

NRLS organisation patient safety incident reports: commentary

September 2020

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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 both incidents reported and incidents reported as occurring to the NRLS by English NHS organisations was higher between October 2019 and March 2020 compared with October 2018 and March 2019, by 14% and 9.2% respectively.

The average (median) time to report incidents nationally was 21 days, which is a small improvement on 22 days in October 2018 to March 2019.

Nationally, the overall profile of incident characteristics (incident type, reported degree of harm and care setting where the incident occurs) was the same as that for October 2018 to March 2019 and previous time periods.

The data period this commentary covers does not include the peak of reported COVID-19 cases, hospital admissions or deaths. We may observe the impact of COVID-19 on NRLS data in subsequent OPSIR publications.

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2. Introduction

This commentary interprets the data published in the organisation patient safety incident reports ([OPSIR](#)) for October 2019 to March 2020 for English NHS organisations. OPSIR provide organisation-level data on patient safety incidents for NHS organisations, broken down by cluster. A cluster is a group of organisations with similar characteristics that may influence the number and type of patients they treat and the range of healthcare services provided. The organisation **reporting** the patient safety incident determines the cluster we use. This may or may not be the organisation where the incident **occurred**.

We use these clusters:

- NHS acute non-specialist trusts
- NHS acute specialist trusts
- NHS mental health trusts
- NHS community trusts
- NHS ambulance trusts.

Organisations that do not fall within these clusters are not included in OPSIR (see Table 1 for more information).

In our commentaries we analyse the published data for the current six-month period (in this instance October 2019 to March 2020) and compare it to the data for the same six-month period in the previous year (ie October 2018 to March 2019) to allow more meaningful interpretation. This is because of 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 routine data publications. So, comparing data for April to June with that for July to September for the same year would show a decline in the number of incidents reported because of the peak in reported incidents in May. Comparing data for the same months in consecutive years (eg October 2018 to March 2019 and October 2019 to March 2020) better reflects whether the number of incidents reported is increasing or decreasing.

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

- national patient safety incident reports ([NaPSIR](#), previously the quarterly data summaries – QDS)
- [monthly summary data](#) on patient safety incident reports.¹

This document should be read alongside the [OPSIR](#) data tables. The data contained in OPSIR and NaPSIR 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 is available on the [OPSIR](#) webpage.

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

Feature	NaPSIR	OPSIR	Monthly summaries
Purpose	To provide a national picture of the reporting of patient safety incidents and of the characteristics of incidents (type, care setting, degree of harm). This dataset forms the basis of the indicator 'improving the culture of safety reporting' in Domain 5 of the NHS outcomes framework (Treating and caring for people in a safe environment and protecting them from avoidable harm).	To provide data on individual organisation's reporting and patient safety characteristics. 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.*	To provide timely data on reporting to the NRLS to encourage more consistent reporting and support organisations to monitor potential under-reporting of incidents. Data is provided by organisation, degree of harm and month of reporting to the NRLS. Organisations are not grouped into 'clusters'.
Dataset type	Dynamic [†]	Fixed/static	Dynamic
Dataset used	Reported and occurring datasets [‡]	Reported and occurring datasets [‡]	Reported dataset [‡]

¹ Although not formally an official statistic this output is included here due to its similarity to the OPSIR and NaPSIR.

Feature	NaPSIR	OPSIR	Monthly summaries
Period covered	Reported dataset: rolling quarters from October to December 2003 to the most recent quarter available. Occurring dataset: rolling quarters covering the last four available quarters.	The most recent six months only.	A rolling 12-month period covering the preceding 12 complete months of available data.
Updated	Every six months	Every six months	Every month
Geography/ breakdown	All geographical locations, by care setting	England, by individual NHS organisation (organised by cluster)	England, by individual organisation
Inclusions	The following care settings: <ul style="list-style-type: none"> • acute/general hospital • mental health service • community nursing, medical and therapy service • learning disabilities service • ambulance service • general practice • community pharmacy • community and general dental service • community optometry/ optician service 	The following organisation types: <ul style="list-style-type: none"> • acute/general hospital • mental health service • community trust • ambulance service 	The following organisation types: <ul style="list-style-type: none"> • acute/general hospital • mental health service • community trust • ambulance service • integrated care organisation

* [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 they occurred).

