

# NRLS organisation patient safety incident reports: commentary

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 generally 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 period from April 2021 to March 2022, a period characterised by the restoration of services following the outbreak of the COVID-19 pandemic. 54.9% of the population of England had received a first dose of the COVID-19 vaccination at the start of this period; by the end of the period this figure was 91.8%<sup>1</sup>. NRLS reporting levels increased during this period across care settings when compared to the previous year.

The average (median) time to report incidents nationally was 20 days, which is a small increase on 19 days in April 2020 to March 2021.

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 2021 – March 2022 against April 2020 – March 2021.

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<sup>1</sup> <https://coronavirus.data.gov.uk/details/vaccinations?areaType=nation&areaName=England>. Date accessed: 30<sup>th</sup> September 2022

# 2. Introduction

## 2.1 Impact of COVID-19

This commentary interprets the data published in the organisation patient safety incident reports ([OPSIR](#)) for April 2021 to March 2022 for English NHS organisations. This covers the period characterised by the restoration of services following the outbreak of the COVID-19 pandemic. The pandemic has had a profound and far-reaching impact on society and health provision globally, including the United Kingdom. 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, 2020<sup>3</sup>). 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, and changes were made to allow social distancing and the subsequent roll out of the COVID-19 vaccine (Health Foundation, 2021<sup>4</sup>).

Healthcare staff faced considerable burden with COVID-19. The 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. We also made clear there should be no criticism of staff for incident reporting decisions during this time. We 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.

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.

<sup>3</sup> 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](#)>

<sup>4</sup> 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? \(health.org.uk\)](#)>

## 2.2 OPSIR overview

OPSIRs 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 setting of the majority of their care they deliver.

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).

This OPSIR publication presents data for a 12-month period, April 2021 to March 2022.

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.<sup>6</sup>

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,

<sup>6</sup> Although not formally an official statistic this output is included here due to its similarity to the OPSIR and NaPSIR.

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
<b>Purpose</b>	<p>To provide a national picture of the reporting of patient safety incidents and of the characteristics of incidents (type, care setting, degree of harm).</p> <p>This dataset forms the basis of the indicator 'improving the culture of safety reporting' in Domain 5 of the <a href="#">NHS outcomes framework</a> (Treating and caring for people in a safe environment and protecting them from avoidable harm).</p>	<p>To provide data on individual organisation's reporting and patient safety characteristics.</p> <p>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.*</p>	<p>To provide timely data on reporting to the NRLS to encourage more consistent reporting and support organisations to monitor potential under-reporting of incidents.</p> <p>Data is provided by organisation, degree of harm and month of reporting to the NRLS. Organisations are not grouped into 'clusters'.</p>
<b>Dataset type</b>	Dynamic <sup>†</sup> and fixed/static	Fixed/static	Dynamic
<b>Dataset used</b>	Reported and occurring datasets <sup>‡</sup>	Reported and occurring datasets <sup>‡</sup>	Reported dataset <sup>‡</sup>
<b>Period covered</b>	<p>Reported dataset: rolling quarters from October to December 2003 to the most recent quarter available.</p> <p>Occurring dataset: the most recent financial year. Historically the occurring data was rolling quarters covering the last four available quarters.</p>	The most recent financial year. Historically, data was published for six-monthly periods, April-September and October-March.	A rolling 12-month period covering the preceding 12 complete months of available data.
<b>Updated</b>	Annually	Annually	Monthly

Feature	NaPSIR	OPSIR	Monthly summaries
<b>Geography/ breakdown</b>	All geographical locations, by care setting	England, by individual NHS organisation (organised by cluster)	England, by individual organisation
<b>Inclusions</b>	The following care settings: <ul style="list-style-type: none"> <li>• acute/general hospital</li> <li>• mental health service</li> <li>• community nursing, medical and therapy service</li> <li>• learning disabilities service</li> <li>• ambulance service</li> <li>• general practice</li> <li>• community pharmacy</li> <li>• community and general dental service</li> <li>• community optometry/optician service</li> </ul>	The following organisation types: <ul style="list-style-type: none"> <li>• acute/general hospital</li> <li>• mental health service</li> <li>• community trust</li> <li>• ambulance service</li> </ul>	The following organisation types: <ul style="list-style-type: none"> <li>• acute/general hospital</li> <li>• mental health service</li> <li>• community trust</li> <li>• ambulance service</li> <li>• integrated care organisation</li> </ul>

\* Information on clusters 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

Two 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 allocate the newly merged organisation to an appropriate cluster. Neither merger involved a change in cluster.

