

Data handling notes for Organisation Patient Safety Incident Reports (NRLS Official Statistics) for April to September 2016

March 2017

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

Contents

1. Purpose.....	4
2. Background.....	4
2.1. The National Reporting and Learning System.....	4
2.2. Organisational change.....	5
2.3. Changes to national reporting requirements.....	6
3. Scope, methods and reasoning.....	7
3.1. Scope.....	7
3.2. Methods and reasoning.....	7
4. Quality.....	12
Dimension 1: Relevance.....	12
Dimension 2: Accuracy.....	13
Dimension 3: Timeliness and punctuality.....	15
Dimension 4: Accessibility and clarity.....	15
Dimension 5: Comparability.....	15
Dimension 6: Coherence.....	17
Appendix 1: List of organisations with specific issues.....	19

1. Purpose

These reports provide NHS organisations with an easy-to-use summary of their current position on patient safety incidents reported to the National Reporting and Learning System (NRLS), in terms of patient safety incident reporting and the characteristics of their incidents. The information in the reports should be used alongside other local patient safety intelligence and expertise, and is intended to support NHS organisations to deliver improvements in patient safety.

2. Background

2.1. The National Reporting and Learning System

What is the NRLS?

The primary purpose of the NRLS 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, and therefore does not provide the definitive number of patient safety incidents occurring in the NHS.

What is reported to the NRLS?

All NHS organisations in England and Wales have been able to report to the system since 2005. In April 2010, it became mandatory for NHS organisations to report all patient safety incidents resulting in severe harm or death. All patient safety incident reports submitted to the NRLS coded as resulting in severe harm or death are individually reviewed by clinicians at NHS England to make sure we learn as much as we can from them and, if appropriate, take action at a national level.

The NRLS is a dynamic reporting system. As incidents can be submitted to the NRLS at any time after the event, numbers of incidents reported at any point in time may increase at a later date. Experience in other industries has shown that as an organisation's reporting culture matures, staff become more likely to report incidents. Therefore, an increase in incident reporting should not be taken as an indication of worsening patient safety, rather as greater awareness of safety issues among healthcare professionals and a more open and transparent culture across the organisation.

How do we make it as easy as possible for organisations to share information with the NRLS?

NHS staff can report incidents directly to the NRLS, using the [NRLS web eform](#),¹ or to their local NHS organisation. NHS organisations collect patient safety data on their local risk management systems, which can be uploaded to the NRLS. These local systems are often used for a number of reasons, not just recording patient safety incidents. As a result, local definitions and classification systems often differ. We collate this information into the national database to reduce the burden on local organisations. There can be a time lag between an incident occurring and being reported to the NRLS, as some organisations wait until the investigation is complete before submitting the incident to the NRLS. Organisations are encouraged to report patient safety incidents to the NRLS at least once a month, but many still group incidents and send them to the NRLS in large batches.

2.2. Organisational change

A number of important events between January 2009 to April 2013 are likely to have had an impact on patient safety incident reporting. These include:

Community services

Transforming community services: enabling new patterns of provision (January 2009) specified the need to improve and integrate community services, and to separate the primary care trust (PCT) functions of commissioning and service provision (by April 2011). This means that as of April 2011, PCTs became commissioning-only organisations and community service providers now exist in three different forms: as newly created separate provider organisations; integrated within acute service providers; or integrated within mental health service providers.

Quango reform

In addition, *Liberating the NHS: report of the arms-length bodies review* (July 2010) proposed that the National Patient Safety Agency (NPSA) be abolished. This was confirmed by the Health and Social Care Bill 2011, and on 1 June 2012, the key functions and expertise for patient safety (developed by the NPSA) transferred to NHS England. The operational management of the NRLS had previously transferred to Imperial College Healthcare NHS Trust in April 2012, initially for a period of two years.

¹ improvement.nhs.uk/resources/learning-from-patient-safety-incidents/

Clinical commissioning groups (CCGs)

Under reforms outlined in the Health and Social Care Bill (2011), PCTs and strategic health authorities (SHAs) were dissolved by April 2013, with local CCGs established to commission most NHS services in England. CCGs came into being as statutory bodies in April 2013 and are supported by NHS England. Requirements for the reporting of patient safety incidents from CCGs have yet to be formally established.

