

NRLS organisation patient safety incident reports: commentary

September 2021 (updated October 2022)

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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 to facilitate learning from error.

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.

This report covers the early stages of the COVID-19 pandemic in England, from April 2020 through to the end of March 2021, when cases had declined rapidly. Despite a small reduction, NRLS reporting levels remained high during this period; with the largest reduction, of 21.5%, seen in acute (specialist) trusts, but an increase of 7.1% in ambulance trusts.

The average (median) time to report incidents nationally was 19 days, which is a small reduction on 21 days in April 2019 to March 2020.

Nationally, the overall profile of incident characteristics (incident type, reported degree of harm and care setting where the incident occurs) was similar for most groups, when comparing April 2020 – March 2021 against April 2019 – March 2020.

We revised our publishing schedule for this data, as a result it is now published annually rather than biannually. This report is the first publication to cover a 12-month reporting period, based on fiscal years running from April – March. Comparisons are made against previously unpublished 12-month period, formed by combining data from the two previous six-month publications.

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2. Introduction

2.1 Impact of COVID-19

This commentary interprets the data published in the organisation patient safety incident reports ([OPSIR](#)) for April 2020 to March 2021 for English NHS organisations. This covers the period from the start of the COVID-19 pandemic in England, through to the peak at the end of 2020 (Figure 1), and ending in March 2021. The pandemic has had a profound and far-reaching impact on society and healthcare provision globally.

To protect the NHS and release capacity in hospitals for COVID-19 patients the NHS in England underwent rapid changes to the types of services provided (Health Foundation, 2020¹). For example: non-urgent elective procedures were postponed and patients who were “medically ready” were discharged with support packages; primary care services were modified to include virtual appointments, allow for social distancing, and to support the subsequent roll out of the COVID-19 vaccine (Health Foundation, 2021²).

Responding to COVID-19 placed considerable extra burden on healthcare staff. The NHS England and NHS Improvement National Patient Safety Team’s position was that NHS staff should continue to report anything that concerned them and that they felt others needed to know. It was also made clear there should be no criticism of staff for incident reporting decisions during this time.

The team also provided advice to regional teams to support providers by clarifying expectations related to hospital-onset healthcare associated COVID-19 infections in October 2020, and again in March 2021. This advice reiterated existing definitions of ‘hospital-onset probable or definite healthcare acquired infections’, and that these also meet the definition of a patient safety incident. This has contributed to a sharp rise in infection control incidents related to COVID-19.

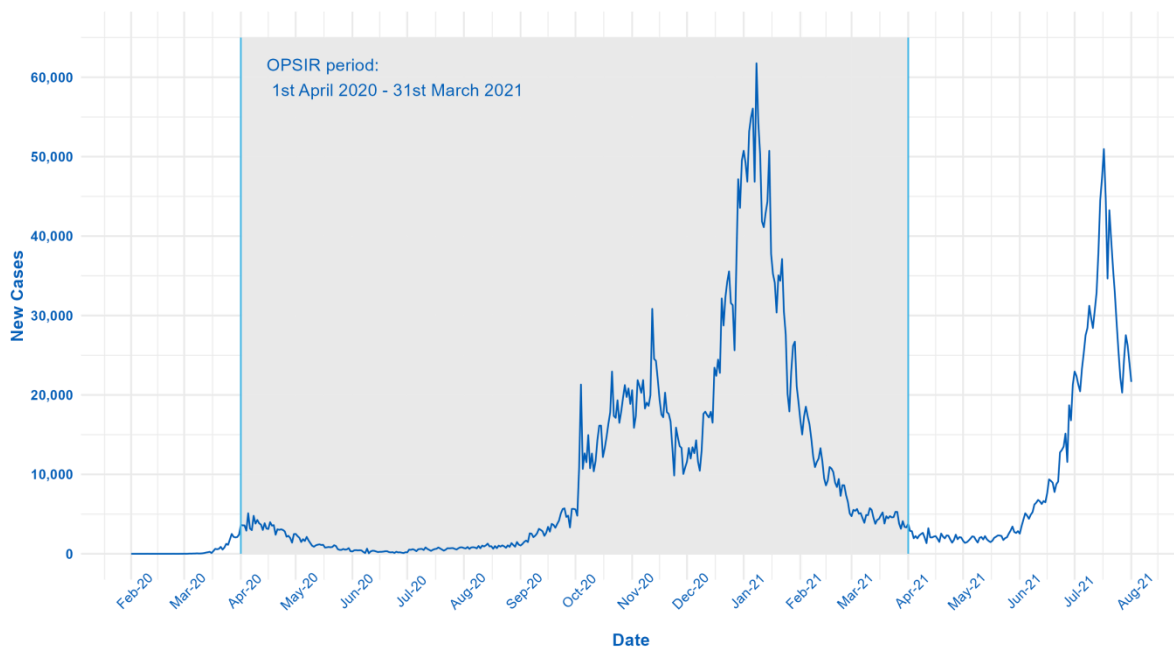
¹ Health Foundation, November 2020. Elective care in England. Assessing the impact of COVID-19 and where next. Accessed 20 Sep. 21 < [Elective care in England - The Health Foundation](#)>