‡ 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 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](#); but as a summary:

- 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 [Patient Safety Information Management System \(PSIMS\)](#) will replace the 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 England and 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 shows where we are at and what the next stages will be. As our approach means things can change rapidly, their exact timing is difficult to predict. Note that the predicted start of public beta has been delayed to this autumn. We will provide more information as it becomes available alongside our data outputs.

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

Development phase	What will change	When
Private beta (pilot testing)	<p>Organisations participating in the pilot record incidents onto PSIMS and not the NRLS (some choose to double-report).</p> <p>Any output that includes 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 2019 to Summer 2020
Public beta	<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> <p>The intention is that any organisation joining the PSIMS public beta will no longer report to NRLS. Public beta marks the start of the transition from 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. Explanatory guidance will be provided on this.</p>	Autumn 2020 onwards
Live	National transition from recording incidents on NRLS to PSIMS.	Late 2020/21 onwards

Data quality note on organisations' cluster placement

Three organisational mergers occurred during the current reporting period. One did not change the cluster for the two acute (non-specialist) cluster predecessor organisations, and therefore has not affected comparisons over time for that cluster in this commentary and associated data tables:

- On 1 October 2019 Aintree University Hospital NHS Foundation Trust (REM; acute non-specialist cluster) merged with Royal Liverpool and Broadgreen University Hospitals NHS Trust (RQ6; acute non-specialist cluster) to form Liverpool University Hospitals NHS Foundation Trust (REM; acute non-specialist cluster).

The other two may have affected comparisons over time for the predecessor and newly designated clusters in this commentary and associated data tables as they involve mergers between predecessor organisations from different clusters:

- On 1 October 2019 Cumbria Partnership NHS Foundation Trust (RNN; mental health cluster) merged with North Cumbria University Hospitals NHS Trust (RNL; acute non-specialist cluster) to form North Cumbria Integrated Care NHS Foundation Trust (RNN; acute non-specialist cluster).
- On 1 October 2019 2GETHER NHS Foundation Trust (RTQ; mental health cluster) merged with Gloucestershire Care Services NHS Trust (R1J; community cluster) to form Gloucestershire Health and Care NHS Foundation Trust (RTQ; mental health cluster).

Based on the merged organisations' mix of services as well as detailed analysis of the incident types and care settings reported by each predecessor, we have assigned North Cumbria Integrated Care NHS Foundation Trust (RNN) to the acute non-specialist cluster and Gloucestershire Health and Care NHS Foundation Trust (RTQ) to the mental health cluster. This best reflects the services they provided during this publication period.

All cluster designations may be revised in the event of substantial changes in service provision in future publication periods.

Statement on the potential impact of COVID-19

The publication period for incidents reported as occurring ended at the end of March 2020 when reports of positive COVID-19 cases were low but rising in England.² Likewise, the cut-off date for reporting these incidents to the NRLS was 31 May 2020, weeks after the peak in reported COVID-19 cases and deaths.

Available OPSIR data shows that the number of incidents reported and reporting as occurring has increased from October 2019 to March 2020 compared to October 2018 to March 2019. This combined with the accompanying [NaPSIR](#) data and our routine [monthly statistics](#) show that reporting to the NRLS remains high.

We thank all organisations for continuing to report anything of concern and acting on Patient Safety Alerts while responding to the COVID-19 pandemic. By reporting NRLS incidents, NHS staff have demonstrated the values of a just culture by approaching incident reporting decisions in an open and transparent manner.

More detailed insight on the impact of COVID-19 on NRLS data will be given in subsequent OPSIR publications.

² <https://coronavirus.data.gov.uk/>

3. Incidents reported from October 2019 to March 2020

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 before the end of March 2020) and may include incidents that occurred a long time before this. This dataset reflects seasonality in when incidents are reported to the NRLS.

Reported number of incidents

From October 2019 to March 2020, 1,187,708 incidents were reported from England, 14% more than during October 2018 to March 2019 (1,041,714), which continues the upward trend.

Timeliness of reporting incidents

We encourage organisations to report incidents to the NRLS regularly and at least once a month. This is so that the NRLS contains up-to-date and complete information to allow the best learning possible. However, reporting delays are still seen in the NRLS data, and organisations often submit large batches of incidents every six months close to the cut-offs for the NaPSIR and OPSIR publications. This causes marked peaks in reporting patterns as discussed above. Chart 1.1 in the [NaPSIR data workbook](#) shows seasonality based on the reported dataset for national-level data. Another practice which delays reporting is reporting an incident only once a full investigation has been completed – often a considerable time after the incident occurred.