2.3. Changes to national reporting requirements

Serious incidents

From 1 April 2010, information on serious incidents (ie incidents that result in severe harm or death) reported by English NHS trusts to the NLRs has been shared with the Care Quality Commission (CQC) in fulfilment of the requirements of the Care Quality Commission (Registration) Regulations 2009 (Regulation 16).

Suicides

In October 2011, CQC revised its guidance on the reporting of apparent and actual suicides. The definition of incidents that should be reported has now been widened to include all actual or apparent suicides of people with an open episode of care in specialist mental health services (either inpatient or community patients) at the time of death – that is, it is no longer restricted to deaths related to patient safety incidents.

Never Events

Never Events are a specific type of patient safety incident: serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. A policy and framework on Never Events was introduced in the NHS in England in April 2009; this has evolved into a list of 14 clearly defined incidents covering all care settings.

Clearly, Never Events are Serious Incidents, and as such they should be reported to comply with the Serious Incident Framework and with Care Quality Commission Regulations (The Health and Social Care Act 2008 (Registration of Regulated Activities) Regulations 2010).

The Never Events policy and framework was updated in March 2015 to address areas of uncertainty and provide greater clarity about Never Events and how organisations should respond to them. Section 7.3 states a Never Event should be reported on the provider's local risk management system and must be reported to both the Strategic Executive Information System (StEIS) and the NLRs, ideally within two working days of identification.

3. Scope, methods and reasoning

3.1. Scope

The NRLS was established in late 2003 as a voluntary scheme for reporting patient safety incidents, and therefore does not provide the definitive number of patient safety incidents in the NHS. Consequently, the data in these reports is that for patient safety incidents reported to the NRLS within the specified timeframes.

Patient safety incidents reported to the NRLS are just that – incidents reported to the NRLS. They should not be presented as the number of incidents occurring in an organisation. Please refer to Section 4: Quality for more information.

3.2. Methods and reasoning

Decision point 1: How do we define the datasets we use?

DP1a Reporting data (the ‘reported dataset’) The ‘reported dataset’ contains incidents reported to the NRLS within the period 1 April 2016 to 30 September 2016. This dataset is used to measure levels of reporting from NHS organisations.

Patient safety incidents reported to the NRLS are just that – incidents reported to the NRLS. They should not be presented as the number of incidents actually occurring in an organisation. Please refer to Section 4: Quality for more information.

DP1b Incident characteristics (the ‘occurring dataset’) The ‘occurring dataset’ contains incidents reported as occurring within the period 1 April 2016 to 30 September 2016, and reported to the NRLS by 30 November 2016. This dataset is used to identify incident characteristics, compare patterns and calculate benchmarking rates. All organisations were given until 30 November 2016 to update incidents in the NRLS, an opportunity to add any further information pertaining to the nature of the incident discovered in investigation.

Seemingly ‘inconsistent’ datasets Organisations can have no incidents in their ‘reported dataset’, yet incident data in their ‘occurring dataset’ if they do not report any incidents between 1 April 2016 and 30 September 2016, but catch up on reporting between 1 October 2016 and 30 November 2016. Organisations are encouraged to report patient safety incidents to the NRLS at least once a month but many continue to group incidents and report them to the NRLS in large batches.

Exclusions Reports from the following are excluded from the datasets:

- Welsh NHS and non-NHS organisations
- the public or patients
- non-NHS organisations
- CCGs
- area teams
- social enterprises;
- GP practices
- community pharmacies.

Decision point 2: How do we handle small/low numbers?

Some organisations have reported very few incidents (ten or fewer) as having occurred between 1 April 2016 and 30 September 2016. There can be legitimate reasons for not uploading and and/or obstacles to uploading incidents to the NRLS.

Where an organisation has reported ten or fewer incidents as having occurred between 1 April 2016 and 30 September 2016, 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 also not calculated for such organisations.

Decision point 3: How do we help organisations compare their data?

Benchmarking allows comparisons of reporting patterns/behaviour with similar health organisations. Below we describe the methods we use to make the comparative data as meaningful as possible.

Decision 3a: By grouping organisations into clusters of similar organisations Different NHS organisations provide different services and serve different populations. To make comparisons as meaningful as possible we group NHS organisations into 'clusters'. Since April 2014, the number of clusters has reduced from nine to five English NRLS clusters:

- acute specialist
- acute (non-specialist)*
- ambulance
- mental health
- NHS community trusts.

