NHS Improvement

Guidance notes on National Reporting and Learning System organisation patient safety incident reports

September 2016

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1. What is the National Reporting and Learning System?

The primary purpose of the National Reporting and Learning System (NRLS) is to enable learning from patient safety incidents occurring in the NHS. The NRLS was established in late 2003 as a voluntary scheme for reporting patient safety incidents, so it does not provide the definitive number of patient safety incidents occurring in the NHS.

For more information on the NRLS click here.

2. How are the NRLS data collected?

The NRLS collects data on patient safety incidents in England and Wales. Most patient safety incident reports are submitted electronically from local NHS organisation risk management systems. Organisations vary in how their local systems are set up, how many incidents are reported locally and how frequently they send data to the NRLS.

For more information on how the data is collected click here.

3. Why are these data published?

A greater level of transparency, together with more thorough reporting and analysis of safety-related incidents, provides a real opportunity for the NHS at a local level and the NRLS at a national level to share experiences and learn from them. The transparency agenda is a pan-government initiative, in which healthcare data figures prominently. These organisation patient safety incident reports (OPSIR) Official Statistics are made available to the public to make data on patient safety incident reports from the NRLS more accessible. Patients, the public, academics, NHS commissioners and other organisations can all access the data and make comparisons that enable more informed choices.

Increased transparency is key to:

- improving outcomes and productivity in NHS services
- promoting higher quality and more efficient services, choice and accountability
- facilitating enhanced commissioning
- driving economic growth by enabling the development of tools to support users, commissioners and providers of NHS services.

4. In what format are the data published?

Since September 2011, these data have been published as data workbooks (in Excel and CSV formats). Further information about individual organisations can also be accessed via the online NRLS Explorer Tool.

5. These data have been designated as UK Official Statistics. What does this mean?

A general definition is that these are statistics at national level, which are of public interest. The Statistics and Registration Service Act 2007 defines 'Official Statistics' as all statistical outputs produced by the UK Statistics Authority's executive office (the Office for National Statistics), by central government departments and agencies, by the devolved administrations in Northern Ireland, Scotland and Wales, and by other Crown bodies (over 200 bodies in total). The production of such statistics should follow the UK Statistics Authority Code of Practice for Official Statistics, ensuring that these statistics are produced, managed and disseminated to high standards, and that they are well explained in a subjective and impartial manner.

6. How often are the data published?

Every six months, in March and September.

7. Why are two datasets used?

To describe NRLS patient safety incident data as accurately as possible, we use two different datasets:

The 'reported dataset' is used to look at patterns in reporting. It contains incidents that were reported to the NRLS within a specific time period.

The 'occurring dataset' is used to look at patient safety incident characteristics. It contains incidents that have been reported as actually taking place within the specific time period (there are often lags between an incident occurring and being reported to the NRLS). This is because there is seasonality in patterns of patient safety incidents.

For more information on seasonality in patient safety incidents click here.

8. Which organisation is the highest reporter and which is the lowest?

There is no 'correct' or 'safe' number of patient safety incidents: a 'low' reporting rate should not be interpreted as a 'safe' organisation, and may represent under- reporting; a 'high' reporting rate should not be interpreted as an 'unsafe' organisation, and may actually represent a culture of greater openness.

An organisation with a low reporting rate does not necessarily mean that it is 'safe' or 'good', nor does it follow that an organisation with a high reporting rate is 'unsafe' or 'bad'. There are known reasons for 'high' and 'low' reporting. Some organisations report daily, others quarterly. In many cases, incidents are grouped and submitted to the NRLS in large batches. It should never be assumed that the total numbers of

patient safety incidents are representative of totals across the NHS. The reporting culture varies between organisation types: reporting in secondary care is far more common than in primary care; ambulance and mental health organisations have the most varied reporting patterns.

For more information on issues impacting on the quantity of incidents reported (including changes in national reporting requirements) click here.

9. Can the data be expanded to cover the whole of England and Wales?

Different NHS organisations provide different services, and serve different populations. Therefore, to make comparisons as meaningful as possible the NRLS groups NHS organisations into 'clusters' of similar organisations. (NRLS data for the whole of England and the whole of Wales are published, by care setting, in the quarterly data summary (QDS) workbooks.)

For more information on the NRLS clusters click here.

For a list of the organisations within each NRLS cluster click here.

10. Why are the rates in the ambulance cluster not measured per 100,000 ambulance journeys?

For ambulance trusts we had previously calculated the rate of reported incidents per 100,000 journeys. Feedback from stakeholders stressed that this was not an appropriate denominator. Directly comparing the number of reports received from one ambulance organisation with another would be misleading, as ambulance organisations vary considerably in size and activity.

11. What if the data in the summary report do not match the local organisations' own records?

This dataset is based on the date an incident report was successfully submitted to the NRLS. Incident reports have been included if they occurred between 1 October 2015 and 31 March 2016 and were submitted by 31 May 2016. If the number of reports in the local database is different this may be because the incidents were not submitted to the NRLS by 31 May 2016, or because the incidents did not meet national data quality checks (eg the NRLS may reject incident reports if mandatory fields are not completed).

Every month the NRLS shares provisional data back with the submitting organisation to help identify possible data quality problems. This gives organisations the opportunity to check the data the NRLS has received and compare it with data in their local risk management system in a timely manner.

12. How do I know if there have been any ‘issues’ highlighted with an organisation’s data?

There can be legitimate reasons and/or obstacles to uploading incidents to the NRLS: some organisations may report very few incidents (ie 10 or fewer incidents) as occurring during the specified time period.

Where an organisation has reported 10 or fewer incidents as occurring during the specific time period, statistics (such as percentages and medians) are not calculated and comparisons are not made. Statistics based on such small numbers are unreliable, as it is almost impossible to distinguish random fluctuation from true changes in the statistic.

Rates are very important in comparing information from one patient population to another. A rate is the measure of frequency of occurrence of a phenomenon in the population under study – in other words how often something happens. It can be thought of as a measure of risk, taking into account the individual’s exposure to risk, and is defined as:

$$\frac{\text{Patient safety incidents}}{\text{Potential opportunities for those incidents to occur}}$$

For this rate to be valid, reliable, and therefore meaningful, both the numerator and denominator need to be as accurate as possible. Rates have always been used to describe the NRLS reporting data.

There are a number of complexities that arise when calculating reporting rates. More information is given in the Data handling notes.

13. What action will be taken if an organisation is a consistently low reporter?

Are they offered any particular support or guidance?

The NRLS encourages consistent, high reporting, which provides organisations with more opportunities to learn from incidents and improve safety. Research has found that high reporting is associated with other indicators of a strong safety culture.

The NRLS team are concerned about organisations with low or inconsistent reports, and provide support and guidance to organisations with difficulties reporting to the NRLS. **Since April 2013, all incidents reported from NHS organisations – regardless of the reported degree of harm – have been shared with the Care Quality Commission.**

14. Where can I find other related information/resources?

www.nrls.npsa.nhs.uk/patient-safety-data/

improvement.nhs.uk/resources/patient-safety-alerts/

www.england.nhs.uk/ourwork/patientsafety/

15. How can I give feedback?

Please contact us at: nrls.datarequests@nhs.net

About NHS Improvement

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

This publication can be made available in a number of other formats on request.

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