Clinical	Non-Clinical
[Base]	*513*	*99*	*386*
	%	*%*	*%*
In your organisation, how high a priority is it to improve patient safety? (In this scale, 0 = very low priority, 10 = the organisation's single most important priority)			
0	0	1	0
1	0	0	0
2	1	1	1
3	2	3	2
4	5	5	5
5	10	16	9
6	12	12	11
7	24	30	23
8	27	24	27
9	9	3	10
10	9	4	10
Not sure	1	0	2
Mean Score	**7.1**	**6.6**	**7.2**

There was some difference between clinical and non-clinical respondents. Among clinicians, 26% awarded their organisation 5 marks or fewer, while only 7% awarded it 9 or 10. Among non-clinicians, just 17% awarded their own organisation 5 points or fewer, while 20% awarded it 9 or 10.

Respondents were then asked to say which, if any, of six measures their organisation took to improve safety. They had the opportunity to list as many measures as applied. On

average they ticked three. Almost nine out of ten say their organisation has a central reporting system for all patient safety incidents. Most say that information generated from their reporting systems leads directly to changes, and that patient safety features 'regularly' on board or management agendas.

While two out of three organisations have an executive board member responsible for patient safety, only one in five respondents say their division or department has an official patient safety champion. Just over one in three say that staff in their division or department regularly receive training in patient safety.

[Base]	*513*
	%
Which of the following measures does your organisation currently employ to improve patient safety?	
The organisation has a central reporting system for all patient safety incidents	88
Information generated through risk registers and incident reporting systems leads directly to changes	73
There is an executive board member responsible for patient safety	65
Patient safety regularly features on Board or management team meeting agendas	64
Staff in your division or department regularly receive training in patient safety	38
There is an official patient safety champion in your division or department	21
None of these	2
Not sure	3