*The original NRLS clusters were based on categories used by the Healthcare Commission. The Health and Social Care Act 2008 replaced the Healthcare Commission with a single, integrated regulator for health and adult social care: the Care Quality Commission. CQC became operational on 1 April 2009.

Clearly, there have been numerous changes to the delivery of healthcare since 2008 which has reduced the relevance of the original NRLS cluster configuration. In the absence of any national guidance, an iterative approach to updating clusters, in terms of the actual cluster types as well as the member organisations, has been taken.

NRLS cluster (pre-April 2014)	NRLS cluster (post-April 2014)
Acute specialist	Acute specialist
Acute teaching	Acute (non-specialist)
Acute large	Acute (non-specialist)
Acute medium	Acute (non-specialist)
Acute small	Acute (non-specialist)
Ambulance	Ambulance
Mental health	Mental health
NHS community trusts	NHS community trusts

All acute (non-specialist) trusts have been grouped together to form one cluster group.

The remaining clusters used in these reports relate to the old NHS landscape. This is in the absence of any new national guidance on the definition of organisational clusters/peer groups, and remains in line with [HSCIC guidance](#) stating that published statistics should align with the old NHS structure. Our clusters will be updated to conform to national guidance, as soon as such guidance is published.

Decision 3b: By using rates Rates are important in comparing information from one population to another population.

Rates 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 account of the individual’s exposure to risk. It 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.

Numerator data The issues concerning bias in calculating the numerator are described in Section 4: Quality (specifically Dimension 2: Accuracy; Dimension 3: Timeliness and punctuality; and Dimension 5: Comparability).

Denominator data The denominator used in the calculation of the rates is intended to represent the population exposed to risk over the same time period. Clearly, the accuracy of ‘potential opportunities for those incidents to occur’ is linked to a number of issues, including the types of service(s) provided and the type of patient safety incident of interest (eg medication incidents, obstetric incidents).

Changing practice Before April 2014, for organisations providing inpatient services, either admissions or bed days data, published by Hospital Episode Statistics (HES), were used for the calculation of rates.

NRLS statistics now use quarterly KH03 data on average daily overnight bed occupancy (published by NHS England) to estimate total number of bed days for the specified time period of the analysis. The KH03 data is more up to date than HES data. (This excludes residential care beds, critical care beds, and well baby cots.) The analytical team has assessed the impact of these changes to see if any specific organisations will be particularly affected.

Historically, the NRLS denominator has been driven by the cluster type. The ‘new denominators’ better reflect the individual’s exposure to risk and are listed below.

Pre-April 2014 NRLS cluster	Denominator unit	Denominator source
Acute specialist	100 admissions	HES
Acute teaching	100 admissions	HES
Acute large	100 admissions	HES
Acute medium	100 admissions	HES
Acute small	100 admissions	HES
Ambulance	N/A	
Mental health	1,000 bed days	HES
NHS community trusts	1,000 bed days	HES

Post April 2014 NRLS cluster	Denominator unit	Denominator source
Acute specialist	1,000 bed days	Bed occupancy data (KH03)
Acute (non-specialist)	1,000 bed days	Bed occupancy data (KH03)
Ambulance	N/A	
Mental health	1,000 bed days	Bed occupancy data (KH03)
NHS community trusts*	N/A	

***Change to the Organisation Patient Safety Incident Reports for NHS community trusts** 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 deliver inpatient services. As they now provide different and diverse services 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. Therefore, no reporting rate is calculated for this cluster until further guidance on grouping and comparing community trusts and/or integrated organisations is available.

For English organisations providing inpatient services, bed days' data published by NHS England.² is used to calculate incident rates. KH03 data for April to June 2016 and July to September 2016 was used to calculate a six-month estimate for bed days.

Individual organisation-level denominator data is provided in the denominator sheet in the [Organisation Data Workbook](#).

Benchmarking rates from April 2014 cannot be compared with earlier time periods for which the denominator and data source used for calculating rates were different.

Decision 3c: By using alternative denominator data if necessary/appropriate

Outliers To avoid outliers from distorting comparisons, where organisations have missing data or possibly inaccurate published data, methods to estimate or substitute the denominator have been used to give a more accurate rate. Alternatives to the published data are used if an organisation has undergone a structural change which is not reflected in the published dataset used for

² NHS England Statistics – collects performance data from all organisations in England. For more information see <http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/>

denominators. If no appropriate denominator data is available no rate is calculated.