During the period of this report, Pennine Acute Hospitals NHS Trust (RW6) was dissolved and transferred to Northern Care Alliance NHS Foundation Trust (RM3) and Manchester University NHS Foundation Trust (R0A). All three organisations are reported separately against their original codes for the purposes of this report.

Milton Keynes University Hospital NHS Foundation Trust (RD8) and West Midlands Ambulance Service University NHS Foundation Trust (RYA) were early adopters to LFPSE via their local risk management systems, and submitted to LFPSE during this reporting period; as a result, the number of incidents submitted to the NRLS by these trusts should be interpreted with caution.

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 2021 to March 2022

Affected organisations	Change type	New code	New organisation name
<p>North West Boroughs Healthcare NHS Foundation Trust (RTV)</p> <p>Mersey Care NHS Foundation Trust (RW4)</p>	NHS trust acquisition	RW4	Mersey Care NHS Foundation Trust
<p>Western Sussex Hospitals NHS Foundation Trust (RYR)</p> <p>Brighton and Sussex University Hospitals NHS Trust (RXH)</p>	NHS trust acquisition	RYR	University Hospitals Sussex NHS Foundation Trust

# 3. Incidents reported from April 2021 to March 2022

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 2022) 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 2021 to March 2022, 2,364,869 incidents were reported from England, an increase of 10% when compared to April 2020 to March 2021. Given the changes in healthcare provision due to COVID-19, and the resumption of services with backlogs, an increase is expected and may appear exaggerated by a regression to the mean effect after an exceptionally low year. When compared to April 2019 to March 2020, it represents only a 2.1% increase in reporting.

## 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 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 1.1 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 increased from 19 to 20 days in April 2021 to March 2022 when compared to April 2020 to March 2021. In April 2021 to March 2022, this time ranged from 0 days to 36,974 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 because we do not know with certainty the true date that should have been entered.

# 4. Incidents reported as occurring from April 2021 to March 2022

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 2021 to March 2022 and reported to the NRLS by 31 May 2022. 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 2021 to March 2022 will include those that occurred in this period **and**, because of delays in reporting, those occurring before April 2021.

From April 2021 to March 2022, English NHS organisations reported 2,331,192 incidents as occurring within the same period. This is a 11.5% increase when compared with April 2020 to March 2021 (2,090,718). 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. An increase was seen across all clusters, however, the scale of the increase varied by cluster (Table 3). Acute (non-specialist trusts), whose reporting accounts for approximately 76% of incident reports received by NRLS, saw the largest comparative change, increasing by 14.0% compared with the previous year. NHS ambulance trusts showed the smallest percentage increase, rising by 1.6% compared to the previous year.

**Table 3: Number and percentage of patient safety incidents reported to the NRLS as occurring April 2020 to March 2021 and April 2021 to March 2022**

NHS cluster	April 2020 to March 2021		April 2021 to March 2022		% change
	N	%	N	%	
Acute (non-specialist)	1,550,533	74.2	1,767,264	75.8	14.0
Acute (specialist)	41,053	2.0	45,638	2.0	11.2
Mental health	424,986	20.3	440,969	18.9	3.8
Community	54,815	2.6	57,684	2.5	5.2
Ambulance	19,331	0.9	19,637	0.8	1.6
<b>Total</b>	2,090,718	100.0	2,331,192	100.00%	11.5

## 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

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The distribution of reported degree of harm in the current period (April 2021 to March 2022) is broadly consistent with that for April 2020 to March 2021.

All clusters reported most incidents as causing 'no harm' or 'low harm' (Table 4). The percentage of 'no harm' incidents ranged from 76.2% in acute specialist trusts to 54.0% in community trusts. Of 'severe harm' or 'death' incidents, proportions were 1.0% or lower across all clusters except ambulance trusts, where the figure was 2.6%. In absolute numbers, most deaths were reported by mental health 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)	1,300,060	73.6%	421,111	23.8%	38,977	2.2%	4,603	0.3%	2,513	0.1%	1,767,264
Acute (specialist)	34,788	76.2%	10,040	22.0%	706	1.5%	59	0.1%	45	0.1%	45,638
Mental health	269,588	61.1%	143,368	32.5%	23,548	5.3%	1,658	0.4%	2,807	0.6%	440,969
Community	31,133	54.0%	23,374	40.5%	2,833	4.9%	197	0.3%	147	0.3%	57,684
Ambulance	14,747	75.1%	3,440	17.5%	938	4.8%	320	1.6%	192	1.0%	19,637



## 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 (22.4%), representing an increase of 11.6%. 'Self-harming behaviour' was the most common category among mental health trusts (26.4%), and saw an increase of 4.9% compared with the previous year.