² Health Foundation, May 2021. How has the COVID-19 pandemic impacted primary care? Accessed 20 Sep. 21 < [How has the COVID-19 pandemic impacted primary care? \(health.org.uk\)](#)>

These COVID-19 related changes can be observed in routine national NHS-related datasets as well as the NRLS and will affect any comparisons over time. For example: we anticipated a static or declining trend in the number of incidents reported to the NRLS and a change in the types of incidents reported because of pressures on NHS staff capacity and fewer elective procedures.

The [OPSIR workbooks](#) include a reporting rate for certain organisations which is calculated by dividing the number of incidents reported by the number of occupied beds. Bed occupancy during the OPSIR period has declined nationally (Nuffield Trust, 2021³) and by up to 60% in some NHS trusts, therefore reporting rates in this publication will not be consistent with previous years. These will be discussed in more detail throughout this commentary.

Figure 1: Daily COVID-19 cases, England*



* Reproduced from <https://coronavirus.data.gov.uk/details/cases>, accessed 16/08/2021.

³ Nuffield Trust, June 2021. Hospital Bed Occupancy. Accessed 20 Sep. 21 <
<https://www.nuffieldtrust.org.uk/resource/hospital-bed-occupancy>>

2.2 OPSIR Overview

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 and services provided 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**. As organisations move towards integrated care systems, we will see more organisations delivering care across multiple settings.

For the purposes of this publication, organisations are assigned to a single cluster that represents the setting in which the majority of their care is delivered.

We use the following 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).

This is the first OPSIR publication to present data for a 12-month period. Previously we [published data every six months](#), covering the six-month periods of April to September and October to March. Any comparisons between this OPSIR and those published previously must account for this, alongside the impact of COVID-19. Comparison of a 12 month and six-month period will lead to misleading conclusions about any changes over time.

To allow us to make appropriate comparisons over time, in this commentary we have added together the previously published data for April 2019 to September 2019 and October 2019 to March 2020. This means that, in this publication, we are comparing data for April 2020 to March 2021 with April 2019 to March 2020.

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](#))
- [monthly summary data](#) on patient safety incident reports.⁴

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 directly 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 [†] and fixed/static	Fixed/static	Dynamic
Dataset used	Reported and occurring datasets [‡]	Reported and occurring datasets [‡]	Reported dataset [‡]

⁴ 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	<p>Reported dataset: rolling quarters from October to December 2003 to the most recent quarter available.</p> <p>Occurring dataset: NaPSIR now covers the most recent financial year. Previously, the occurring data was published as rolling quarters covering the last four available quarters.</p>	OPSIR now covers the most recent financial year. Previously, data was published as six-monthly periods, April-September and October-March.	A rolling 12-month period covering the preceding 12 complete months of available data.
Updated	Annually	Annually	Every month
Geography/ breakdown	All geographical locations, by care setting	England, by individual NHS organisation (organised by cluster)	England, by individual organisation
Inclusions	<p>The following care settings:</p> <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 	<p>The following organisation types:</p> <ul style="list-style-type: none"> • acute/general hospital • mental health service • community trust • ambulance service 	<p>The following organisation types:</p> <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 on the [Welsh Government website](#).

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 Learn from Patient Safety Events service (LFPSE; formerly [Patient Safety Information Management System \(PSIMS\)](#)) will fully replace the NRLS. It will change the way information is collected to make it easier to record and learn from

patient safety events, including patient safety incidents. 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 in future years.

