

# NRLS national patient safety incident reports: commentary

March 2019

We support providers to give patients safe, high quality, compassionate care, within local health systems that are financially sustainable.

# Contents

1. Summary .....	2
2. Introduction.....	3
3. Incidents reported up to September 2018.....	8
4. Incidents reported as occurring from October 2017 to September 2018.....	9
5. Final remarks.....	15
6. Contact us for help .....	16

# 1. Summary

Reporting to the National Reporting and Learning System (NRLS) is largely voluntary, to encourage openness and continual increases in reporting.

Increases in the number of incidents reported reflects an improved reporting culture and should not be interpreted as a decrease in the safety of the NHS. Equally, a decrease cannot be interpreted as an increase in the safety of the NHS.

The number of incidents reported to the NRLS for England continues to increase. The 488,242 incidents reported from July to September 2018 represents a 4.1% increase on the number reported from July to September 2017 (485,156).

Nationally there are still peaks every six months in the number of incidents reported. This is when users submit large batches of data at the cut-off for the six-monthly official statistics publications.

Nationally, the overall profile of incident characteristics (incident type, degree of harm, care setting where the incident occurred) reported as occurring is consistent between October 2017 to September 2018 and October 2016 to September 2017.

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## 2. Introduction

This commentary interprets the data published in the national patient safety incident reports ([NaPSIR](#)) for England. NaPSIR provides data on patient safety incidents at a national level. We analyse data for the current 12- or three-month period being published, rather than by month or calendar or financial year. We make comparisons over time using the same 12- or three-month period but in a previous year. This is because of known seasonality in reporting patterns and when incidents occur. For example, the number of incidents **reported** peaks every May and November around the cut-offs for two of our data publications. So comparing consecutive periods may be misleading: for example, if the previous period included a known reporting peak.

The data and this commentary are part of a range of official statistics on patient safety incidents reported to the NRLS. Our other official statistic outputs are:

- organisation patient safety incident reports ([OPSIR](#))
- [monthly summary data](#) on patient safety incident reports.<sup>1</sup>

This document should be read alongside the [NaPSIR](#) data tables. The data contained in NaPSIR and OPSIR differs for the reasons listed in Table 1. Therefore the statistics are not comparable and numbers should not be expected to match.

Detailed information on how we manage data quality and revisions and corrections to the data is available on the [NaPSIR](#) webpage.

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<sup>1</sup> The monthly summary data will shortly be classified as [experimental statistics](#) and we are working to the code of practice for these statistics. Further information will be provided on our [webpages](#).

**Table 1: Main features of NaPSIR, OPSIR and monthly workbooks**

Feature	NaPSIR	OPSIR	Monthly summaries
<b>Purpose</b>	<p>To provide a national picture of the reporting of patient safety incidents and of the characteristics of incidents (type, care setting, degree of harm).</p> <p>This dataset forms the basis of the indicator 'improving the culture of safety reporting' in Domain 5 of the <a href="#">NHS outcomes framework</a> (treating and caring for people in a safe environment and protecting them from avoidable harm).</p>	<p>To provide data on individual organisations' reporting and patient safety characteristics.</p> <p>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.*</p>	<p>To provide timely data on reporting to the NRLS to encourage more consistent reporting and support organisations to monitor potential under-reporting of incidents.</p> <p>Data is provided by organisation, degree of harm and month of report to the NRLS. Organisations are not grouped into 'clusters'.</p>
<b>Dataset type</b>	Dynamic <sup>†</sup>	Fixed/static	Dynamic
<b>Dataset used</b>	Reported and occurring datasets <sup>‡</sup>	Reported and occurring datasets <sup>‡</sup>	Reported dataset <sup>‡</sup>
<b>Period covered</b>	<p>Reported dataset: rolling quarters from October to December 2003 to the most recent quarter available.</p> <p>Occurring dataset: rolling quarters covering the last four available quarters.</p>	The most recent six months only.	A rolling 12-month period covering the preceding 12 complete months of available data.
<b>Updated</b>	Every six months	Every six months	Every month
<b>Geography/breakdown</b>	All geographical locations, by care setting	England, by individual NHS organisation (organised by cluster)	England, by individual organisation