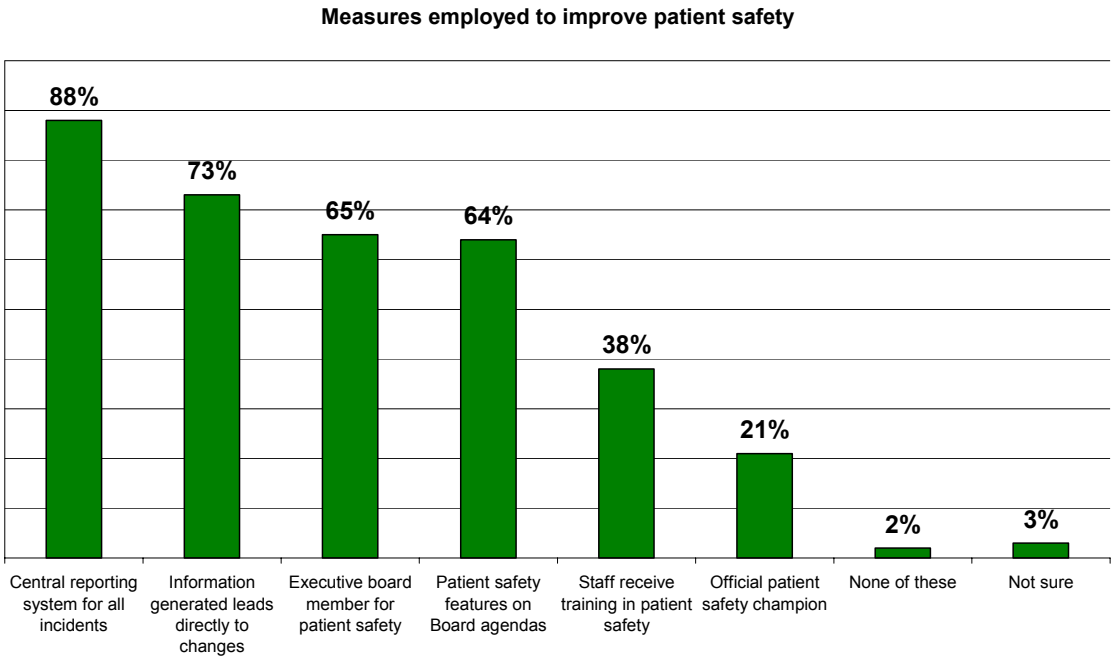


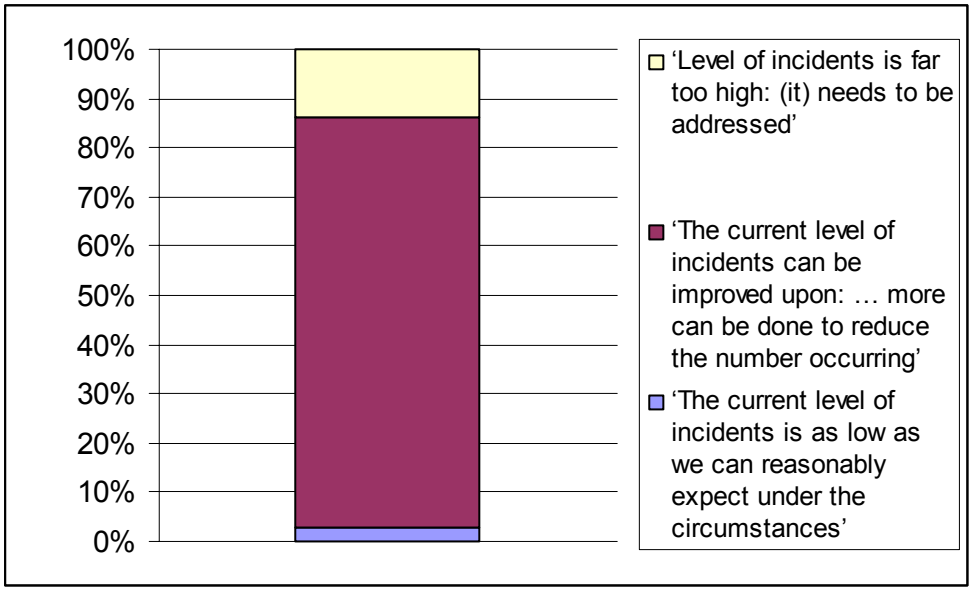
Fig. 5 Which of the following measures does your organisation currently employ to improve patient safety?

Respondents were evenly divided on whether human error or system error was the greater cause of patient safety incidents in their own organisation. 47% said system error, compared with 42% who said human error. In a sample of 513, this five-point margin is not statistically significant. However, it should be noted that clinical respondents divided two-to-one in saying that system error (63%) rather than human error (33%) is the greater problem, while non-clinical respondents divided almost exactly equally (44% system error, 43% human error)

Asked about the health service as a whole, there was a slightly greater tendency to plump for system error (53%) rather than human error (40%); but the striking thing is how similar these figures are to those for 'your own organisation', rather than how different.

Healthcare leaders are virtually unanimous in saying that there is room for improvement, but only one in seven thinks that the problem is so vast that fundamental changes are needed.

Fig. 6 Thinking about the current level of patient safety incidents occurring in the health service as a whole, which of the following comes closest to your view?



[Base]	*513*
	%
Thinking about the current level of patient safety incidents occurring in the health service as a whole, which of the following comes closest to your view;	
'The current level of incidents is as low as we can reasonably expect under the circumstances: there is a certain level of incidents which cannot be eliminated'	3
'The current level of incidents can be improved upon: there will probably always be some incidents but more can be done to reduce the number occurring'	83
'The current level of incidents is far too high: there is something going wrong that needs to be addressed'	14
Not sure	1

4. Patient safety – how to improve it

Our panel was invited to say which five, from a list of 15 possible measures, would be most beneficial in improving patient safety. The two most widely supported were: a culture that encourages reporting and avoids blame (80%) and more emphasis on infection control (73%). There was little support for reducing junior hospital doctors' hours to avoid mistakes (13%) or relaxing the penalties on staff who make mistakes (4%). On the other hand, only two respondents (therefore statistically 0%) wanted stronger penalties for staff who makes mistakes, while just 4% think matters would be improved by a government agency with the power to punish hospitals which have too many patient safety incidents.

Clinical and non-clinical respondents broadly shared their sense of priorities, although relatively speaking, clinical staff give a higher priority than their non-clinical colleagues to including pharmacists on hospital rounds and increasing the number of hospital nurses.

