NHS
Improvement

Data Handling Notes

Organisation Patient Safety Incident Reports (NRLS official statistics):
October 2015 to March 2016 (released: September 2016)

CONTENTS

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Overall goal

The purpose of these reports is to 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, 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.

1 BACKGROUND

1.1 The National Reporting and Learning System (NRLS)

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

1.1.2 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 which result 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 that we learn as much as we can from these incidents, and, if appropriate, take action at a national level.

The NRLS is a dynamic reporting system and the number of incidents reported as occurring at any point in time may increase as more incidents are reported. 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, but rather as an increasing level of awareness of safety issues amongst healthcare professionals and a more open and transparent culture across the organisation.

1.1.3 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 (http://www.nrls.nhs.uk/report-a-patient-safety-incident/healthcare-staff-reporting/), or report it to their local NHS organisation. NHS organisations collect patient safety data on their local risk management systems, which can be uploaded to the NRLS.

Organisations' local risk management systems are often used for a number of reasons and not just for recording patient safety incidents. As a result, organisations often have different definitions and classification systems locally. We collate this information into the national database to ensure that there is no additional burden to the local organisation. There can be time lags between incidents occurring and then 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. Nevertheless in many cases, incidents are grouped and sent to the NRLS in large batches.

1.2 Organisational Change

There were a number of key events during the period January 2009 to April 2013 that are likely to have had an impact on patient safety incident reporting. These include:

Community Services
 'Transforming Community Services: Enabling new patterns of provision' (published 13 January 2009) specified the need to improve and integrate community services, and the need to separate the 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, the Arms Length Bodies review (published in July 2010) proposed that the National Patient Safety Agency (NPSA) be abolished. This was confirmed by the Health and Social Care Bill 2011, and on1June2012, the key functions and expertise for patient safety (developed by the NPSA) were transferred to NHS England. The operational management of the National Reporting and Learning System had previously been transferred to Imperial College Healthcare NHS Trust in April 2012, initially for a temporary period of two years.

Clinical Commissioning Groups (CCGs)
Under reforms outlined in the Health and Social Care Bill (2011), Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) were dissolved by April 2013 with new local CCGs established to take over responsibility for commissioning the majority of 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 not been formally established as yet.

1.3 Changes to National Reporting Requirements

Serious incidents
The NRLS was established in late 2003 as a voluntary scheme, and all NHS organisations in England and Wales have been able to report to the system since 2005.From 1 April 2010, serious incidents (i.e. incidents that result in severe harm or

death) reported by English NHS trusts to the NLRS have been shared with the Care Quality Commission (CQC) in fulfilment of the requirements of the Care Quality Commission (Registration) Regulations 2009 (Regulation16).

Suicides

In October 2011, the Care Quality Commission 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, i.e. no longer restricted to deaths related to patient safety incidents.

Never events

Never events are a specific type of patient safety incident: serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. A policy on never events was introduced in the NHS in England from April2009. Initially the National Patient Safety Agency (NPSA) specified a list of eight never events. Following engagement with the NHS, patients and the public, there are now 25 never events specified in the NHS in England.

Clearly, never events are serious incidents, and as such they should be reported in order to comply with the Care Quality Commission (Registration) Regulations 2009 (Regulation16).

The never events policy framework was updated in April 2013, in order to address areas of uncertainty and provide greater clarity about never events and the response to them. Section3.4 of the updated policy framework explicitly covers the issue of reporting of never events that do not result in severe harm or death. It states that "Never events are defined inguidanceas'Grade2' serious incidents requiring investigation and should be reported to the CQC via the NRLS (even where there may be 'no harm'). They should be reported to the NRLS and also be recorded on the Strategic Executive Information System."

2 SCOPE, METHODS AND REASONING

2.1 Scope

The NRLS was established in late 2003 as a voluntary scheme for reporting patient safety incidents, and therefore it does not provide the definitive number of patient safety incidents occurring in the NHS (see section1:Background). Consequently, the data in these reports is composed entirely of patient safety incidents reported to the NRLS within the specified timeframes.