Feature	NaPSIR	OPSIR	Monthly summaries
<b>Inclusions</b>	<p>The following care settings:</p> <ul style="list-style-type: none"> <li>• acute/general hospital</li> <li>• mental health service</li> <li>• community nursing, medical and therapy service</li> <li>• learning disabilities service</li> <li>• ambulance service</li> <li>• general practice</li> <li>• community pharmacy</li> <li>• community and general dental service</li> <li>• community optometry/optician service</li> </ul>	<p>The following organisation types:</p> <ul style="list-style-type: none"> <li>• acute/general hospital</li> <li>• mental health service</li> <li>• community trust</li> <li>• ambulance service</li> </ul>	<p>The following organisation types:</p> <ul style="list-style-type: none"> <li>• acute/general hospital</li> <li>• mental health service</li> <li>• community trust</li> <li>• ambulance service</li> <li>• integrated care organisation</li> </ul>

\* [Information on clusters](#) is available in or accompanies the relevant publication.

† Figures for previous quarters may change slightly (figures for four consecutive quarters are given in each workbook for incidents ‘occurring’, from Tab 5 onwards) as the NRLS is a dynamic system (and incidents can be reported, or updated, at any time after the event).

‡ The reported dataset refers to incidents reported by, or within, a certain period. The occurring dataset refers to incidents occurring by, or within, a certain period. See above for more information.

## Overview of NRLS data collection and interpretation

The NRLS collects data on patient safety incidents in England and Wales. This commentary covers data reported by English organisations; data relating to Wales is available [online](#).

Most data is submitted to the NRLS from an NHS organisation’s local risk management system. A small number of reports are also submitted using online ‘[eForms](#)’ by individuals and organisations that do not have local risk management systems. More information is available in our [accompanying guidance notes](#).

Many factors affect how NRLS data and statistics are interpreted. Detailed information is available in our [accompanying guidance notes and data quality statement](#); this is a summary of factors influencing interpretation:

- Data reflects incidents reported to the NRLS, not the number of incidents actually occurring in the NHS.
- There can be a delay between an incident occurring and when it is reported to the NRLS, so we publish data based on the occurring dataset (the date when an incident is reported to have occurred) and the reported dataset (the date when the incident is reported to the NRLS). For any given period, the number of incidents occurring and incidents reported is unlikely to match.
- Reporting error and bias affect trends in the number of incidents reported to the NRLS; known sources include: the type of organisations that report to us; the type of incidents reported; changes in policy; seasonality in when incidents are reported and when incidents occur (as detailed above); delays in reporting incidents to us.

It is important to consider these factors when interpreting or comparing any NRLS data over time.

## Changes to patient safety data outputs

The [Development of the Patient Safety Information Management System \(DPSIMS\) project](#) will replace the existing NRLS, changing the way information is collected to make it easier to record patient safety incidents and to analyse and learn from the information shared with NHS Improvement. This will support learning and improvement in the safety of NHS-funded services.

These improvements mean any output using the patient safety data currently collected on the NRLS will also change, including the OPSIR data tables and associated outputs.

We are using [agile methodology](#) to build the new system which means we constantly refine it in response to user need. Table 2 provides estimates of what will change and when but as this approach means things can change rapidly, these estimates are difficult to make with any certainty. We will provide more information as it becomes available alongside our data outputs.



**Table 2: Anticipated impacts on NRLS data during PSIMS roll-out**

DPSIMS Phase	What will change	Anticipated timeline
<b>Private beta (pilot testing)</b>	<p>Organisations participating in the pilot will likely record incidents onto PSIMS and not the NRLS (some may choose to double-report).</p> <p>Any output that may include these participating organisations may not include their data in full.</p> <p>National and other totals may be lower than expected.</p> <p>PSIMS and NRLS data is not comparable so including pilot PSIMS data into NRLS outputs may be misleading.</p>	April-June 2019
<b>Public beta</b>	<p>Any organisation that wishes to record into PSIMS rather than NRLS will be encouraged to do so. The above changes and impacts will then apply to these organisations as well as to the initial private beta pilot sites.</p>	July 2019 onwards
<b>Live</b>	<p>National-scale transition from recording incidents on NRLS to PSIMS.</p> <p>Outputs will start to present PSIMS data in addition to NRLS data.</p> <p>PSIMS and NRLS data will not be comparable so the data from the two sources cannot be added and must be treated differently.</p> <p>National and other totals may fluctuate in an unpredictable way.</p>	2020 onwards