Organisations with denominator data issues are listed in Appendix 1. All these organisations were contacted to discuss the issues encountered.

Special cases

- Tavistock and Portman NHS Foundation Trust: does not provide inpatient services; therefore bed day data is unavailable.
- Wirral Community NHS Trust: does not provide inpatient services; therefore bed day data is unavailable.
- Isle of Wight NHS Trust: provides ambulance and primary care services alongside acute, mental health and learning disability care; therefore, is unlikely to be directly comparable with others within its cluster or any other cluster.
- Moorfields Eye Hospital: does not generally provide inpatient services; therefore it is now appropriate to calculate rates using overnight bed data.

4. Quality

Known quality issues should be borne in mind when interpreting NRLS data. These are described below in the context of the six dimensions of the European Statistical System Quality Framework.

Dimension 1: Relevance

NRLS data is an essential component for assessing, monitoring and managing patient safety. NRLS data is shared with a range of national bodies to support the identification of hazards, and the development of patient safety guidance and solutions. These organisations include: NHS England, Public Health England, the Medicines and Healthcare products Regulatory Agency (MHRA), CQC and the Royal Colleges.

The national data collected in the NRLS database allows trends to be identified; these inform the development of patient safety resources, such as Patient Safety Alerts.

NRLS data is used within Domain 5 of the NHS Outcomes Framework (*Treating and caring for people in a safe environment and protecting them from avoidable harm*). This framework directs the approach to improving outcomes, and offers

the NHS an opportunity to begin to understand what its focus on outcomes means for individuals, organisations and health economies.

Dimension 2: Accuracy

D2a: There is no ‘correct’ or ‘safe’ number of patient safety incidents There are known reasons for ‘high’ and ‘low’ reporting. Some organisations report daily, others quarterly. Many group reports and send them to the NRLS in large batches. It should never be assumed that the total numbers of patient safety incidents represent the 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. Even in acute care, it has been estimated between 22% and 83% of incidents are estimated locally to go unreported.³ Certain incident types have been suggested to be under-reported, in particular medication incidents in primary care.³

‘Low’ reporting Under-reporting of patient safety incidents at a local level is a recognised issue. Over 99% of patient safety incidents reported to the NRLS by local organisations are uploaded (via a secure website) from local risk management systems. This potential source of bias will be embedded in subsequent reporting to the NRLS.

A ‘low’ reporting rate should not be interpreted as a ‘safe’ organisation as it may represent under-reporting.

‘High’ reporting Experience in other industries has shown that as an organisation’s reporting culture matures, staff become more likely to report incidents. (But even in ‘high’ reporting organisations, there may still be some degree of under-reporting.)

These local systems are often used for a number of reasons, not just recording patient safety incidents. Sometimes incidents are inappropriately reported to the NRLS. There is a formal process for organisations to request that incidents are ‘deleted’ – that is, removed from the analytical layer of the NRLS database – in specific circumstances.

A ‘high’ reporting rate should not be interpreted as an ‘unsafe’ organisation as it may actually represent a culture of greater openness.

D2b: Incidence of patient safety incidents versus reporting rates Patient safety incidents reported to the NRLS are just that – incidents reported to the

³ House of Commons Health Committee (2009) An open, reporting and learning NHS Chapter 5 In: *Patient safety, Volume 1* (Sixth report of Session 2008-09) HC 151-I. London: The Stationery Office Ltd.

NRLS. They should not be presented as the number of incidents actually occurring in an organisation, especially as gaps in coverage result from missing submission deadlines.

D2c: The NRLS is a dynamic reporting system. As incidents can be submitted to the NRLS at any time after the event, numbers of incidents reported at any point in time may increase at a later date. Reporting to the NRLS has increased year on year since its inception in 2003, and it is anticipated that this trend will continue as the culture of reporting all incidents spreads more widely and deeply across the NHS. Therefore, comparisons over time are confounded by increases in the underlying numbers.

Experience in other industries has shown that as an organisation's reporting culture matures, staff are more likely to report incidents. An increase in incident reporting should not be taken as an indication of worsening patient safety, rather as an increasing level of awareness of safety issues among healthcare professionals and a more open and transparent culture across the organisation.