Consequently, patient safety incidents reported to the NRLS are simply just that – incidents reported to the NRLS. They should not be presented as the number of incidents actually occurring in an organisation*. Please see the Quality section (pages 9-13) for more information.*

2.2 Methods and Reasoning

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

DP1a Reporting data (the 'Reported Dataset')

The 'Reported Dataset' contains incidents that were reported to the NRLS within the period 1 October 2015 to 31 March 2016. This dataset is used to measure levels of reporting from NHS organisations.

Patient safety incidents reported to the NRLS are simply just that–incidents reported to the NRLS. They should not be presented as the number of incidents actually occurring in an organisation*. Please see the Quality section for more information.*

DP1b Incident characteristics (the 'Occurring Dataset')

The 'Occurring Dataset' contains incidents that have been reported as occurring within the period 1 October 2015 to 31 March 2016, and were reported to the NRLS by 31 May 2016.This data set is used to identify incident characteristics, compare patterns and to calculate benchmarking rates. All organisations were given until 31 May 2016 to update incidents in the NRLS. This is to allow any further information pertaining to the nature of the incident, discovered in investigation, to be included in the reports.

Seemingly 'Inconsistent' Datasets

Organisations could have zero incidents in their 'Reported Dataset', yet have incident data in their 'Occurring Dataset'. This situation can arise when an organisation does not report between 1 October 2015 and 31 March 2016, but catches up on reporting between 1 April 2016 and 31 May 2016. Organisations are encouraged to report patient safety incidents to the NRLS at least once a month. Nevertheless in many cases, incidents are grouped and sent to the NRLS in large batches.

Exclusions

The following are excluded from the datasets:
- reports from the public or patients;
- reports from non-NHS organisations;
- reports from Clinical Commissioning Groups;
- reports from Social Enterprises; and
- reports from Community Pharmacies.

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

There can be legitimate reasons and/or obstacles to uploading incidents to the NRLS: some organisations may report very few incidents (i.e.10 or fewer incidents) that occurred between 1 October 2015 and 31 March 2016.

Where an organisation has reported 10 or fewer incidents as occurring during 1 October 2015 and 31 March 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 where an organisation has reported 10 or fewer incidents.

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

Benchmarking allows comparisons of current performance with the performance of 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. In order to make comparisons as meaningful as possible we group NHS organisations into 'clusters'. Since April 2014, the number of clusters has been reduced from nine to six NRLS clusters:

- Acute specialist
- Acute (non-specialist)*
- Ambulance
- Mental health
- NHS Community Trusts
- Welsh Local Health Boards

*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. 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
Welsh Local Health Boards	Welsh Local Health Boards

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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 states that statistics published should align with the old NHS structure. For more information please see http://www.hscic.gov.uk/article/2757/Aligning-statistics-to-the-new-health-landscape. Our clusters will be updated to conform to national guidance, as soon as such guidance is published.

Decision 3b: By using rates

Rates are very important in comparing information from one population to another population.

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:

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

In order 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.

Numerator Data

The issues of bias in attempting to accurately calculate the numerator are described in the Quality section of this document (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 (e.g. medication incidents, obstetric incidents) of interest.

Changing Practice

Prior to April 2014, for organisations providing inpatient services, either admissions or bed days data, published by Hospital Episode Statistics (HES) were used.

NRLS statistics will now use quarterly KH03 data on average daily overnight bed occupancy (published by NHS England) to determine an estimated total number of bed days for the specified time period of the analysis. This is because 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 have undertaken a number of analyses to assess 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' are intended to better reflect the individual's exposure to risk and are listed below.