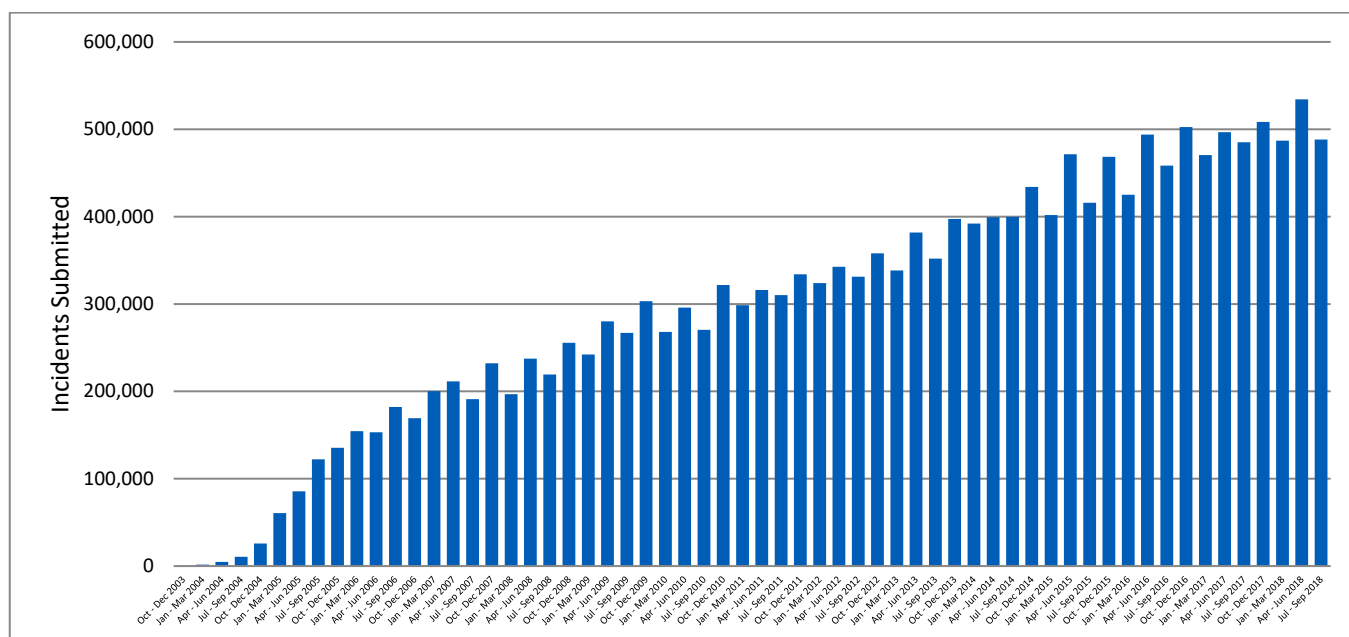
# 3. Incidents reported up to September 2018

This section analyses incidents reported to the NRLS using the ‘**reported dataset**’, the dataset used to look at patterns in reporting, such as frequency and timeliness. It contains incidents **reported** to the NRLS within a specified period (in this case up to September 2018) and reflects seasonality in when incidents are reported to the NRLS.

## Reported number of incidents

Patient safety incidents have been reported to the NRLS since October 2003 (Figure 1), with all NHS organisations being able to access the system from 2005. From July to September 2018, 488,242 incidents were reported to the NRLS from England. This compares with 153 incidents reported in the first quarter of the NRLS (October to December 2003). The peaks observed in the number of incidents reported (Figure 1) reflect when many reporting organisations submit large batches of incidents to the NRLS close to the cut-offs for the NaPSIR and OPSIR publications.

**Figure 1: Number of incidents reported to the NRLS, October to December 2003 up to July to September 2018**



# 4. Incidents reported as occurring from October 2017 to September 2018

This section analyses incidents using the '**occurring dataset**' to look at patient safety incident characteristics. This dataset contains incidents reported as actually happening (occurring) in a specific period and reflects seasonality in when incidents occur. Analysis based on it may be biased by fluctuation in numbers over time due to reporting delays.

This report includes analysis of incidents reported to have occurred between October 2017 and September 2018 and reported to the NRLS by 30 November 2018. This cut-off allows time for quality assurance and analysis.