	Healthcare Leaders	Clinical	Non-Clinical
[Base]	*513*	*99*	*386*
	%	*%*	*%*
Here is a list of some possible steps that could be used to improve patient safety. Please select the 5 you think would be most beneficial.:			
An organisational culture that encourages reporting and avoids blame	80	72	83
More emphasis on infection control, including hand washing	73	76	73
Better communication between staff and patients	64	57	65
Better training of health professionals	56	45	59
Standardisation of medical equipment and devices	49	44	49
Using computerised patient records	34	31	35
Making greater use of IT in dispensing and administering medication	31	38	28
Including a pharmacist on hospital rounds	29	44	26
Increasing the number of hospital nurses	22	31	19
Stronger leadership from Board members	20	16	21
Confidential reporting of patient safety incidents to an independent agency	14	14	13
Reducing junior doctors' hours to avoid fatigue	13	5	15
Relaxation of penalties for staff who make mistakes	4	6	3
Having a Government regulatory agency sanction hospitals for too many patient safety incidents	4	3	4
Stronger penalties for staff who make mistakes	0	0	1

5. What information should be given, and to whom?

Non-clinical healthcare managers are fairly evenly divided between those who think that records of patient safety incidents should be kept confidential within the community of health organisations, and those who think the information should be supplied in some form to the general public. However, a majority of more than two-to-one among clinical respondents consider that such information should be confined to the community of health organisations:

	Clinical	Non-Clinical
[Base]	*99*	*386*
	%	*%*
Should records of patient safety incidents be kept confidential and only used to learn how to prevent similar problems in the future, or should they be made publicly available (without breaching the confidentiality of individual patients)?		
Kept confidential within the organisation	1	2
Shared in confidence with other health organisations	66	47
Released to the public	2	4
Released to the public, accompanied by additional explanations	27	45
Don't know	4	2

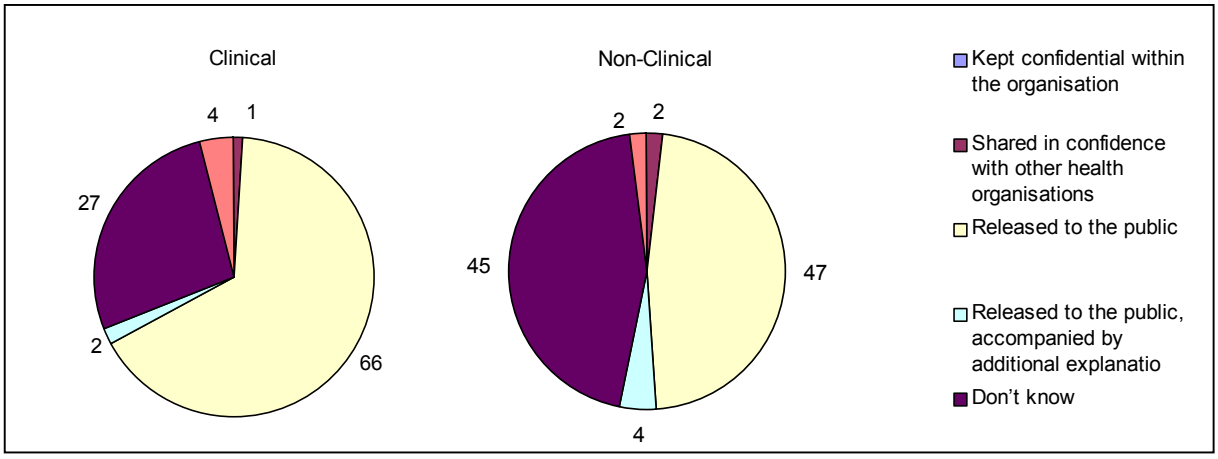


Fig. 7 Should records of patient safety incidents be kept confidential and only used to learn how to prevent similar problems in the future, or should they be made publicly available (without breaching the confidentiality of individual patients)?

What about patients and their families – should they be told when there has been a breakdown in patient safety as part of their care? In this instance, nearly every respondent was in favour of disclosure in some form: more than half took the stronger view that patients or families should be told whether or not the patient has suffered any harm. A further 38% said they should be told when some harm, however slight, has occurred. Just 8% said patients or their families should be told only when the result has been significant harm.

Non-clinical managers tend to favour disclosure more than clinicians: 55% of non-clinicians said patients should be told even when no harm has been done; the figure for clinical respondents is 40%. Only 6% of non-clinical managers think information should be confined to those occasions when significant harm has been done; three times as many clinical respondents, 18%, hold this view.

