**NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE**

**NICE indicator validity assessment**

Assurance date: August 2020

Review date: August 2023

# Indicator IAP00140 (See also IAP00037 (Trust version) and IAP00038 (severity sub indicator))

Patient safety incident recording

# Validity assessment

|  |  |  |
| --- | --- | --- |
| **Domain** | **Notes** | **Assessment** |
| Importance | This indicator is part of the CCG Outcomes Indicator Set, based on the CQC mandatory requirement to report incidents resulting in severe harm or death.  A national rate for this indicator is not produced.  Variation cannot be assessed at CCG level. At Trust level the rate per 1,000 bed days varies from 499 to 13 for the period October 2018 - March 2019. | The indicator evidences a CQC requirement for incident reporting. It links to area 5 of the National Quality Framework (Patient Safety) |
| Evidence base | This indicator is not specifically tied to a NICE recommendation.  From original application form[[1]](#footnote-1):  “Building A Safer NHS For Patients’ sets out the Government's plans for promoting patient safety following the publication of the report ‘An Organisation with a Memory’ and the commitment to implement it in the NHS Plan. It places patient safety in the context of the Government's NHS quality programme and highlights key linkages to other Government initiatives. Central to the plan is the new mandatory, national reporting scheme for adverse health care events and near misses within the NHS. This will enhance existing mechanisms for improving quality of care and promoting patient safety by harnessing learning throughout the NHS when something goes wrong.” | 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 |
| Specification | Numerator: Number of patient safety incidents from NRLS  Denominator: Bed days commissioned by CCG, derived from Hospital Episode Statistics (HES)  Exclusions: None.  Methodology: Rate per 1,000 bed days  Geography: Trust (acute, mental health and community)  Data Source: National reporting and learning system (NRLS)  Disclosure control: No small number suppression | The indicator has defined components necessary to construct the indicator, including numerator, denominator and exclusions. |
| Feasibility | Numerator data is all available from one source (NRLS). Source data has been published since 2013.  Denominator data comes from HES which will continue. | The indicator is repeatable.  There are challenges with this indicator in that reporting is variable with some evidence that higher reporters overall have better safety culture and other measures of safety. It is not an absolute or reliable measure of actual incidents, but it has value in contributing to overall support for patient safety.  The indicator uses existing data fields within published data. |
| Acceptability | The indicator does not produce a national value, and ‘CCG’ values are Trust values. | The indicator assesses performance that is only indirectly attributable to or within the control of the audience. |
| Risk | From current quality statement[[2]](#footnote-2):  “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.” | Risk of misinterpretation by users if seen as an absolute measure of number of incidents occurring (though this should be well understood by the majority of users).  The main value of the overall indicator is to highlight the importance and value of reporting. Improvement at a local and national level relies on learning from specific incidents. Analysis of incident reporting data alongside other trust data (e.g. complaints) can help identify areas to address locally. |

**Summary:** Indicator to be renewed.

**NHS Digital Indicator Reference:**

CCG Outcomes Indicator Set - 5.1 Patient safety incidents

1. NHS Digital. Application Form. Indicator and Methodology Assurance Service. Patient safety incidents. Set or domain: CCG OIS 5.1. IAS Reference Code: IAP00140. V0.1 11/08/2017 [↑](#footnote-ref-1)
2. NHS Digital. CCG Outcome Indicator Set. Indicator 5.1. Patient safety incidents. Indicator quality statement

   Version: 1.6. Date: March 2018 [↑](#footnote-ref-2)