Pre – Apr 2014 NRLS Cluster	Denominator unit	Denominator source
Acute specialist	100 admissions	Hospital Episode Statistics (HES)
Acute teaching	100 admissions	Hospital Episode Statistics (HES)
Acute large	100 admissions	Hospital Episode Statistics (HES)
Acute medium	100 admissions	Hospital Episode Statistics (HES)
Acute small	100 admissions	Hospital Episode Statistics (HES)
Ambulance	NA	
Mental health	1,000 bed days	Hospital Episode Statistics (HES)
NHS Community Trusts	1,000 bed days	Hospital Episode Statistics (HES)
Welsh Local Health Boards	10,000 population	Health and Social Care Information Centre (HSC IC)

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	NA	
Mental health	1,000 bed days	Bed occupancy data (KH03)
NHS Community Trusts	1,000 bed days	Bed occupancy data (KH03)
Welsh Local Health Boards	10,000 population	Health and Social Care Information Centre (HSC IC)

For English organisations providing inpatient services, bed days data published by NHS England[1] are used to calculate incident rates. KH03 data for October to December 2014 and January to March 2015 was used to calculate a six month estimate for bed days.

For Welsh acute organisations bed days data published by Health Solutions Wales (HSW)[2] are used to calculate incident rates.
LHBs in Wales have population data as their denominator which are supplied by the Health and Social Care Information Centre[3].

Individual organisation level denominator data is provided in the denominator sheet in the Organisation Data Workbook on the NRLS website.

Benchmarking rates from April 2014 <u>CANNOT</u> be used to compare against previous time periods where the denominator and data source used for calculating rates was different.

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

Outliers

In order to avoid outliers from distorting comparisons, where organisations have missing or possibly inaccurate published data, methods to estimate or substitute the denominator have been used in order to provide a more accurate rate. Alternatives to the published data are used if:

- An organisation has had a structural change which is not reflected in the published dataset used for denominators,

In the event that no appropriate denominator data is available no rate is calculated.

All organisations with denominator data issues are listed in the Table in Annex 1. In all cases, the NHS organisations involved were contacted to discuss the issues encountered.

Special Cases

- Tavistock and Portman NHS Foundation Trust: this trust does not provide inpatient services; therefore bed day data is unavailable.

- Wirral Community NHS Trust: this trust does not provide inpatient services; therefore bed day data is unavailable.

- Isle of Wight NHS Trust: this 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 their cluster, or any other cluster.

- Moorfields Eye Hospital: this trust does not generally provide inpatient services; therefore overnight bed data is not appropriate to calculate rates.

3 QUALITY

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

Dimension 1: Relevance

NRLS data are an essential component in assessing, monitoring and managing patient safety. NRLS data are 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, the Health Protection Agency, the Medicines and Healthcare products Regulatory Agency (MHRA), the Care Quality Commission (CQC), the Royal College of Anaesthetists, Connecting for Health, and the NHS Wales Informatics Service.

The national data collected in the NRLS database allows trends to be identified and this information informs the development of patient safety resources, such as Rapid Response Reports, Patient Safety Alerts, and Safer Practice Notices.

NRLS data are currently used within Domain 5 of the NHS Outcomes Framework (*Treating and caring for people in a safe environment and protecting them from avoidable harm*). The Outcomes Framework sets the direction of travel in the journey towards improving outcomes, and offers an opportunity for the NHS to begin to understand what an NHS focussed 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. In many cases, incidents are grouped and sent 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. Even in acute care, it has been estimated that anything between 22% and 83% of incidents go un-reported locally.[5] It has also been suggested that specific incident types are under-reported (in particular medication incidents in primary care).[5]

'Low' reporting

Under-reporting of patient safety incidents at a local level is a recognised issue. Over 99% of patient safety incidents are reported to the NRLS by local organisations uploading incidents from their local risk management systems. (The upload process is via a secure website).Therefore, this potential source of bias will be embedded into the subsequent reporting to the NRLS.

A 'low' reporting rate should not be interpreted as a 'safe' organisation, and 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. (Even in 'high' reporting organisations, there may still be some degree of under-reporting.)

Organisations' local risk management systems are often used for a number of reasons and not just for recording patient safety incidents. Sometimes incidents are inappropriately reported to the NRLS. There is a formal process in place for organisations to request that incidents be 'deleted', i.e. removed from the analytical layer of the NRLS database, in very specific circumstances.