D2d: Poor recording of the patient safety incident The quality of the data submitted to the NRLS relies on three things:

- the incident being recognised as a patient safety incident
- sufficient detail being documented in the patient's notes
- adequate and consistent coding in the local risk management system before uploading to the NRLS.

D2e: Harm as a direct result of the patient safety incident The NRLS aims to record the actual degree of harm suffered by the patient as a direct result of the patient safety incident, but this is not always achieved.

Sometimes reporters confuse the **potential** degree of harm of an incident with the actual degree of harm that occurred. For example, the resulting degree of harm is sometimes coded as 'severe' for 'near misses' (where no harm results as the impact is prevented).

Reporters may code the degree of harm as 'severe' when the patient is **expected** to suffer severe but transient harm (eg severe bruising), instead of the NRLS definition of significant and permanent harm. On the other hand, a report on Patient Safety by the House of Commons Health Committee³ refers to work showing that "incidents leading to serious harm were among the least likely to be reported".

As described in D2a above, some incidents reported to the NRLS are not patient safety incidents, and these can also confound the data.

Dimension 3: Timeliness and punctuality

D3a: Known delays in reporting to the NRLS – the time lag between the incident it being reported to the NRLS Organisations are encouraged to report patient safety incidents to the NRLS at least once a month. CQC guidance for the reporting of serious incidents recommends reporting “without delay”.

However, in practice there is often a delay between an incident occurring and it being reported to the NRLS. We monitor the average (median) number of days delay in reporting both serious incidents and all incidents. Every month provisional data is shared with the submitting organisations on the NRLS reporting portal. This gives them the opportunity to check the data received by the NRLS matches that in their local risk management system. Detailed guidance on what to look for and known reporting issues is given in an online FAQ document. Organisations should contact the Patient Safety Reporting Leads for further support if needed.

As this delay is well known, we allow a minimum of two months lag in defining our ‘occurring dataset’ (see D1b above). This also gives organisations time to update incidents, if appropriate.

D3b: Frequency of publication These statistics are published bi-annually. Data is always released on the pre-announced dates. As stated above, a two-month time lag is factored into the definition of the ‘occurring dataset’. A comprehensive quality assurance process is undertaken before this data is used in any analysis.

As a result, there is a delay of approximately four months between the cut-off for inclusion in the dataset and publication of the data, to maximise the usefulness/accuracy of the data while minimising the delay in publication.

Dimension 4: Accessibility and clarity

D4a: Accessibility This data is available at improvement.nhs.uk/resources/learning-from-patient-safety-incident.

D4b: Clarity All releases are accompanied by documentation that supports use of the data by identifying and explain quality issues. Background data is also provided to clarify the context of the data. Limitations to its use are made explicit.

Dimension 5: Comparability

D5a: Comparing over time It is important to compare data for the same time period in a year(s). This takes into account the affect of ‘seasonality’ on the data. There are at least two causes of seasonality in the reporting of patient safety

incidents to the NRLS: 'administrative seasonality' and incident seasonality.

'Administrative seasonality' Large spikes result from reporting of patient safety incidents to the NRLS every six months (at the end of May and the end of November). Organisations upload batches of data to meet the cut-off dates for submission to the NRLS for inclusion in the UK Official Statistics dataset.

'Incident seasonality' Research suggests that rates of postsurgical morbidity and mortality are higher at certain times of the year, with disruption to systems of care in academic medical centres at the start of a new academic year sufficient to affect patient outcomes.⁴

Seasonality also has an impact on some of the national mandatory reporting requirements. For example, suicides have at least two seasonal peaks.³ In October 2011, CQC revised its guidance on the reporting of apparent and actual suicides. This is now a wider definition to include all actual or apparent suicides of people with an open episode of care in specialist mental health services (either inpatient or community patients) at the time of death – that is, it is no longer restricted to deaths related to patient safety incidents.

Reporting to the NRLS has increased year on year since its inception in 2003, and it is anticipated that this trend will continue as the culture of reporting all incidents spreads more widely and deeply across the NHS. Comparisons over time are confounded by a number of factors. Although the NRLS is a dynamic database, the datasets behind a number of NRLS outputs (including the UK Official Statistics and QDS workbooks) are 'fixed/static'.