From July 2021 patient safety events have been reported to LFPSE by individuals and organisations that previously used the 'eForm' reporting method. This currently represents a minority of incidents that would have been reported to the NRLS. We are currently developing new LFPSE-related outputs. However as most incidents are still reported via the NRLS we anticipate that NRLS outputs will remain unchanged until the volume of events recorded via LFPSE increases.

Data quality note on organisation mergers and cluster placement

Six organisational mergers occurred during the current reporting period (Table 2). 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 allocated each newly merged organisation to an appropriate cluster. Four mergers did not involve a change in cluster, whilst two did. This will impact on comparisons over time, particularly where one or more merged organisations changes cluster.

An organisational name change on 1 April 2020, from Dudley and Walsall Mental Health Partnership NHS Trust (RYK) to Dudley Integrated Health and Care NHS Trust (RYK), was associated with a change in service provision. This organisation was previously a mental health provider but is now providing primary care services. As the OPSIR does not publish data from primary care organisations, RYK has been removed from the current OPSIR.

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

Table 2: Organisational mergers affecting OPSIR data reported for the period April 2020 to March 2021

New organisation name and code		New cluster	Old organisation name and code		Old cluster
Bedfordshire Hospitals NHS Foundation Trust	RC9	Acute (non-specialist) trust	Luton and Dunstable University Hospital NHS Foundation Trust	RC9	Acute (non-specialist) trust
			Bedford Hospital NHS Trust	RC1	Acute (non-specialist) trust
Guy's and St Thomas' NHS Foundation Trust	RJ1	Acute (non-specialist) trust	Royal Brompton and Harefield NHS Foundation Trust	RT3	Acute (specialist)
			Guy's and St Thomas' NHS Foundation Trust	RJ1	Acute (non-specialist) trust
Mid and South Essex NHS Foundation Trust	RAJ	Acute (non-specialist) trust	Mid Essex Hospital Services NHS Trust	RQ8	Acute (non-specialist) trust
			Southend University Hospital NHS Foundation Trust	RAJ	Acute (non-specialist) trust
			Basildon and Thurrock University Hospitals NHS	RDD	Acute (non-specialist) trust
Somerset NHS Foundation Trust	RH5	Acute (non-specialist) trust	Taunton and Somerset NHS Foundation Trust	RBA	Acute (non-specialist) trust
			Somerset Partnership NHS Foundation Trust	RH5	Mental health
University Hospitals Bristol and Weston NHS Foundation Trust	RA7	Acute (non-specialist) trust	Weston Area Health NHS Trust	RA3	Acute (non-specialist) trust
			University Hospitals Bristol NHS Foundation Trust	RA7	Acute (non-specialist) trust
University Hospitals Dorset NHS Foundation Trust	R0D	Acute (non-specialist) trust	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	RDZ	Acute (non-specialist) trust
			Poole Hospital NHS Foundation Trust	RD3	Acute (non-specialist) trust

3. Incidents reported from April 2020 to March 2021

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 2021) 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 April 2020 to March 2021, 2,127,526 incidents were reported in England, a 7.1% reduction when compared to April 2019 to March 2020. Given the changes in healthcare provision due to COVID-19, a reduction is expected and may represent many factors such as the reduction in acute planned care, the reduction of on-site services in non-acute trusts to comply with pandemic restrictions, the transition to digital-first delivery methods, and additional pressures on staff.

Timeliness of reporting incidents

We encourage organisations to report incidents to the NRLS regularly and at least once a month. This is so the NRLS contains up-to-date and complete information to allow the best learning possible. However, reporting delays are still routinely seen in the NRLS data, and organisations often submit large batches of incidents every six months close to the historical cut-offs for the NaPSIR and OPSIR publications. This causes marked peaks in reporting patterns as discussed above.

Chart 2 in the [NaPSIR data workbook](#) shows seasonality based on the reported dataset for national-level data, as well as a dip from April to September 2020. 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 21 to 19 days in April 2020 to March 2021 when compared to April 2019 to March 2020. In April 2020 to March 2021 this time ranged from 0 days to 36,649 days. Instances where the incident date was incorrectly entered, e.g. the year '1917' rather than a more recent and feasible date, account for the large maximum. We cannot correct these data quality issues as we do not know with certainty the true date that should have been entered.