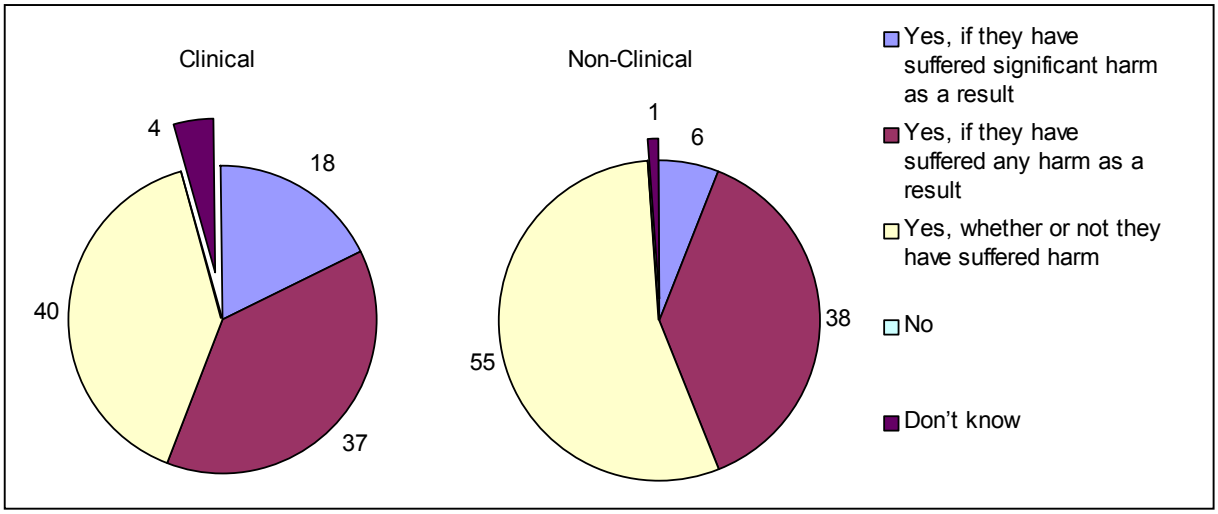
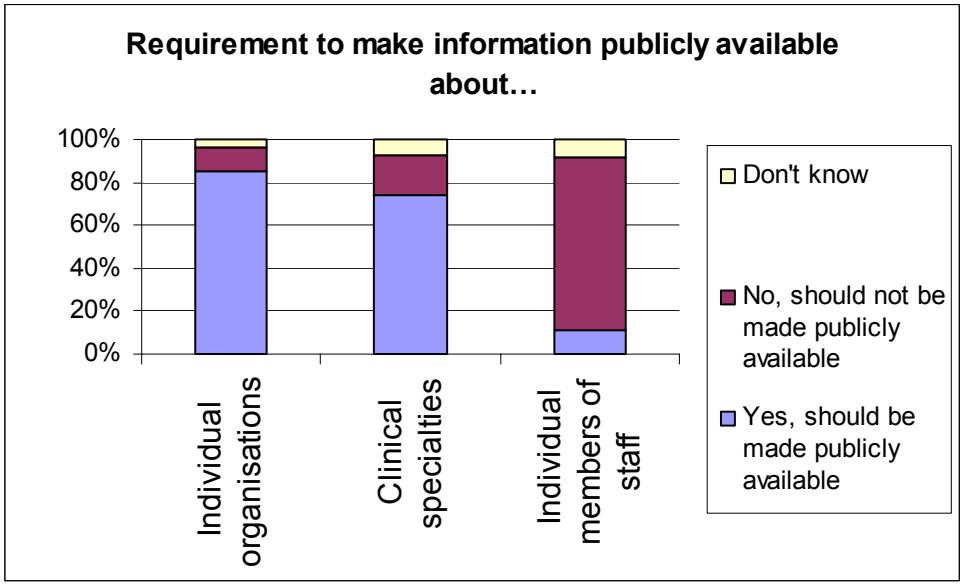


Fig. 8 Should patients or their families be told when a breakdown in patient safety has happened as part of their treatment or care?