A 'high' reporting rate should not be interpreted as an 'unsafe' organisation, and 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 simply just that – incidents reported to the NRLS. They should not be presented as the number of incidents actually occurring in an organisation, especially as some organisations fail to meet the submission deadlines which results in gaps in coverage.

D2c: The NRLS is a dynamic reporting system

The NRLS is a dynamic reporting system, and the number of incidents reported as occurring at any point in time may increase as more incidents are reported. Reporting to the NRLS has increased year on year since its inception in 2003, and it is anticipated that this will continue to increase 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. Therefore, an increase in incident reporting should not be taken as an indication of worsening of patient safety, but rather as an increasing level of awareness of safety issues amongst 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; and

* adequate and consistent coding in the local risk management system prior to uploading to the NRLS.

D2e: Harm as a direct result of the patient safety incident

The degree of harm in the NRLS is intended to record the actual degree of harm suffered by the patient as a direct result of the patient safety incident. However, this is not always the case.

Sometimes reporters confuse the <u>potential</u> degree of harm of an incident with the actual degree of harm that occurred. For example, in the case of 'near misses' (where no harm resulted as the impact was prevented) the resulting degree of harm is sometimes coded as 'severe'.

Reporters may code the degree of harm as 'severe' when the patient is expected to suffer severe but transient harm (for example, 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 Committee[5] refers to earlier work showing that "incidents leading to serious harm were among the least likely to be reported".

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

Dimension 3: Timeliness and Punctuality

D3a: Known delays in reporting to the NRLS – the time lag between the incident occurring to the incident being reported to the NRLS

Organisations are encouraged to report patient safety incidents to the NRLS at least once a month, and the CQC guidance for the reporting of serious incidents recommends reporting "without delay".

However, in practice there is a delay between an incident occurring and it being reported to the NRLS. We monitor the average (median) number of days delay for both serious incidents and all incidents, and feed these data back to NHS organisations. Every month, provisional data are shared back with the submitting organisation to help identify possible data quality problems with data uploaded to the NRLS. This gives organisations the opportunity to check the data that the NRLS has received and compare them with data in their local risk management system. Detailed guidance on what to look for and known reporting issues is given in an online FAQ document, along with the option to contact the Patient Safety Reporting Leads for further support if needed.

As this delay is well known, we always allow a minimum of two months lag in defining our 'Occurring Dataset' (see DP1b). This also provides sufficient opportunity for organisations to update incidents, if appropriate.

D3b: Frequency of publication

These statistics are published bi-annually to a time table agreed with NHS England.

Releases are always punctual, and 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 prior to 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, in order to maximise the usefulness/accuracy of the data whilst minimising the delay in publication.

Dimension 4: Accessibility and Clarity

D4a: Accessibility

These data are available for free via a public website (http://www.nrls.nhs.uk/resources/).

D4b: Clarity

All releases are accompanied by a range of documentation in order to support the user by identifying and explaining interpretation and quality issues. Background data are also provided to help clarify the context of the data, and the limitations in the use of the data are explicitly documented.

Dimension 5: Comparability

D5a: Comparing over time

When comparing NRLS data across time periods, it is important to compare data to the same time period in the previous year(s). This is to take into account known 'seasonality' in 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'

There are large spikes in the reporting of patient safety incidents to the NRLS every six months (at the end of May and the end of November), as organisations upload batches of data in order to meet the cut-off dates for submission to the NRLS for inclusion in the UK Official Statistics data set.

Incident seasonality

Research suggests that higher rates of postsurgical morbidity and mortality relate to the time of the year, with systems of care within academic medical centres sufficiently disrupted with the beginning of a new academic year to affect patient outcomes.[6]

Seasonality also has an impact on some of the national mandatory reporting requirements. For example, suicides have been found to have at least two seasonal peaks.[7] In October 2011, the Care Quality Commission 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, i.e. 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 will continue to increase 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 of changes in mandatory reporting requirements, as these may have a 'one-off' impact, affecting a specific time frame. Organisational change should also be borne in mind, as newly created and newly merged organisations take time to mature and set up their 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);
  and

- either the same time period in the previous year, or a full year's worth of data are used
  (in order to take seasonality into account);
  and

- checks are made that any 'change/difference' is not an artefact due to either new/amended national mandatory reporting requirements, or organisational restructuring.