4. Incidents reported as occurring from April 2020 to March 2021

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 April 2020 to March 2021, and reported to the NRLS by 31 May 2021. 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 April 2020 to March 2021 will include those that occurred in this period **and**, because of delays in reporting, those occurring before April 2020.

From April 2020 to March 2021, English NHS organisations reported 2,090,718 incidents as occurring. This is a 6% decrease when compared with April 2019 to March 2020 (2,224,330).

As with reported incidents in section 3, COVID-19 has changed both the volume and type of healthcare activity in the NHS which has affected incident reporting. However, the scale of the decrease varied by cluster (Table 3). Acute specialist trusts saw the largest comparative change, with incident reports reducing 21.5% compared with the previous year. Acute (non-specialist trusts), whose reporting accounts for approximately 75% of incident reports received by NRLS, reduced by 7.6% compared with the previous year. NHS community trusts also showed a small decrease. Increases were observed in mental health (1.4%, rising by 5,932) and in NHS ambulance trusts (7.1%, rising by 1,284) compared to the previous year.

Table 3: Number and percentage of patient safety incidents reported to the NRLS as occurring; April 2019 to March 2020 and April 2020 to March 2021

NHS cluster	April 2019 to March 2020		April 2020 to March 2021		% change
	N	%	N	%	
Acute (non-specialist)	1,677,318	75.4	1,550,533	74.2%	-7.6%
Acute (specialist)	52,308	2.4	41,053	2.0%	-21.5%
Mental health	419,054	18.8	424,986	20.3%	1.4%
Community	57,603	2.6	54,815	2.6%	-4.8%
Ambulance	18,047	0.8	19,331	0.9%	7.1%
Total	2,224,330	100	2,090,718	100.0%	-6.0%

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](#). The review process uses NRLS data to identify new or emerging issues that may need national action, such as issuing a [National 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 (April 2020 to March 2021) is broadly consistent with that for April 2019 to March 2020.

All clusters reported most incidents as causing 'no harm' or 'low harm' (Table 4). The percentage of 'no harm' incidents ranged from 77.96% (15,088/19,331) in ambulance trusts to 51.8 (28,378/54,815) in community trusts. Of 'severe harm' or 'death' incidents, proportions for all clusters were 1.1% or lower across all clusters. In absolute numbers, most deaths were reported by acute trusts.

Table 4: Reported degree of harm by NHS cluster; incidents reported as occurring from April 2020 to March 2021

NHS cluster	Reported degree of harm										Total	
	No harm		Low		Moderate		Severe		Death			
	N	%	N	%	N	%	N	%	N	%	N	%
Acute (non-specialist)	1,128,344	72.8	381,215	24.6	34,207	2.2	3,768	0.2	2,999	0.2	1,550,533	100
Acute (specialist)	31,778	77.4	8,544	20.8	631	1.5	48	0.1	52	0.1	41,053	100
Mental health	250,188	58.9	145,797	34.3	24,521	5.8	1,588	0.4	2,892	0.7	424,986	100
Community	28,379	51.8	23,318	42.5	2,773	5.1	226	0.4	119	0.2	54,815	100
Ambulance	15,088	78.1	3,571	18.5	384	2.0	200	1.0	88	0.5	19,331	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, and percentage change against the previous year. For example, 'Implementation of care and ongoing monitoring / review' was the most commonly reported incident category among acute (non-specialist) trusts (22.8%; 354,097), representing an increase of 6.5%. 'Self-harming behaviour' was the most common category among mental health trusts (26.1%; 110,834/424,986), and saw an increase of 11.3% compared with the previous year. A large reduction (21.5%, 11,255 fewer reports) was seen in the acute (specialist) cluster, likely linked to reductions in planned care due to COVID-19.

