NHS Improvement

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

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Delivering better healthcare by inspiring and supporting everyone we work with, and challenging ourselves and others to help improve outcomes for all.

Contents

1. What is the National Reporting and Learning system

The primary purpose of the National Reporting and Learning System (NRLS)[1] is to enable learning from patient safety incidents in the NHS. The NRLS was established in late 2003 as a voluntary scheme for reporting patient safety incidents; therefore it does not provide the definitive number of patient safety incidents occurring in the NHS.

2. How are the NRLS data collected?

The NRLS collects data on patient safety incidents in England and Wales.[1] 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.

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 these incidents. The transparency agenda is a pan-government initiative, in which healthcare data figures prominently. We publish these organisation patient safety incident reports (OPSIR) UK Official Statistics to make data on patient safety incident reports from the NRLS more accessible.

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.

[1] For more information on the NRLS and how information is collected see improvement.nhs.uk/resources/learning-from-patient-safety-incidents/

4. In what format are the data published?

Since September 2011, this data has 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. This data has 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 to ensure they are produced, managed and disseminated to high standards, and 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 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 is often a lag between an incident occurring and being reported to the NRLS). This is because patterns of patient safety incidents show seasonality.[2]

[2] For more information on seasonality in patient safety incidents see http://www.nrls.npsa.nhs.uk/easysiteweb/getresource.axd?assetid=135271@amp;servicetype=attachment

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 represent a culture of greater openness.[3]

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.

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

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'[4] of similar organisations.[5] (NRLS data for the whole of England are published, by care setting, in the National quarterly data summary (QDS) workbooks.)

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

For ambulance trusts we did previously calculate 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.

[3] For more information on issues impacting on the quantity of incidents reported (including changes in national reporting requirements) http://www.nrls.npsa.nhs.uk/easysiteweb/getresource.axd?assetid=135266@amp;servicetype=attachment

[4] For more information on the NRLS clusters see http://www.nrls.npsa.nhs.uk/easysiteweb/getresource.axd?assetid=135401@amp;servicetype=attachment

[5] For a list of the organisations within each NRLS cluster see improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-data/

11. Why have no rates been calculated for NHS community trusts since April 2016?

For NHS community trusts we did previously calculate a rate per 1,000 bed days.

The NRLS cluster group for NHS community trusts was formed following the formation of new NHS organisations as a result of the Transforming Community Services programme. Structural changes within these organisations mean many no longer have inpatient services and the diversity of the services they provide means this cluster can no longer be described as a homogenous group. A comparative reporting rate per 1,000 bed days is not appropriate within this cluster and comparing organisations based on this rate will be misleading.

12. What if the data in the summary report do not match the local organisation's own records?

This dataset is based on the date an incident report was successfully submitted to the NRLS. Incident reports occurring between 1 April and 30 September 2016 and submitted by 30 November 2016 have been included. If the number of reports in the local database is different from the NRLS record of incidents, this may be because some incidents were not submitted to the NRLS by 30 November 2016, or because some 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 the provisional data received from a submitting organisation with that 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.

13. How do I know if any 'issues' highlighted with an organisation's data have been highlighted?

There can be legitimate reasons for not uploading and/or obstacles to uploading incidents to the NRLS: some organisations may report very few incidents (ten or fewer) as occurring during the specified time period.

Where an organisation does report ten 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 important in comparing information from one patient population to another and have always been used to describe the NRLS reporting data. A rate is the frequency of occurrence of a phenomenon in the population under study – that is, how often something happens. It can be

thought of as a measure of risk, taking into account the individual's exposure to risk, and in this context 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.

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

14. 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**.

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

improvement.nhs.uk/resources/learning-from-patient-safety-incidents/

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

16. How can I give feedback?

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