D5b: Comparing across organisations

There are a number of issues that can affect comparability. The steps that have been taken to address these issues, and therefore make the data as useful as possible, are described in detail in Decision Point 3 (parts a, b and c).

The focus of these publications is at an individual NHS organisation level, as part of our commitment to the transparency and open data agenda, to help 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 will continue to increase 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 (see1.3). When reviewing changes over time, it is recommended that proportions are used rather than actual numbers (e.g. the proportion of incidents that result in severe harm or death), that a full year's worth of data are used (in order 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 organisations in England and Wales, 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 2.2), and a rigorous quality assurance process.

Although it is possible for NHS organisations to use different methods to report to the NRLS (uploading from their local system or by completing an eform on the NRLS website), almost all – more than 99% – upload their incidents directly from their local risk management systems. The data fields from these commercial local risk management systems have been mapped to our national dataset by the Patient Safety Reporting Leads in a consistent and systematic way. This provides 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 1.3 add to the complexity of data interpretation, and should be taken into consideration when making any comparisons over time.

D6c: Comparability with other sources of information

There are many ways to measure 'safe' care, each with unique perspectives, and specific strengths and limitations. Individual organisations are encouraged to apply their local knowledge and expertise – in addition to considering these other related sources of patient safety information (such as 'the patient voice', their local complaints data, their CQC reports, and their local serious incidents requiring investigation) alongside their NRLS data, in order to check that the messages from each data source are consistent before prioritising areas for action.

References:

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

[2] Health Solutions Wales
– collects patient episode data from Welsh organisations
For more information visit http://www.wales.nhs.uk/sites3/home.cfm?orgid=527

[3] NHS Information Centre for Health and Social Care
http://www.ic.nhs.uk/statistics-and-data-collections/population-and-geography/gp-registered-populations

[4] Department of Health performance data and statistics
http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/

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

[6] Englesbe MJ, Pelletier SJ, Magee JC *et al*. *Seasonal variation in surgical outcomes as measured by the American College of Surgeons-National Surgical Quality Improvement Program (ACS-NSQIP)*. Ann Surg 2007;Sept 246(3):456-62.

[7] Christodoulou C, Douzenis A, Papadopoulos FC *et al. Suicide and seasonality*. Acta Psychiatr Scand 2012; Feb 125(2):127-46. doi: 10.1111/j.1600-0447.2011.01750

Annex 1: List of organisations with specific issues

Organisation name	Cluster	Issue
BRIDGEWATER COMMUNITY HEALTHCARE NHS TRUST	NHS Community trust	No denominator data available, no rate calculated
GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST	Mental health	Rate based on partial KH03 submission, rate should be used with caution
HERTFORDSHIRE COMMUNITY NHS TRUST	NHS Community trust	No denominator data available, no rate calculated
HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	Mental health	Rate based on partial KH03 submission, rate should be used with caution
HOUNSLOW AND RICHMOND COMMUNITY HEALTHCARE NHS TRUST	NHS Community trust	No denominator data available, no rate calculated
KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	NHS Community trust	No denominator data available, no rate calculated
LEICESTERSHIRE PARTNERSHIP NHS TRUST	Mental health	Rate based on partial KH03 submission, rate should be used with caution
LIVERPOOL COMMUNITY HEALTH NHS TRUST	NHS Community trust	No denominator data available, no rate calculated
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	Acute specialist trust	Outlier, no rate calculated
SHROPSHIRE COMMUNITY HEALTH NHS TRUST	NHS Community trust	No denominator data available, no rate calculated
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	Mental health	Rate based on partial KH03 submission, rate should be used with caution
TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	Mental health	No denominator data available, no rate calculated
TORBAY AND SOUTHERN DEVON HEALTH AND CARE NHS TRUST	NHS Community trust	No denominator data available, no rate calculated
WIRRAL COMMUNITY NHS TRUST	NHS Community trust	No denominator data available, no rate calculated