The number of incidents **reported as occurring** for any period will differ from the number of incidents **reported** in the same period because they capture different data. For example, incidents reported between October 2017 and September 2018 will include those that occurred in this period **and** those occurring before October 2017 because of known delays in reporting.

The number of incidents reported to the NRLS as occurring continues to increase. Between October 2017 and September 2018, English NHS organisations reported 1,991,797 incidents as occurring. This is 5.1% more than between October 2016 and September 2017 (1,895,834).

## Incident characteristics

When submitting incidents to the NRLS, users enter information describing the incident in more detail. For example, we collect information on the type of incident and where it occurred. This helps us learn more about the types of incidents occurring in the NHS and focus our efforts to reduce harm to patients. Key incident characteristics are described below.

## Incident category

Incident category is important because it helps us understand if certain types of incident are more common than others, so we can target our learning. Many factors can affect the types of incident reported by different organisations, and this can cause variation within and between different care settings.

Nationally, the top four incident categories reported were: ‘patient accident’ (14.7%; 293,272/1,991,797); ‘implementation of care and ongoing monitoring/review’ (14.2%; n=282,539); ‘access, admission, transfer, discharge (including missing patient)’ (11.8%; n=235,599); ‘medication’ (10.6%; n=211,278) – see Table 2. These are the same as those for October 2016 to September 2017.

**Table 2: Reported incident categories by quarter, England: incidents reported as occurring from October 2016 to September 2017 and from October 2017 to September 2018**

Incident category	October 2016 to September 2017		October 2017 to September 2018		% change
	N	%	N	%	
Patient accident	302,125	15.9	293,272	14.7	-2.9
Implementation of care and ongoing monitoring/review	262,141	13.8	282,539	14.2	7.8
Access, admission, transfer, discharge (including missing patient)	210,325	11.1	235,599	11.8	12.1
Medication	201,142	10.6	211,278	10.6	5.0
All other incident categories	920,101	48.5	969,109	48.7	5.3
<b>Total</b>	<b>1,895,834</b>	<b>100</b>	<b>1,991,797</b>	<b>100</b>	<b>5.1</b>

## Care setting of occurrence

Information on the reported care setting of occurrence helps us understand where reported incidents have taken place. This is needed because any organisation can report an incident, even one that occurred at another organisation.

Nationally the top four reported care settings of occurrence were: ‘acute/general hospital’ (73.7%; n=1,467,411); ‘mental health service’ (13.4%; n=266,955); ‘community nursing, medical and therapy service’ (10.7%; n=212,232); ‘ambulance service’ (0.7%; n=14,133) – see Table 3. Apart from ‘ambulance service’ these are the same as for October 2016 to September 2017.

**Table 3: Reported incidents by care setting by quarter, England: incidents reported as occurring from October 2016 to September 2017 and from October 2017 to September 2018**

Care setting	October 2016 to September 2017		October 2017 to September 2018		% change
	N	%	N	%	
Acute/general hospital	1,405,052	74.1	1,467,411	73.7	4.4
Mental health service	243,974	12.9	266,955	13.4	9.4
Community nursing, medical and therapy service (inc community hospital)	203,707	10.7	212,232	10.7	4.2
Ambulance service	12,581	0.7	14,133	0.7	12.3
All other care settings	30,520	1.6	31,066	1.6	1.8
<b>Total</b>	<b>1,895,834</b>	<b>100</b>	<b>1,991,797</b>	<b>100</b>	<b>5.1</b>

## Incident type by care setting

Due to the differences in the care provided and patients seen, the type of incident reported varies by care setting. For example, in the acute and general care setting three of the top four reported incident types are the same as those for the whole dataset (as most incidents are reported in this care setting): ‘patient accident’ (15.2%; 223,677/1,467,411); ‘implementation of care and ongoing monitoring/review’ (13.5%; n=197,386); ‘access, admission, transfer, discharge

(including missing patient)' (12.7%; n=186,839). The fourth most common incident type in the acute and general care setting nationally is 'treatment, procedure' (12.1%; n=177,568) as opposed to 'medication'. By contrast, 'patient accident' was not the most commonly reported incident category in any other care setting.

Full breakdowns of the data are available in the accompanying [NaPSIR data workbooks](#).