Table 5a: Reported incident category – acute (non-specialist) cluster; incidents reported as occurring from April 2019 to March 2020 and April 2020 to March 2021

Incident category	April 2019 to March 2020		April 2020 to March 2021		% change
	N	%	N	%	
Implementation of care and ongoing monitoring / review	332,601	20.4	354,097	22.8	6.5
Patient accident	230,735	13.8	214,513	13.8	-7.0
Treatment, procedure	184,890	11	187,255	12.1	1.3
Access, admission, transfer, discharge (including missing patient)	210,773	12.9	164,982	10.6	-21.7
All other incident categories	671,777	41.2	629,686	40.6	-6.3
Total	1,630,776	100	1,550,533	100.	-4.9

Table 5b: Reported incident category – acute (specialist) cluster; incidents reported as occurring from April 2019 to March 2020 and April 2020 to March 2021

Incident category	April 2019 to March 2020		April 2020 to March 2021		% change
	N	%	N	%	
Medication	9,474	18.1	7,437	18.1	-21.5
Treatment, procedure	7,312	14	4,761	11.6	-34.9
Access, admission, transfer, discharge (including missing patient)	5,519	10.6	4,634	11.3	-16.0
Implementation of care and ongoing monitoring / review	3,947	7.5	4,316	10.5	8.6
All other categories	26,056	49.8	19,905	48.5	-23.5
Total	52,308	100	41,053	100	-21.5

Table 5c: Reported incident category – mental health cluster; incidents reported as occurring from April 2019 to March 2020 and April 2020 to March 2021

Incident category	April 2019 to March 2020		April 2020 to March 2021		% change
	N	%	N	%	
Self-harming behaviour	99,583	23.8	110,834	26.1	11.3
Implementation of care and ongoing monitoring / review	66,023	15.8	72,999	17.2	10.6
Disruptive, aggressive behaviour (includes patient-to-patient)	47,149	11.3	46,481	10.9	-1.4
Patient accident	44,756	10.7	40,857	9.6	-8.7
All other incident categories	161,543	38.5	153,815	36.2	-4.9
Total	419,054	100	424,986	100	1.4

Table 5d: Reported incident category – NHS community cluster; incidents reported as occurring from April 2019 to March 2020 and April 2020 and March 2021

Incident category	April 2019 to March 2020		April 2020 to March 2021		% change
	N	%	N	%	
Implementation of care and ongoing monitoring / review	22,134	38.4	23,278	42.5	5.2
Patient accident	7,439	12.9	6,582	12	-11.5
Medication	5,623	9.8	4,899	8.9	-12.9
Access, admission, transfer, discharge (including missing patient)	6,506	11.3	4,736	8.6	-27.2
All other incident categories	15,901	27.6	15,320	27.9	-3.7
Total	57,603	100.0	54,815	100	-4.8

Table 5e: Reported incident category – ambulance cluster; incidents reported as occurring from April 2019 to March 2020 and April 2020 to March 2021

Incident category	April 2019 to March 2020		April 2020 to March 2021		% change
	N	%	N	%	
Access, admission, transfer, discharge (including missing patient)	5,030	27.9	5,239	27.1	4.2
Clinical assessment (including diagnosis, scans, tests, assessments)	2,846	15.8	2,636	13.6	-7.4
Treatment, procedure	2,061	11.4	2,185	11.3	6.0
Medical device / equipment	1,651	9.1	1,905	9.9	15.4
All other incident categories	6,459	35.8	7,366	38.1	14
Total	18,047	100.0	19,331	100.0	7.1

Care setting of occurrence

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

Tables 6a to 6e rank the four most commonly reported care settings for each cluster, for the current and previous comparable periods. For example, 'acute/general hospital' was the most commonly reported 'care setting of occurrence' for acute (non-specialist) trusts (92.2%; 1,429,853/1,550,533), and 'ambulance service' the most common for the ambulance trust cluster (95.3%; 18,417/19,331).

A large increase (523.6%) was seen in the 'mental health service' setting for acute non-specialist trusts, but this was driven by the merger of Taunton and Somerset NHS Foundation Trust (RBA) and Somerset Partnership NHS Foundation Trust (RH5), with the combined organisation now reported in the acute (non-specialist) cluster (Table 2).

A large increase (70.2%) was seen for 'Acute/general hospital' location in the mental health trust cluster. This was driven by two organisations: Midlands Partnership Trust (RRE), the main reporter for this setting in 2019/2020, reporting double the incidents in 2020/2021, and South West Yorkshire Partnership Trust (RXG) reporting a substantial increase to 2,744 incident reports in 2020/2021, having reported only 6 in this setting in 2019/2020. This may reflect changes in service provision with the mergers, but also improvements in reporting.