We measure the timeliness of reporting as the difference in days between the date the incident was **reported to have occurred** and the date the **incident was reported to the NRLS**. The overall reporting timelines nationally are reported as an average (median).

The average (median) time for English NHS organisations to report decreased from 22 to 21 days in October 2019 to March 2020 when compared to October 2018 to March 2019. In October 2019 to March 2020 this time ranged from 0 days to 40,206 days. Instances where the incident date was incorrectly entered, eg the year '1917' rather than a more recent and feasible date, account for the large maximum. We cannot correct these data quality issues because we do not know with certainty the true date that should have been entered.

4. Incidents reported as occurring from October 2019 to March 2020

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

This report includes analysis of incidents reported to have occurred from October 2019 to March 2020, and reported to the NRLS by 31 May 2020. This cut-off allows time for local 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 from October 2019 to March 2020 will include those that occurred in this period **and**, because of delays in reporting, those occurring before October 2019.

From October 2019 to March 2020, English NHS organisations reported 1,103,817 incidents as occurring. This is 9.2% more than from October 2018 to March 2019 (1,010,913), continuing the upward trend, but the scale of increase varied by cluster (Table 3). NHS ambulance trusts showed the greatest increase in incidents (28%), but this was primarily driven by two ambulance trusts and we are working to tease out the reasons for this increase in more detail. Conversely, acute specialist trusts showed the greatest decrease (-5.3%).

Table 3: Number and percentage of patient safety incidents reported to the NRLS as occurring; October 2018 to March 2019 and October 2019 to March 2020

NHS cluster	October 2018 to March 2019		October 2019 to March 2020		% change
	N	%	N	%	
Acute non-specialist	765,221	75.7	838,722	76.0	9.6
Acute specialist	25,001	2.5	23,675	2.1	-5.3
Mental health	187,499	18.5	204,307	18.5	9.0
Community	26,293	2.6	28,280	2.6	7.6
Ambulance	6,899	0.7	8,833	0.8	28.0 [†]
Total	1,010,913	100	1,103,817	100	9.2

[†]This increase was not uniform across all ambulance trusts or incident types and we are currently looking into what drove it. Please interpret figures for this cluster with caution.

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, by cluster, are described below.

Degree of harm definition

Degree of harm should describe the actual level of harm a patient suffered as a direct result of the patient safety incident. There are five NRLS categories for this:

- 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) so we can prioritise their clinical review. [Clinical review](#) uses NRLS data to identify new or emerging issues that may need national action, such as issuing a Patient Safety Alert. It is still important that incidents causing all degrees of harm are reported to the NRLS as breadth of information is fundamental to improving patient safety.

Sometimes reporters give an incident's **potential** degree of harm instead; for example, coding the degree of harm as 'severe' for a 'near miss' even though no harm was caused because preventative action was taken. This needs to be considered when interpreting the degree of harm data.

Reported degree of harm

The distribution of reported degree of harm in the current period (October 2019 to March 2020) is broadly consistent with that for October 2018 to March 2019.

All clusters reported most incidents as causing 'no harm' or 'low harm' (Table 4). The percentage of 'no harm' incidents ranged from 81.5% (7,201/8,833) in ambulance trusts to 56% (15,849/28,280) in community trusts, and of 'severe harm' or 'death' only around 1.0% or less across all clusters. Numerically most deaths were reported by mental health trusts.

Table 4: Reported degree of harm by NHS cluster; incidents reported as occurring from October 2019 to March 2020

NHS cluster	Reported degree of harm										Total	
	No harm		Low		Moderate		Severe		Death		N	%
	N	%	N	%	N	%	N	%	N	%		
Acute non-specialist	622,652	74.2	198,164	23.6	15,370	1.8	1,870	0.2	666	0.1	838,722	100
Acute specialist	18,796	79.4	4,535	19.2	316	1.3	16	0.1	12	0.1	23,675	100
Mental health	123,674	60.5	67,130	32.9	11,520	5.6	770	0.4	1,213	0.6	204,307	100
Community	15,849	56.0	10,892	38.5	1,391	4.9	107	0.4	41	0.1	28,280	100
Ambulance	7,201	81.5	1,306	14.8	150	1.7	105	1.2	71	0.8	8,833	100

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 different organisations report, with resulting variation within and between clusters.