There is a broad consensus that information should be made publicly available about the patient safety performance of organisations and clinical specialities, but not of individual members of staff:

Fig. 9 Should there be a requirement to make information publicly available about the patient safety performance of:



Should there be a requirement to make information publicly available about the patient safety performance of:

513	**Individual organisations %**	**Clinical specialties %**	**Individual members of staff %**
Yes, should be made publicly available	85	74	11
No, should not be made publicly available	11	19	81
Don't know	4	7	8

The minority of clinical respondents who opposed disclosure was larger than the minority of non-clinical respondents. For example, 31% of clinicians, compared with 16% of managers, opposed the disclosure of information about clinical specialities. Even so, a clear majority of clinicians, 61%, supported disclosure.

6. Patient involvement

Currently, patients are occasionally, but not routinely, involved in activities to improve safety and reduce risk. Only one respondent told us that 'all patients are actively involved'; six per cent said that most patients are involved. The biggest group, 46%, stated that 'some patients are actively involved', but as many as 30% said that 'patients are not actively involved'. An unusually high proportion, 18%, did not know whether patients were involved or not – an indicator that this is not yet a central issue for many healthcare leaders.

One in four healthcare leaders think most or all patients know enough about their condition to play a major role in improving the safety of their care. However, four in ten think few if any patients know enough.

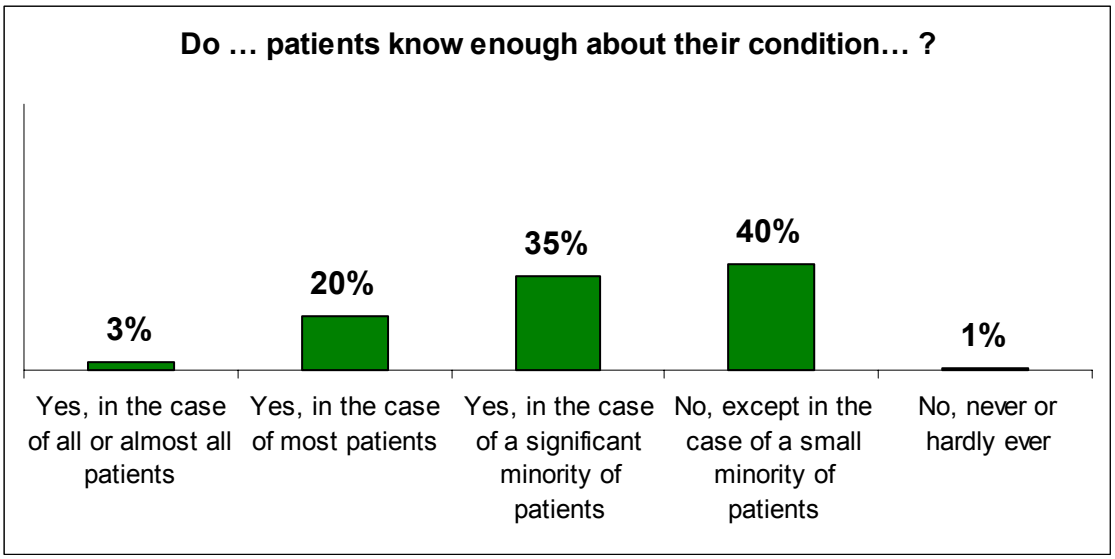


Fig. 10 In general, do you think patients know enough about their condition, such as their medication, possible side effects, or complications, to play an active role in improving the safety of their care?

[Base]	*513*
	%
In general, do you think patients know enough about their condition, such as their medication, possible side effects, or complications, to play an active role in improving the safety of their care?	
Yes, in the case of all or almost all patients	3
Yes, in the case of most patients	20
Yes, in the case of a significant minority of patients	35
No, except in the case of a small minority of patients	40
No, never or hardly ever	1
Not sure	1

Appendix: Interpretation of Survey Findings

i. Samples & Sub-Samples

This research is based on a sample of 513 senior healthcare managers and decision-makers across the United Kingdom. No weighting has been applied to the data. YouGov provided a breakdown of results for the sample based on single or multiple variables including types, demographics or attitude classifications.