**Table 5a: Reported incident category – acute (non-specialist) cluster; incidents reported as occurring from April 2020 to March 2021 and April 2021 to March 2022**

Incident category	April 2020 to March 2021		April 2021 to March 2022		% change
	N	%	N	%	
Implementation of care and ongoing monitoring / review	354,097	22.8%	395,150	22.4%	11.6%
Patient accident	214,513	13.8%	238,970	13.5%	11.4%
Access, admission, transfer, discharge (including missing patient)	164,982	10.6%	213,061	12.1%	29.1%
Treatment, procedure	187,255	12.1%	198,481	11.2%	6.0%
All other incident categories	629,686	40.6%	721,602	40.8%	14.6%
<b>Total</b>	<b>1,550,533</b>	<b>100.0%</b>	<b>1,767,264</b>	<b>100.0%</b>	<b>14.0%</b>

**Table 5b: Reported incident category – acute (specialist) cluster; incidents reported as occurring from April 2020 to March 2021 and April 2021 to March 2022**

Incident category	April 2020 to March 2021		April 2021 to March 2022		% change
	N	%	N	%	
Medication	7,437	18.1%	7,967	17.5%	7.1%
Access, admission, transfer, discharge (including missing patient)	4,634	11.3%	5,394	11.8%	16.4%
Treatment, procedure	4,761	11.6%	5,153	11.3%	8.2%
Implementation of care and ongoing monitoring / review	3,970	9.7%	4,875	10.7%	22.8%
All other incident categories	20,251	49.3%	22,249	48.8%	9.9%
<b>Total</b>	<b>41,053</b>	<b>100.0%</b>	<b>45,638</b>	<b>100.0%</b>	<b>11.2%</b>

**Table 5c: Reported incident category – mental health cluster; incidents reported as occurring from April 2020 to March 2021 and April 2021 to March 2022**

Incident category	April 2020 to March 2021		April 2021 to March 2022		% change
	N	%	N	%	
Self-harming behaviour	110,834	26.6%	116,317	26.4%	4.9%
Implementation of care and ongoing monitoring / review	72,999	17.5%	69,601	15.8%	-4.7%
Disruptive, aggressive behaviour	46,481	11.2%	41,918	9.5%	-9.8%
Patient accident	40,857	9.8%	40,701	9.2%	-0.4%
All other incident categories	153,815	34.9%	172,432	39.1%	18.4%
<b>Total</b>	<b>424,986</b>	<b>100.0%</b>	<b>440,969</b>	<b>100.0%</b>	<b>5.8%</b>

**Table 5d: Reported incident category – NHS community cluster; incidents reported as occurring from April 2020 to March 2021 and April 2021 to March 2022**

Incident category	April 2020 to March 2021		April 2021 to March 2022		% change
	N	%	N	%	
Implementation of care and ongoing monitoring / review	23,278	42.5%	23,816	41.3%	2.3%
Patient accident	6,582	12.0%	6,688	11.6%	1.6%
Access, admission, transfer, discharge (including missing patient)	4,736	8.6%	5,409	9.4%	14.2%
Medication	4,899	8.9%	5,149	8.9%	5.1%
All other incident categories	15,320	27.9%	16,622	28.8%	8.5%
<b>Total</b>	<b>54,815</b>	<b>100.0%</b>	<b>57,684</b>	<b>100.0%</b>	<b>5.2%</b>

**Table 5e: Reported incident category – ambulance cluster; incidents reported as occurring from April 2020 to March 2021 and April 2021 to March 2022**

Incident category	April 2020 to March 2021		April 2021 to March 2022		% change
	N	%	N	%	
Access, admission, transfer, discharge (including missing patient)	5,239	27.1%	5,074	25.8%	-3.1%
Treatment, procedure	2,185	11.3%	2,531	12.9%	15.8%
Clinical assessment (including diagnosis, scans, tests, assessments)	2,636	13.6%	2,190	11.2%	-16.9%
Consent, communication, confidentiality	1,792	9.3%	1,883	9.6%	5.1%
All other incident categories	7,479	38.7%	7,959	40.5%	6.4%
<b>Total</b>	<b>19,331</b>	<b>100.0%</b>	<b>19,637</b>	<b>100.0%</b>	<b>1.6%</b>

## Care setting of occurrence

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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 (92.5%), and 'ambulance service' the most common for the ambulance trust cluster (95.1%).