Careful consideration should be given to the dates when changes to mandatory reporting requirements were made, as these may have a 'one-off' impact, affecting a specific timeframe. Organisational change should also be borne in mind, as newly created and newly merged organisations take time to mature and set up systems and processes.

When reviewing changes over time, it is recommended that:

- proportions or percentages are used rather than actual numbers (to allow for the differences in the underlying numbers of incidents)
- the same time period in the previous year or a full year's worth of data is compared (to take seasonality into account)
- it is checked that any 'change/difference' is not an artefact due to either new/amended national mandatory reporting requirements or organisational restructuring.

⁴ Englesbe MJ, Pelletier SJ, Magee JC et al (2007) Seasonal variation in surgical outcomes as measured by the American College of Surgeons-National Surgical Quality Improvement Program (ACS-NSQIP). *Ann Surg* 246(3): 456–462.

D5b: Comparing across organisations A number of issues that can affect comparability. Steps have been taken to address these, to make the data as useful as possible; see D3a, b and c.

These data publications are focused on the individual NHS organisation level. This is consistent with our commitment to the transparency and open data agenda, to inform public services and empower patients and the public.

Reporting to the NRLS has increased year on year since its inception in 2003, and it is anticipated that this trend will continue as the culture of reporting all incidents spreads more widely and deeply across the NHS. Therefore, comparisons over time are confounded by increases in the underlying numbers, and changes in national reporting requirements (see Section 2.3). When reviewing changes over time, it is recommended that proportions are used rather than actual numbers (eg the proportion of incidents that result in severe harm or death), that a full year's worth of data is used (to take any seasonality into account) and that careful consideration is given to the dates of changes in mandatory reporting requirements.

D5c: Comparing between countries These statistics relate to NHS provider organisations in England, and there are no directly comparable figures to allow international comparison.

Dimension 6: Coherence

Coherence does not necessarily imply full numerical consistency, rather consistency in methods and collection standards.

D6a: Consistency (dataset and methods) The statistics in this release are all drawn from the same data source (the NRLS), using a coherent and consistent method (see Section 3.2) and a rigorous quality assurance process.

Although NHS organisations can use one of two methods to report to the NRLS - uploading direct from their local system or by completing the [NRLS web eform](#) - almost all (>99%) use the first of these methods. The Patient Safety Reporting Leads have mapped the data fields from these commercial local risk management systems to our national dataset in a consistent and systematic way. This gives a high degree of assurance regarding the uniformity of reporting of categorical data.

D6b: Consistency (changes in mandatory reporting requirements) The national changes to reporting requirements described in Section 2.3 add to the complexity of data interpretation, and should be considered when making any comparisons over time.

D6c: Comparability with other sources of information There are many ways to measure 'Safe' care can be measured in many ways, each having a unique

perspectives, and specific strengths and limitations. Before prioritising areas for action, individual organisations are encouraged to apply their local knowledge and expertise – in addition to considering these related sources of local patient safety information (such as ‘the patient voice’, local complaints data, CQC reports and local serious incidents requiring investigation) alongside their NRLS data, to check the messages from each data source are consistent.

Appendix 1: List of organisations with specific issues

Organisation name	Cluster	Issue
Greater Manchester West Mental Health NHS Foundation Trust	Mental health	Data quality issue, rate should be used with caution
Hertfordshire Partnership University NHS Foundation Trust	Mental health	Data quality issue, rate should be used with caution
Leicestershire Partnership NHS Trust	Mental health	Data quality issue, rate should be used with caution
Mersey Care NHS Foundation Trust	Mental health	Organisation change, rate should be used with caution
Moorfields Eye Hospital NHS Foundation Trust	Acute specialist	Outlier, no rate calculated (see D3c special cases)
South London and Maudsley NHS Foundation Trust	Mental health	Data quality issue, rate should be used with caution
Tavistock and Portman NHS Foundation Trust	Mental health	No denominator data available, no rate calculated
West Suffolk NHS Foundation Trust	Acute (non-specialist)	Data quality issue, rate should be used with caution

Contact us:

NHS Improvement

Wellington House
133-155 Waterloo Road
London
SE1 8UG

0300 123 2257

enquiries@improvement.nhs.uk

improvement.nhs.uk



Follow us on Twitter [@NHSImprovement](https://twitter.com/NHSImprovement)

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

© NHS Improvement 2017 Publication code: IG 12/17