The research uses routing so that questions were asked only of appropriate groups. Routing can take place based on a single or multiple variables. Attention should therefore be paid to the base for each question – these are clearly marked on the tables of results.

ii. Notes on values displayed

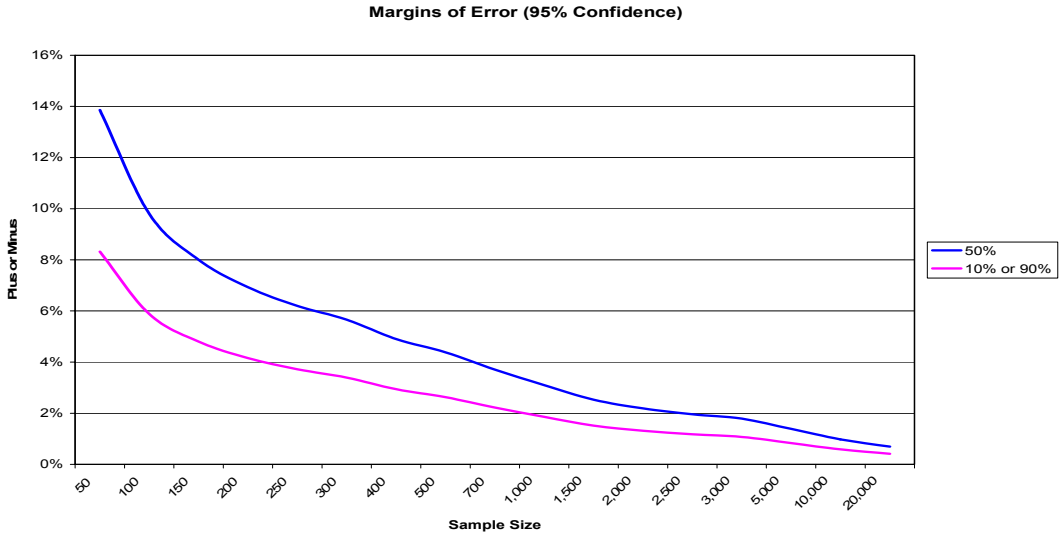
Values displayed are given in percentages, rounded to the nearest integer. Where percentages do not add up to 100, this may be due to rounding, the exclusion of "don't know" categories, or multi-choice questions in which each value is out of 100%.

iii. Error Margins

Findings are subject to the normal error margins for sample surveys - these are small for relatively large sample sizes. YouGov provides extensive tabular analysis; this can result in relatively small numbers of respondents in some sub-samples. Some findings may be drawn from small sub-samples for which the margins of error may be high (see statistical reliability below). Care should be taken when interpreting findings based on answers from a small number of respondents.

iv. Statistical reliability

The respondents to the questionnaire are only samples of the total "population", so we cannot be certain that the figures obtained are exactly those we would have if everybody had been interviewed (the "true" values). We can however, predict the variation between the sample results and the "true" values from a knowledge of the size of the samples on which the results are based and the number of times a particular answer is given. The confidence with which we can make this prediction is usually chosen to be 95%. The chart below indicates the predicted ranges for different sample sizes and percentage results at the 95% confidence interval.



YouGov Survey Results: Patient Safety

Prepared for The Health Foundation Healthcare Leaders Panel

Fieldwork dates: 11th - 23rd August, 2004
Sample Size: 513 senior healthcare leaders

Tracking Questions: General

[TEXT] The survey begins with four general questions about the state of the health service. We will be asking these same questions each time we do a survey to see how people's views change over time.

	Total	Clinical vs non-Clinical	
		Clinical	Non-Clinical
Base	**513**	99	386
Which of the following statements comes closest to describing your overall view of the healthcare system in the UK?			
On the whole the system works pretty well and only minor changes are needed to make it work better'	**26**	27	26
There are some good things in our healthcare system, but fundamental changes are needed to make it work better'	**72**	70	72
Our healthcare system has so much wrong with it that we need to completely rebuild it'	**2**	3	1
Not sure	**1**	0	1
And which of the statements comes closest to describing your overall view of the healthcare system for the part of the UK in which your organisation is based?			
There are some good things in our healthcare system, but fundamental changes are needed to make it work better'	**71**	70	71
Our healthcare system has so much wrong with it that we need to completely rebuild it'	**3**	5	3
Not sure	**1**	0	1
Compared to this time last year, do you think the overall quality of care provided to patients in your organisation is:			
Better	**54**	39	59
Worse	**6**	15	4
About the same	**39**	44	36
Not sure	**1**	1	2
This year, is the amount of funding available for your organisation…			
Sufficient for care to be improved and/or expanded	**10**	6	10
Sufficient for maintaining current levels of service	**22**	14	23
Not quite sufficient for maintaining current levels of service	**43**	41	44
So insufficient that patient care is compromised	**23**	36	20
Not sure	**2**	2	2

Patient Safety - awareness

[TEXT] The rest of this survey focuses on patient safety. While the health service treats the majority of patients safely and successfully, some patients suffer harm as a result of the treatment and care they receive. Some of these incidents are unavoidable, but many can be prevented. The questions that follow use the terms 'patient safety incident' and 'breakdown in patient safety' to describe preventable events that harm or narrowly avoid harming patients.