The four most commonly reported incident categories for each cluster in the current and previous period are summarised in Tables 5a to 5e. (Full detail is available in the [OPSIR data tables](#).) These tables show the variation across clusters in the top four incident categories, their rank and percentage. For example, ‘implementation of care and ongoing monitoring/review’ was the most commonly reported incident category among acute non-specialist trusts (21.1%; 177,107/838,722), but ‘self-harming behaviour’ was the most common among mental health trusts (23.6%; 48,195/204,307).

Table 5a: Reported incident category – acute non-specialist cluster; incidents reported as occurring from October 2018 to March 2019 and October 2019 to March 2020

Incident category	October 2018 to March 2019		October 2019 to March 2020		% change
	N	%	N	%	
Implementation of care and ongoing monitoring/review	122,156	16.0	177,107	21.1	45.0
Patient accident	113,235	14.8	117,671	14.0	3.9
Access, admission, transfer, discharge (including missing patient)	96,505	12.6	103,801	12.4	7.6
Treatment, procedure	89,950	11.8	89,823	10.7	-0.1
All other incident categories	343,375	44.9	350,320	41.8	2.0
Total	765,221	100	838,722	100	9.6

Table 5b: Reported incident category – acute specialist cluster; incidents reported as occurring from October 2018 to March 2019 and October 2019 to March 2020

Incident category	October 2018 to March 2019		October 2019 to March 2020		% change
	N	%	N	%	
Medication	4,396	17.6	4,319	18.2	-1.8
Treatment, procedure	3,229	12.9	3,484	14.7	7.9
Documentation (including records, identification)	4,083	16.3	2,577	10.9	-36.9
Access, admission, transfer, discharge (including missing patient)	2,433	9.7	2,479	10.5	1.9
All other incident categories	10,860	43.4	10,816	45.7	-0.4
Total	25,001	100	23,675	100	-5.3

Table 5c: Reported incident category – mental health cluster; incidents reported as occurring from October 2018 to March 2019 and October 2019 to March 2020

Incident category	October 2018 to March 2019		October 2019 to March 2020		% change
	N	%	N	%	
Self-harming behaviour	43,938	23.4	48,195	23.6	9.7
Implementation of care and ongoing monitoring / review	23,437	12.5	34,049	16.7	45.3
Disruptive, aggressive behaviour	21,761	11.6	22,456	11.0	3.2
Patient accident	22,812	12.2	21,957	10.7	-3.7
All other incident categories	75,551	40.3	77,650	38.0	2.8
Total	187,499	100	204,307	100	9.0

Table 5d: Reported incident category – NHS community cluster; incidents reported as occurring from October 2018 to March 2019 and October 2019 to March 2020

Incident category	October 2018 to March 2019		October 2019 to March 2020		% change
	N	%	N	%	
Implementation of care and ongoing monitoring/review	8,966	34.1	10,891	38.5	21.5
Patient accident	4,090	15.6	3,614	12.8	-11.6
Access, admission, transfer, discharge (including missing patient)	2,820	10.7	3,247	11.5	15.1
Medication	2,944	11.2	2,720	9.6	-7.6
All other incident categories	7,473	28.4	7,808	27.6	4.5
Total	26,293	100	28,280	100	7.6

Table 5e: Reported incident category – ambulance cluster; incidents reported as occurring from October 2018 to March 2019 and October 2019 to March 2020

Incident category	October 2018 to March 2019		October 2019 to March 2020		% change
	N	%	N	%	
Access, admission, transfer, discharge (including missing patient)	2,164	31.4	2,470	28.0	14.1
Clinical assessment (including diagnosis, scans, tests, assessment)	724	10.5	1,534	17.4	111.9
Treatment, procedure	688	10.0	999	11.3	45.2
Medical device/equipment	682	9.9	822	9.3	20.5
All other incident categories	2,641	38.3	3,008	34.1	13.9
Total	6,899	100	8,833	100	28.0[†]

[†] This increase is not uniform across all ambulance trusts. Please interpret figures for this cluster with caution.

