Quarterly Dataset Summary (QDS) workbook: Jan to Mar 2015 update – Commentary

Date: September 2015

Introduction

The QDS workbooks contain four consecutive quarters of aggregated data, with a view to providing a national picture of patterns and trends in patient safety incident reporting and the characteristics of patient safety incidents (type, care setting, and degree of harm). The Care Quality Commission (CQC), Monitor and the National Audit Office all use aggregated datasets to build up trend analyses from the time series information within national datasets in order to schedule their audit functions and prioritise resources. These data also provide background and context for scoping work undertaken by academic organisations and Royal Colleges. They also provide trend and context data to support NHS England in the development of patient safety resources, such as Safer Practice Notices.

Data from the QDS workbooks are used for three of the four NRLS indicators in Domain 5 of the NHS Outcomes Framework: '*Treating and caring for people in a safe environment and protecting them from avoidable harm'*. The Outcomes Framework stresses the importance of a service focussed on the outcomes achieved for patients, and not the processes by which they are achieved.

The Datasets

To describe NLRS patient safety incident data as accurately as possible, two different datasets are used.

The 'Reported Dataset'

To look at patterns in reporting, the 'Reported Dataset' is used, which contains incidents that were reported to the NRLS within a specific time period.

The 'Occurring Dataset'

To look at patient safety incident characteristics, the 'Occurring Dataset' is used, which contains incidents that have been reported as actually taking place within the specific time period (this is because, for range of legitimate reasons, there are often time lags between an incident occurring and being reported to the NRLS). The date that the incident is reported to have occurred is also important because there is seasonality in patterns of patient safety incidents. (Seasonality is due to the fact that patterns, variations and fluctuations in patient safety incidents are caused by the season, month, day of the week, or some other time period they occur in.) Therefore, in order to reduce the effects of 'administrative seasonality', when looking at the characteristics of patient safety incidents, the dataset is based on the date that the incident was reported to have actually taken place. This is done to minimise any artificially-created seasonality, whilst recognising inherent incident seasonality.

Patient Safety Incident Reporting

(based on the date that the incident report was submitted to the NRLS, Jan-Mar 2015)

The total number of patient safety incidents reported to the NRLS this quarter (Jan to Mar 2015) continues to increase compared with the same period of the previous year: overall this shows an increase of 2.5%.

During Jan to Mar 2015, the number of incidents reported from England was 401,866. In terms of English data, this is an increase of 2.5% compared to the same quarter in the previous year (Jan to Mar 2014). The total number of incidents reported by English organisations to the end of March 2015 was 11,209,663.

During Jan to Mar 2015, the number of incidents reported from Wales was 15,653. In terms of Welsh data, the number of patient safety incident reports increased by 1.8% compared to the same quarter in the previous year (Jan to Mar 2014). The total number of incidents reported by Welsh organisations to the end of March 2015 was 570,439.

Patient Safety Incident Characteristics

(based on the date that the incident report stated the incident actually occurred, for the period Oct to Dec 2014)

Harm

The proportion of incidents reported as resulting in severe harm or death remains less than one per cent (0.6%) of patient safety incidents reported to the NRLS, in both England (0.6%) and Wales (0.5%).

Table 1: Percentage reported degree of harm
(for incidents stated as occurring during Oct to Dec 2014)

Reported degree of harm	England	Wales	Total*
No harm	70.4	68.7	71.4
Low	23.9	23.3	23.4
Moderate	5.0	7.6	4.6
Severe harm or death	0.6	0.5	0.6

* the 'total' figures upon which these percentages are based may exceed those of the sum of England and Wales, as in some cases the location of the patient safety incident is unidentifiable (e.g. where the incident location is missing or unknown, or the incident has been reported from a large pharmacy chain, such as Boots or Lloyds, with branches in both England and Wales).

In England, the percentage of incidents reported as resulting in severe harm or death has decreased this quarter (0.62% during Oct to Dec 2014) compared to the same quarter the previous year (0.68% during Oct to Dec 2013) and is statistically significant at the 95% confidence level. This appears to have been driven by a significant drop in the number of such reports where the care setting was acute/general hospital service. However, note

there has been a smaller increase of incidents reported as severe harm or death as reported by Ambulance services. This increase is significant at the 95% confidence level.

In Wales, the percentage of incidents reported as resulting in severe harm or death has increased this quarter (0.49% during Oct to Dec 2014) compared to the same quarter the previous year (0.37% during Oct to Dec 2013). This overall increase is statistically significant at the 95% confidence level but likely to be confounded by a reporting issue at one of the seven Local health boards in Wales during Oct to Dec.

Incident Type

The most commonly reported incident types have changed little this quarter (Oct to Dec 2014): 'Patient accident' remains the most frequently reported incident type.

In England, 'Patient accident' incidents account for one in every five of patient safety incidents reported as occurring each quarter. The percentage of incidents coded as 'Implementation of care and ongoing monitoring / review' has increased every quarter from 11.74% (Jan–Mar 2014) 12.91 in (Oct-Dec 2014).

In Wales, the 'Patient accident' category alone consistently accounts for one in three incidents every quarter. The percentage of incidents coded as 'Implementation of care and ongoing monitoring / review' has increased every quarter over the last year from 10.06% (Jan–Mar 2014) to 12.11 (Oct-Dec 2014).

Care Setting

The most frequently reported care settings have not changed this quarter (Oct to Dec 2014): The top three remain: 'Acute/general hospital', 'Mental health service' and 'Community nursing, medical and therapy service (incl. community hospitals)'. These three care settings have remained the three most commonly reported care settings in the last four quarters.

In England, approximately three of every four patient safety incidents reported as during the last four quarters (Jan2014 to Dec2014), were reported as having taken place in an acute /general hospital.
Although the overall percentages are small (less than 0.5%), there have been consistent increases in both the percentages and the actual numbers of patient safety incident reports reported as occurring in general practice every quarter over the last year (Jan–Mar 2014 to Oct–Dec 2014).

In Wales, approximately four of every five patient safety incidents reported as occurring in Welsh NHS organisations during 2014, were reported as having taken place in the top two most frequently reported care settings('Acute /general hospital' or 'Community nursing, medical and therapy service (incl. community hospitals)').

Although the percentages are small overall, there has been a drop in both the percentages and the actual numbers of patient safety incident reports reported as occurring in Ambulance services every quarter from 1.19% (Jan-Mar 2014) to 0.91% (Oct-Dec 2014).