## Degree of harm

The degree of harm should describe the actual degree of harm suffered by the patient as a direct result of the patient safety incident. There are five NRLS categories for the degree of harm:

- no harm – a situation where no harm occurred: either a prevented patient safety incident or a no harm incident
- low harm – any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons
- moderate harm – any unexpected or unintended incident that resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused short-term harm to one or more persons
- severe harm – any unexpected or unintended incident that caused permanent or long-term harm to one or more persons
- death – any unexpected or unintended event that caused the death of one or more persons.

The degree of harm helps us learn about the impact of incidents on patients and identify those causing most harm (severe harm and death), to prioritise clinical review of these incidents. [Clinical review](#) uses NRLS data to identify new or emerging issues that may need national action, such as a Patient Safety Alert. It is still important that incidents causing all degrees of harm are reported to the NRLS, as this breadth of information is fundamental to improving patient safety.

Sometimes reporters give an incident's **potential** degree of harm instead. For example, the resulting degree of harm is occasionally coded as 'severe' for 'near

miss' even though no harm resulted as the impact was prevented. This should be considered when interpreting the degree of harm.

Nationally most incidents are reported as causing no or low harm. Approximately three-quarters of incidents were reported as causing no harm (74.7%; 1,487,988/1,991,783) and 22.1% (n= 440,836) as causing low harm (Table 4). The remaining incidents were reported as causing moderate harm (2.6%; n=52,716), severe harm (0.3%; n=5,526) and death (0.2 %; n=4,717). This pattern is consistent with data for October 2016 to September 2017.

**Table 4: Reported incidents by degree of harm and by quarter, England: incidents reported as occurring from October 2016 to September 2017 and from October 2017 to September 2018\***

Degree of harm	October 2016 to September 2017		October 2017 to September 2018		% change
	N	%	N	%	
No harm	1,398,748	73.8	1,487,988	74.7	6.4
Low	434,562	22.9	440,836	22.1	1.4
Moderate	52,536	2.8	52,716	2.6	0.3
Severe	5,525	0.3	5,526	0.3	0.0
Death	4,449	0.2	4,717	0.2	6.0
<b>Total</b>	<b>1,895,823</b>	<b>100</b>	<b>1,991,783</b>	<b>100</b>	<b>5.1</b>

\*Excludes incidents where the degree of harm was not reported.

### Degree of harm by care setting

The degree of harm caused by incidents reported in all care settings follows the same pattern as that observed nationally, with no harm being the most commonly reported degree of harm and death the least common. However, the relative proportion of each degree of harm varied by care setting. For example, the percentage of incidents reported as no harm ranged from over 90% in the community pharmacy (91.3%; 4,470/4,897) and community optometry/optician services (91.2%; 52/57) to 53.6 % (113,839/212,232) in the community nursing, medical and therapy service (including community hospitals).

Full breakdowns of the data are available in the accompanying [NaPSIR data workbook](#).

### **Degree of harm by incident type**

When degree of harm is analysed by the incident type the patterns are generally the same as those observed at a national level, with most incidents being reported as no harm. 'Self-harming behaviour' has the highest percentage of death reported as the degree of harm (1.4%; 1,279/90,254) and one of the lowest percentages reported as no harm (51.3%; n=46,338).

Full breakdowns of the data are available in the accompanying [NaPSIR data workbook](#).



## 5. Final remarks

The NRLS is a system designed to support learning. The incidents collected reflect what is reported to us and the reporting culture. The system is not designed to count the actual number of incidents occurring in the NHS. Therefore, the continual increase in incidents reported to the NRLS over time indicates a constantly improving reporting culture, providing more opportunity for us to learn and reduce the risk of harm to patients. We encourage organisations to report incidents to the NRLS at least every month rather than submitting data in large batches a few times a year.

We rely on the quality and accuracy of information submitted to focus our learning and interventions to reduce harm. We continue to use this information to identify which incidents are clinically reviewed and how we should work to improve patient safety. We also encourage all users to review their own patient safety incidents locally, to understand more about their reporting culture and areas where local improvements in safety culture and patient safety can be made.

We are currently developing a new data collection system (PSIMS) to replace the NRLS. The system will affect the exact type of data we collect and as a result change our statistics outputs in the future. More information is available [online](#).

We thank all staff, patients and members of the public who have taken the time to report incidents. This information is essential in helping us all improve patient safety and protect our patients from harm.

## 6. Contact us for help

If you have any questions about the NRLS data collection, the published data or your organisation's data please contact the NRLS team:

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