**Table 6a: Reported care setting of occurrence – acute (non-specialist) cluster; incidents reported as occurring from April 2020 to March 2021 and April 2021 to March 2022**

Care setting of occurrence	April 2020 to March 2021		April 2021 to March 2022		% change
	N	%	N	%	
Acute/general hospital	1,429,853	92.2%	1,634,833	92.5%	14.3%
Community nursing, medical and therapy service (including community hospital)	113,337	7.3%	124,429	8.0%	9.8%
General practice	3,418	0.2%	3,798	0.2%	11.1%
Mental health service	2,401	0.2%	2,630	0.2%	9.5%
All other care settings	1,524	0.1%	1,574	0.1%	3.3%
<b>Total</b>	<b>1,550,533</b>	<b>100.0%</b>	<b>1,767,264</b>	<b>100.0%</b>	<b>14.0%</b>

**Table 6b: Reported care setting of occurrence – acute (specialist) cluster; incidents reported as occurring from April 2020 to March 2021 and April 2021 to March 2022**

Care setting of occurrence	April 2020 to March 2021		April 2021 to March 2022		% change
	N	%	N	%	
Acute/general hospital	39,415	96.0%	44,220	96.9%	12.2%
Mental health service	1,205	2.9%	936	2.1%	-22.3%
Community nursing, medical and therapy service (including community hospital)	243	0.6%	312	0.7%	28.4%
Ambulance service	130	0.3%	140	0.3%	7.7%
All other care settings	60	0.1%	30	0.1%	-50.0%
<b>Total</b>	<b>41,053</b>	<b>100.0%</b>	<b>45,638</b>	<b>100.0%</b>	<b>11.2%</b>

**Table 6c: Reported care setting of occurrence – mental health cluster; incidents reported as occurring from April 2020 to March 2021 and April 2021 to March 2022**

Care setting of occurrence	April 2020 to March 2021		April 2021 to March 2022		% change
	N	%	N	%	
Mental health service	293,104	69.0%	302,422	68.6%	3.2%
Community nursing, medical and therapy service (incl. community hospital)	100,382	23.6%	97,617	22.1%	-2.8%
Learning disabilities service	17,902	4.2%	16,798	3.8%	-6.2%
Acute / general hospital	7,508	1.8%	8,830	2.0%	17.6%
All other care settings	6,090	1.4%	15,302	3.5%	151.3%
<b>Total</b>	<b>424,986</b>	<b>100.0%</b>	<b>440,969</b>	<b>100.0%</b>	<b>3.8%</b>

**Table 6d: Reported care setting of occurrence – NHS community cluster; incidents reported as occurring from April 2020 to March 2021 and April 2021 to March 2022**

Care setting of occurrence	April 2020 to March 2021		April 2021 to March 2022		% change
	N	%	N	%	
Community nursing, medical and therapy service (incl. community hospital)	51,612	94.2%	53,948	93.5%	4.5%
Mental health service	2,392	4.4%	2,387	4.1%	-0.2%
Acute / general hospital	289	0.5%	451	0.8%	56.1%
Learning disabilities service	214	0.4%	435	0.8%	103.3%
All other care settings	308	0.6%	463	0.8%	50.3%
<b>Total</b>	<b>54,815</b>	<b>100.0%</b>	<b>57,684</b>	<b>100.0%</b>	<b>5.2%</b>

**Table 6e: Reported care setting of occurrence – ambulance cluster; incidents reported as occurring from April 2020 to March 2021 and April 2021 to March 2022**

Care setting of occurrence	April 2020 to March 2021		April 2021 to March 2022		% change
	N	%	N	%	
Ambulance service	18,417	95.3%	18,670	95.1%	1.4%
Acute / general hospital	493	2.6%	457	2.3%	-7.3%
Community nursing, medical and therapy service (incl. community hospital)	222	1.1%	205	1.0%	-7.7%
General practice	162	0.8%	137	0.7%	-15.4%
All other care settings	37	0.2%	168	0.9%	354.1% <sup>†</sup>
<b>Total</b>	<b>19,331</b>	<b>100.0%</b>	<b>19,637</b>	<b>100.0%</b>	<b>1.6%</b>

<sup>†</sup> Fluctuations in small numbers should be interpreted with caution.

## 5. Final remarks

The NRLS is a system designed to support learning. The data 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 the national patient safety team to learn and reduce the risk of harm to patients.

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. National incident reporting will span two systems during the implementation and roll out of LFPSE. 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, however, 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](mailto:nrls.datarequests@nhs.net)

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