Table 6a: Reported care setting of occurrence – acute (non-specialist) cluster; incidents reported as occurring from April 2019 to March 2020 and April 2020 to March 2021

Care setting of occurrence	April 2019 to March 2020		April 2020 to March 2021		% change
	N	%	N	%	
Acute/general hospital	1,571,852	93.7	1,429,853	92.2	-9.0
Community nursing, medical and therapy service (including community hospital)	100,192	6	113,337	7.3	13.1
General practice	3,266	0.2	3,418	0.2	4.7
Mental health service	385	0	2,401	0.2	523.6
All other care settings	1,623	0.1	1,524	0.1	-6.1
Total	1,677,318	100	1,550,533	100.0	-7.6

Table 6b: Reported care setting of occurrence – acute (specialist) cluster; incidents reported as occurring from April 2019 to March 2020 and April 2020 to March 2021

Care setting of occurrence	April 2019 to March 2020		April 2020 to March 2021		% change
	N	%	N	%	
Acute/general hospital	51,024	97.5	39,415	96	-22.8
Mental health service	906	1.7	1,205	2.9	33.0
Community nursing, medical and therapy service (including community hospital)	269	0.5	243	0.6	-9.7
Ambulance service	99	0.2	130	0.3	31.3
All other care settings	10	0	60	0.1	500
Total	52,308	100	41,053	100	-21.5

Table 6c: Reported care setting of occurrence – mental health cluster; incidents reported as occurring from April 2019 to March 2020 and April 2020 to March 2021

Care setting of occurrence	April 2019 to March 2020		April 2020 to March 2021		% change
	N	%	N	%	
Mental health service	290,948	69.4	293,092	69.0	0.7
Community nursing, medical and therapy service (incl. community hospital)	101,153	24.1	100,391	23.6	-0.8
Learning disabilities service	20,554	4.9	17,902	4.2	-12.9
Acute / general hospital	4,414	1.1	7,511	1.8	70.2
All other care settings	1,985	0.5	6,090	1.4	206.8
Total	419,054	100	424,986	100	1.4

Table 6d: Reported care setting of occurrence – NHS community cluster; incidents reported as occurring from April 2019 to March 2020 and April 2020 to March 2021

Care setting of occurrence	April 2019 to March 2020		April 2020 to March 2021		% change
	N	%	N	%	
Community nursing, medical and therapy service (including community hospital)	54,428	94.5	51,612	94.2	-5.2
Mental health service	1,944	3.4	2,392	4.4	23.0
Acute/general hospital	481	0.8	289	0.5	-39.9
Learning disabilities service	436	0.8	214	0.4	-50.9
All other care settings	314	0.5	308	0.6	-1.9
Total	57,603	100	54,815	100	-4.8

Table 6e: Reported care setting of occurrence – ambulance cluster; incidents reported as occurring from April 2019 to March 2020 and April 2020 to March 2021

Care setting of occurrence	April 2019 to March 2020		April 2020 to March 2021		% change
	N	%	N	%	
Ambulance service	17,453	96.7	18,417	95.3	5.5
Acute/general hospital	343	1.9	493	2.6	43.7
Community nursing, medical and therapy service (including community hospital)	140	0.8	222	1.1	58.6
General practice	103	0.6	162	0.8	57.3
All other care settings	8	0	37	0.2	362.5 [†]
Total	18,047	100	19,331	100	7.1

[†] Fluctuations in small numbers should be interpreted 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 at the submitting organisations. The system is not designed to count the actual number of incidents occurring in the NHS. Therefore, the general trend of increases in incidents reported to the NRLS indicates a constantly improving reporting culture. These increases, together with the reduction in the time between an incident occurring and it being reported, have provided more opportunity for us to learn and reduce the risk of harm to patients. The total number of incident reports has reduced in April 2020 – March 2021, and the distribution of incident types has changed; these are likely related to the COVID-19 pandemic and its effects on health services.

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.

The recently launched LFPSE service will replace the NRLS. This will affect the sort of data we collect, and national incident reporting will span two systems during the implementation and roll out. As a result, our statistical outputs are anticipated to change in future years. More information is available [online](#).

The COVID-19 pandemic has drastically affected people's health, healthcare needs and healthcare delivery across the world. The pressures on NHS hospital care and ambulance services, the reduction in elective case provision, and the transition to digital-first delivery methods will all have affected incident reporting. NRLS data continues to be used to learn about emerging patient safety issues and improve safety, but the data in this publication cannot be used to compare against pre-COVID-19 time periods in any meaningful way.

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

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