Submission and use of performance indicators

Guidance for providers of acute hospital services in the independent sector

Version History
This is version 4.0, in use from October 2006, amended July 2009.

New in this version:
Peri-operative mortality indicator has been removed to reflect the changes to this indicator as described in the FAQs.

Denominator for Mortality indicator has been amended to reflect the changes to this indicator as described in the FAQs.

Yearly timetable added.

Clearer drafting throughout.

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Introduction

The Care Quality Commission is continuing to develop the process for registering and inspecting the independent healthcare sector, building on the consultation document *Aligning our assessment of the NHS and independent sectors* (published in December 2005).

We have developed a series of high-level indicators to help monitor the performance of providers in the independent healthcare sector. These indicators will be one of the factors taken into account when we assess a provider’s risk of non-compliance with national minimum standards and plan the frequency of inspections.

About this guidance

We have developed this guidance to help you to understand the process for submitting and using performance indicators. It sets out why the performance indicators are important and how they have been developed, and provides details to help you to ensure that you are collecting and submitting the right data.

If you are a registered responsible individual or a registered manager, you should ensure that you have read and understand this guidance, and that you have distributed copies within your organisation to ensure that you comply fully with the requirements of this process.

Please note: The indicators and guidance outlined in this document does not remove the responsibility of the registered individual or the registered manager for providing a statutory notification under regulation 28 (or any other regulation) of the Private and Voluntary Health Care (England) Regulations 2001. These notifications are still required and providers should comply with the relevant regulations.

Key dates (please note these may be liable to change)

<table>
<thead>
<tr>
<th>Activity/period</th>
<th>2015 - 2016 Quarter 1</th>
<th>2015 - 2016 Quarter 2</th>
<th>2015 - 2016 Quarter 3</th>
<th>2015 - 2016 Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data collection period begins</td>
<td>01 April 2015</td>
<td>01 July 2015</td>
<td>01 October 2015</td>
<td>01 January 2016</td>
</tr>
<tr>
<td>Data submission website goes live</td>
<td>07 July 2015</td>
<td>06 October 2015</td>
<td>05 January 2015</td>
<td>05 April 2016</td>
</tr>
<tr>
<td>Data submission deadline</td>
<td>14 August 2015</td>
<td>06 November 2015</td>
<td>05 February 2015</td>
<td>06 May 2016</td>
</tr>
</tbody>
</table>
Background

The Care Quality Commission currently has a statutory obligation to inspect all independent sector registered establishments at least once every five years. We use information in a structured intelligent manner to help our inspection teams to monitor the performance of registered establishments in the independent acute sector. The first data were collected for the period 1 April 2006 to 30 June 2006. During this pilot phase, we asked providers to submit their data on a voluntary basis.

Indicators are being collected to help our assessment managers to make judgements about the level of inspection required and for ongoing surveillance to assist with the assessment of risk. However, the indicators alone will not trigger an inspection. They may trigger a request for further information. This request will be made to the registered manager of the provider.

Internally, we will compare the data submitted by providers and develop a process to allow us to compare and monitor performance over time.

The dataset

Providers of independent acute hospital services are required to collect and submit data in relation to the following high-level indicators.

Sentinel indicators:

- Mortality.
- Serious injury.

Clinical indicators:

- Returns to theatre.
- Unplanned transfer.
- Unplanned readmissions.

Infection control surveillance:

- Surgical site infections (hip and knee arthroplasty).
- Staphylococcus Aureus bacteraemia.

Denominator data for the above:

- Number of inpatient discharges.
- Number of anaesthetic episodes.
- Number of operative procedures.
- Number of hip and knee arthroplasties.
- Number of inpatient bed days.

We also recognise that indicators are being collected and submitted to other ‘bodies’, such as the central contract monitoring unit for independent sector treatment centres, the International Quality Indicator Project® (IQIP), and the independent healthcare forum as part of their credentialing programme. Many of these indicators cover the same topics, but use different definitions e.g. the timeframe for readmission may differ from 29 days in one hospital to 31 days in another.
Collecting and managing data

It is important for providers to have suitable mechanisms for collecting the data. These mechanisms should ensure that the information is accurate, is used in monitoring performance in the hospital, and that it has been properly checked internally before submission. The Care Quality Commission may assess the hospital’s process for handling clinical information under the requirements of the Independent Healthcare National Minimum Standards Regulations 2002 and the Private and Voluntary Health Care (England) Regulations 2001.