	Total	Clinical vs non-Clinical	
		Clinical	Non-Clinical
Base	**513**	99	386
For the UK as a whole, how many hospital in-patients do you think die each year as result of a breakdown in patient safety?			
Fewer than 1,000	**15**	12	16
1,001-10,000	**40**	40	40
10,001-30,000	**18**	24	16
30,001-60,000	**9**	7	9
60,001-100,000	**4**	4	3
More than 100,000	**2**	0	2
Not sure	**13**	12	14
From what you know, what proportion of the UK's hospital in-patients do you think experience an adverse event?			
0-5%	**12**	7	14
6-15%	**48**	51	46
16-30%	**26**	28	25
31-50%	**8**	8	8
More than 50%	**2**	2	2
Not sure	**5**	4	6
In your organisation, how high a priority is it to improve patient safety? (In this scale, 0 = very low priority, 10 = the organisation's single most important priority)			
0	**0**	1	0
1	**0**	0	0
2	**1**	1	1
3	**2**	3	2
4	**5**	5	5
5	**10**	16	9
6	**12**	12	11
7	**24**	30	23
8	**27**	24	27
9	**9**	3	10
10	**9**	4	10
Not sure	**1**	0	2
Mean Score:	***7.08***	*6.59*	*7.21*

Patient Safety - What happens at present

[TEXT] The next set of questions ask what currently happens in the organisation where you work, and within the health service as a whole. Again, the terms ‘patient safety incident’ and ‘breakdown in patient safety’ are used to describe preventable events that harm or narrowly avoid harming patients.

Which of the following measures does your organisation currently employ to improve patient safety? (Please tick all that apply):

The organisation has a central reporting system for all patient safety incidents	**88**	92	87
Information generated through risk registers and incident reporting systems leads directly to changes	**73**	63	75
There is an executive board member responsible for patient safety	**65**	59	66
Patient safety regularly features on Board or management team meeting agendas	**64**	64	63
Staff in your division or department regularly receive training in patient safety	**38**	35	38
There is an official patient safety champion in your division or department	**21**	23	21
None of these	**2**	2	2
Not sure	**3**	2	4

Patient Safety - What happens at present

	Total	Clinical vs non-Clinical	
		Clinical	Non-Clinical
Base	**513**	99	386
Thinking about your own organisation, which of these do you think is the greater cause of patient safety incidents:			
Human error by doctors, nurses or other members of staff	**42**	33	43
System error	**47**	63	44
Not sure	**11**	4	13
And thinking about the health service as a whole, which of these do you think is the greater cause of patient safety incidents:			
Human error by doctors, nurses or other members of staff	**40**	30	41
System error	**53**	67	49
Not sure	**8**	3	9
Thinking about the current level of patient safety incidents occurring in the health service as a whole, which of the following comes closest to your view;			
'The current level of incidents is as low as we can reasonably expect under the circumstances: there is a certain level of incidents which cannot be eliminated'	**3**	3	3
'The current level of incidents can be improved upon: there will probably always be some incidents but more can be done to reduce the number occurring	**83**	79	84
'The current level of incidents is far too high: there is something going wrong that needs to be addressed'	**14**	18	12
Not sure	**1**	0	1

Patient Safety - How to improve

[TEXT] The next set of questions looks at ways of improving patient safety.