Care setting of occurrence

This information helps us understand where reported incidents have occurred and is needed because any organisation can report any incident, even one that occurred at another organisation.

Tables 6a to 6e rank the four most commonly reported care settings for each cluster in the current and previous comparable period and show the variation by cluster. For example, among acute non-specialist trusts 'acute/general hospital' was the most commonly reported care setting of occurrence (93.5%; 783,910/838,722), but 'ambulance service' was the most common care setting for the ambulance trust cluster (95.9%; 8,469/8,833).

Table 6a: Reported care setting of occurrence – acute non-specialist cluster; incidents reported as occurring from October 2018 to March 2019 and October 2019 to March 2020

Care setting of occurrence	October 2018 to March 2019		October 2019 to March 2020		% change
	N	%	N	%	
Acute/general hospital	723,205	94.5	783,910	93.5	8.4
Community nursing, medical and therapy service (including community hospital)	40,065	5.2	52,161	6.2	30.2
General practice	1,075	0.1	1,837	0.2	70.9
Ambulance service	411	0.1	363	0.0	-11.7
All other care settings	465	0.1	451	0.1	-3.0
Total	765,221	100	838,722	100	9.6

Table 6b: Reported care setting of occurrence – acute specialist cluster; incidents reported as occurring from October 2018 to March 2019 and October 2019 to March 2020

Care setting of occurrence	October 2018 to March 2019		October 2019 to March 2020		% change
	N	%	N	%	
Acute/general hospital	24,383	97.5	23,193	98.0	-4.9
Mental health service	451	1.8	320	1.4	-29.0
Community nursing, medical and therapy service (including community hospital)	106	0.4	111	0.5	4.7
Ambulance service	57	0.2	48	0.2	-15.8
All other care settings	4	0.0	3	0.0	-25.0
Total	25,001	100	23,675	100	-5.3

Table 6c: Reported care setting of occurrence – mental health cluster; incidents reported as occurring from October 2018 to March 2019 and October 2019 to March 2020

Care setting of occurrence	October 2018 to March 2019		October 2019 to March 2020		% change
	N	%	N	%	
Mental health service	133,289	71.1	140,054	68.6	5.1
Community nursing, medical and therapy service (including community hospital)	41,549	22.2	50,894	24.9	22.5
Learning disabilities service	9,250	4.9	10,055	4.9	8.7
Acute/general hospital	2,280	1.2	2,277	1.1	-0.1
All other care settings	1,131	0.6	1,027	0.5	-9.2
Total	187,499	100	204,307	100	9.0

Table 6d: Reported care setting of occurrence – NHS community cluster; incidents reported as occurring from October 2018 to March 2019 and October 2019 to March 2020

Care setting of occurrence	October 2018 to March 2019		October 2019 to March 2020		% change
	N	%	N	%	
Community nursing, medical and therapy service (including community hospital)	24,565	93.4	26,792	94.7	9.1
Mental health service	1,103	4.2	933	3.3	-15.4
Acute/general hospital	264	1.0	242	0.9	-8.3
Learning disabilities service	216	0.8	178	0.6	-17.6
All other care settings	145	0.6	135	0.5	-6.9
Total	26,293	100	28,280	100	7.6

Table 6e: Reported care setting of occurrence – ambulance cluster; incidents reported as occurring from October 2018 to March 2019 and October 2019 to March 2020

Care setting of occurrence	October 2018 to March 2019		October 2019 to March 2020		% change
	N	%	N	%	
Ambulance service	6,688	96.9	8,469	95.9	26.6
Acute/general hospital	132	1.9	192	2.2	45.5
Community nursing, medical and therapy service (including community hospital)	59	0.9	84	1.0	42.4
General practice	20	0.3	83	0.9	315.0 [†]
All other care settings	0	N/A	5	0.1	N/A
Total	6,899	100	8,833	100	28.0[‡]

[†] Fluctuations in small numbers should be interpreted with caution.

[‡] This increase is not uniform across all ambulance trusts. Please interpret figures for this cluster with caution.

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. This increase, together with the reduction in the time between an incident occurring and it being reported, also provides more opportunity for us to learn and reduce the risk of harm to patients. Overall the types of incidents reported to the NRLS have remained similar to those reported from October 2018 to March 2019.

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 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. This 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: nrls.datarequests@nhs.net

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