NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE indicator validity assessment

Assurance date: August 2023

Review date: August 2026

# Indicator IAP00037

Patient safety incident recording.

(See also IAP00140 CCG Outcomes Indicator Set version and IAP00038 NHS Outcomes Framework (severity sub indicator))

# Indicator type

National Library of Quality Indicators.

# Importance

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| **Considerations**  | **Assessment** |
| Indicator is part of the [NHS outcomes framework](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework) domain 5 – treating and caring for people in a safe environment and protecting them from avoidable harm (indicator 5.6, formally 5a, 5b and 5.4).The aim of the indicator is for reporting to increase as the culture of reporting all incidents spreads more widely across the NHS.The CQC has a mandatory requirement to report incidents resulting in severe harm or death. | The indicator reflects a specific priority area identified by NHS England and the CQC. |
| The most recent national rate is 1066.3 incidents per 100,000 population from Apr - Jun 2021. Variation can be seen at provider level. ([NHSOF data for indicator 5.6](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-5---treating-and-caring-for-people-in-a-safe-environment-and-protecting-them-from-avoidable-harm-nof/5.6-patient-safety-incidents-reported-formerly-indicators-5a-5b-and-5.4), March 2022 release). | The indicator relates to an area where there is known variation in practice.The indicator addresses under-treatment. |
| From [supporting documentation for IAP00037](https://www.nice.org.uk/standards-and-indicators/nlindicators/patient-safety-incident-reporting-nhsof): Adverse events in healthcare cannot be completely eliminated. However, the evidence points clearly to the need to learn from events when they occur, and that historically a very incomplete picture of safety has been available from the information collected. Over many years, and with the introduction of the National Reporting and Learning Service, by the National Patient Safety Agency, that picture is improving. However, more needs to be done, and maximising the potential to reduce incidents will be supported by continued improvements in reporting. | The indicator will lead to a meaningful improvement in patient outcomes. |

# Evidence base

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| **Considerations**  | **Assessment** |
| This indicator is primarily policy based rather than evidence based. However, frequent and regular reporting can be viewed as an indication of a positive reporting culture. Reviewing and responding to incident reports is seen as a route to improving safety and preventing repeat incidents and harm.From [supporting documentation for IAP00037](https://www.nice.org.uk/standards-and-indicators/nlindicators/patient-safety-incident-reporting-nhsof): Adverse events in healthcare cannot be completely eliminated. However, the evidence points clearly to the need to learn from events when they occur, and that historically a very incomplete picture of safety has been available from the information collected. Over many years, and with the introduction of the National Reporting and Learning Service, by the National Patient Safety Agency, that picture is improving. However, more needs to be done, and maximising the potential to reduce incidents will be supported by continued improvements in reporting. | The indicator is derived from a high-quality evidence base. The indicator aligns with the evidence base. |

# Specification

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| **Considerations**  | **Assessment** |
| Numerator: Number of patient safety incidents from the [National Reporting and Learning System (NRLS).](https://report.nrls.nhs.uk/nrlsreporting/)Denominator: Varies based on geography (National – population, Trusts – bed days (admissions prior to 2014))Calculation: National – rate per 100,000 population; Trust – rate per 1,000 bed days.Exclusions: None.Definitions: A patient safety incident is defined as ‘any unintended or unexpected incident(s) that could have, or did, lead to harm for one or more person(s) receiving NHS funded healthcare’. Geography: England, region, lower tier local authority. Splits by gender, age of mother and deprivation decile. Data Source: NRLS and population data from Office for National Statistics (ONS).Disclosure control: None.  | The indicator has defined components necessary to construct the indicator, including numerator, denominator and exclusions. |

# Feasibility

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| **Considerations**  | **Assessment** |
| Both numerator and denominator come from reliable sources which will continue.NRLS data has been published since 2003 (all fields since 2008) with quarterly and biannual data available depending on breakdown. | The indicator is repeatable. |
| Patient safety incidents are reported to the NRLS. Population data is available from the ONS. | The indicator is measuring what it is designed to measure. The indicator uses existing data fields. |

# Acceptability

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| **Considerations**  | **Assessment** |
| Reporting is variable with some evidence that higher reporters overall have a better safety culture and other measures of safety. It is not an absolute or reliable measure of actual incidents, but has value in contributing to overall support for patient safety.From April 2016 a denominator and reporting rate has not been included in NHSOF reports for community trusts as reporting per 1,000 bed days is no longer appropriate.The NHSOF report by the most recent name for a provider. Merged providers retain their original name. | The indicator assesses performance that is attributable to or within the control of the audience. |
| The national indicator rate continues to increase over time, though whether this is an improvement in reporting or an increase in incidents needs investigation. | The results of the indicator can be used to improve practice. |

# Risk

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| **Considerations**  | **Assessment** |
| From [NHSOF quality statement](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-5---treating-and-caring-for-people-in-a-safe-environment-and-protecting-them-from-avoidable-harm-nof/5.6-patient-safety-incidents-reported-formerly-indicators-5a-5b-and-5.4) (Feb 2019) and [NHSOF data](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-5---treating-and-caring-for-people-in-a-safe-environment-and-protecting-them-from-avoidable-harm-nof/5.6-patient-safety-incidents-reported-formerly-indicators-5a-5b-and-5.4) (release March 2022):Reporting culture varies between organisation types. The data from NHSOF shows a quarterly fluctuation due to the twice- yearly deadlines for submitting reports. This is not due to seasonal variation in incidents. NHS Improvement guidance is that organisations should be reporting incidents on a regular basis and at least once a month.Incidents not resulting in death or severe harm are reported to the NRLS voluntarily and for the purposes of learning. The number reported by each organisation therefore reflects reporting culture, and is not necessarily the actual number of incidents occurring. A ‘low’ reporting rate for an organisation should not necessarily be interpreted as a ‘safe’ environment; it may represent under-reporting. Conversely a ‘high’ reporting rate should not be interpreted as ‘unsafe’; it may represent a more open culture. Comparability using this indicator is difficult due to the balance between reporting and incidents.Data from 2020 may be affected by the COVID-19 pandemic and should be interpreted with care.Very similar indicator in the CCGOIS (IAP00140). Methodology should match but risk of the indicators saying different things. | The indicator has an acceptable risk of unintended consequences. |

# NICE indicator advisory committee recommendation

The NICE indicator advisory committee approved renewal of this indicator.

**NHS Digital Indicator Reference:**

NHS Outcomes Framework – 5.6 patient safety incidents reported.