	Total	Clinical vs non-Clinical	
		Clinical	Non-Clinical
Base	**513**	99	386
Here is a list of some possible steps that could be used to improve patient safety. Please select the 5 you think would be most beneficial.:			
An organisational culture that encourages reporting and avoids blame	**80**	72	83
More emphasis on infection control, including hand washing	**73**	76	73
Better communication between staff and patients	**64**	57	65
Better training of health professionals	**56**	45	59
Standardisation of medical equipment and devices	**49**	44	49
Using computerised patient records	**34**	31	35
Making greater use of IT in dispensing and administering medication	**31**	38	28
Including a pharmacist on hospital rounds	**29**	44	26
Increasing the number of hospital nurses	**22**	31	19
Stronger leadership from Board members	**20**	16	21
Confidential reporting of patient safety incidents to an independent agency	**14**	14	13
Reducing junior doctors' hours to avoid fatigue	**13**	5	15
Relaxation of penalties for staff who make mistakes	**4**	6	3
Having a Government regulatory agency sanction hospitals for too many patient safety incidents	**4**	3	4
Stronger penalties for staff who make mistakes	**0**	0	1
None of these	**0**	0	0
Should records of patient safety incidents be kept confidential and only used to learn how to prevent similar problems in the future, or should they be made publicly available (without breaching the confidentiality of individual patients)?			
Kept confidential within the organisation	**2**	1	2
Shared in confidence with other health organisations	**50**	66	47
Released to the public	**4**	2	4
Released to the public, accompanied by additional explanation	**42**	27	45
Don't know	**3**	4	2
Should patients or their families be told when a breakdown in patient safety has happened as part of their treatment or care?			
Yes, if they have suffered significant harm as a result	**8**	18	6
Yes, if they have suffered any harm as a result	**38**	37	38
Yes, whether or not they have suffered harm	**52**	40	55
No	**0**	0	0
Don't know	**2**	4	1

Patient Safety - How to improve

	Total	Clinical vs non-Clinical	
		Clinical	Non-Clinical
Base	**513**	99	386
Should there be a requirement to make information publicly available about the patient safety performance of:			
Individual organisations			
Yes, should be made publicly available	**85**	74	88
No, should not be made publicly available	**11**	20	9
Don't know	**4**	6	3
Clinical specialties			
Yes, should be made publicly available	**74**	62	77
No, should not be made publicly available	**19**	31	16
Don't know	**7**	7	7
Individual members of staff			
Yes, should be made publicly available	**11**	7	12
No, should not be made publicly available	**81**	85	80
Don't know	**8**	8	8

Patient Safety - How to improve

[TEXT] The final set of questions look at whether patients can have a role in reducing patient safety incidents.

	Total	Clinical vs non-Clinical	
		Clinical	Non-Clinical
Base	**513**	99	386
In general, do you think patients know enough about their condition, such as their medication, possible side effects, or complications, to play an active role in improving the safety of their care?			
Yes, in the case of all or almost all patients	**3**	2	3
Yes, in the case of most patients	**20**	20	20
Yes, in the case of a significant minority of patients	**35**	42	33
No, except in the case of a small minority of patients	**40**	34	42
No, never or hardly ever	**1**	1	1
Not sure	**1**	0	1
In your organisation, are patients actively involved in activities to improve safety and reduce risk?			
Yes, all patients are actively involved	**0**	0	1
Yes, most patients are actively involved	**6**	6	6
Yes, some patients are actively involved	**46**	46	46
No, patients are not actively involved	**30**	34	28
Not sure	**18**	13	19

YouGov Survey Results: Patient Safety

Prepared for The Health Foundation Healthcare Leaders Panel

Fieldwork dates: 24th - 26rd August, 2004
Sample: 2051 (weighted to the profile of the GB adult population)

	Total	Gender		Age			Region					Social Grade	
		Male	Female	18 to 29	30 to 50	Over 50	London	Rest of South	Midlands & Wales	North	Scotland	ABC1	C2DE
Weighted N	**2080**	988	1092	417	711	952	312	520	522	519	207	1029	1051
Unweighted N	**2051**	1036	1015	490	764	797	458	456	439	487	210	1054	997
Which of the following statements comes closest to describing your overall view of the healthcare system in the UK?													
'On the whole the system works pretty well and only minor changes are needed to make it work better'	**18**	24	13	16	17	20	16	17	20	20	14	20	16
'There are some good things in our healthcare system, but fundamental changes are needed to make it work better'	**68**	60	74	67	71	65	69	68	65	69	69	67	68
'Our healthcare system has so much wrong with it wrong with it that we need to completely rebuild it'	**11**	12	11	10	10	12	14	10	13	9	13	11	12
Not sure	**3**	4	3	7	2	3	2	5	2	2	5	2	4