Registered managers are responsible for deciding exactly how the data are collected. However, we recommend that they consider the following when developing their processes for collecting data:

- Is there a nominated individual to collect and analyse clinical data? If this person is not available, do others have access to relevant files and information?

- Is there an audit trail for individual pieces of information? Where different sources of information have been used, is there evidence to show what information was extracted and when?

- Is there a process for cross checking information submitted by individuals? For example, if information on the number of discharges is collected manually, can this be compared to data from the administration database?

- Is there an explicit process for describing who will see the information? Is this described in a clinical governance or quality policy, and what evidence is available to show that this has happened?

- Has the information been ‘signed off’ as an accurate representation of the facts by someone in a suitable management position? This needs to be done before the information is submitted to the Care Quality Commission. The Department of Health’s website has guidance on the principles of information governance.

Exclusions

Some indicators have specific exclusions. For example, the denominator for readmissions is the number of discharges minus the number of deaths (a death as an inpatient cannot result in a readmission).

Interpreting the data

Indicator data is most valuable when rates of events are calculated in relation to time and compared with others who provided similar services. To calculate the rates of events, divide the numerator (the event) by the denominator (the number of times that event could have happened).

For example: Number of returns to theatre (9) divided by the number of trips to theatre (67) = 0.134 returns to theatre. This translates to 13.4 returns to theatre per 100 surgical procedures.

MRSA bacteraemia is expressed as cases per 10,000 bed days – for example, one case divided by 56,000 bed days multiplied by 10,000 = 0.179.
Submitting the indicators

Indicators are collected on a quarterly basis. You must submit your data one calendar month after the end of the previous quarter in one of three ways:

1. **By web forms submitted through the Care Quality Commission’s website**
   If you choose this method of submission you will need to request access to a web form. This will be password-protected. You can then submit the performance indicators to the Care Quality Commission according to the instructions provided with the web form.

2. **By the International Quality Indicator Project® (IQIP)**
   Subject to formal agreement with IQIP, we will accept indicators directly from IQIP on behalf of its participants. Please note that not all of the indicators are collected by IQIP, so if you choose this route, you will also need to submit other indicators directly to the Care Quality Commission (as outlined above).

3. **By a corporate consolidated submission**
   This applies to groups of hospitals with a responsible individual. We will accept a consolidated submission for groups of hospitals through a corporate office. Data submitted in this manner will need to cover each registered establishment. It cannot be aggregated across the entire group. We will provide a consolidated form, similar to that used for individual submissions.

You can decide which methodology best suits your needs. However, you must tell us which choice you have made, and you need to submit the indicators in this format until you agree a change in writing with the Commission. We will not accept indicators submitted on paper, or forms other than those described above, as valid submissions.

**Responsibility**

The registered individual or registered manager is responsible for ensuring that the indicator set is submitted to the Care Quality Commission. If you decide to submit the indicator corporately, a named individual will need to be identified to act as the contact point for any submission queries. We will direct any queries about the indicators to the registered manager.

**Non-compliance**

By using these indicators to assess risk, the Care Quality Commission is aiming to reduce the regulatory burden on providers. Compliance, in terms of both the quality and timeliness of submission, is therefore critical. All providers must comply with these requirements. You must also assure yourself of the robustness and integrity of the data that you submit. This will be subject to the usual regulatory scrutiny and accountability of registration. Failure to submit data, or submitting data that we feel is unreliable, may result in this area being targeted within your next inspection. Please note that from 2007/2008, site visits have been subject to a charge.

As part of any inspection, including targeted or spot check inspections, we may ask you to provide further information on the indicator set to check the quality of data. Falsification of submitted data may also result in this area being targeted within your next inspection. For further queries relating to the performance indicators, the submission methodology or general topics, please email pvhanalyst@cqc.org.uk.
Indicators and definitions

The following tables provide further detail about the indicators, including definitions of the performance indicators with which you are expected to comply.

1. Mortality

<table>
<thead>
<tr>
<th>Summary/benefit</th>
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<tbody>
<tr>
<td>Rates of death (mortality) in acute hospitals are likely to be very low but it is still important for this information to be collected.</td>
</tr>
<tr>
<td>Providers should report any deaths, and their cause, through the appropriate internal governance systems. They should also analyse in-depth each unexpected death.</td>
</tr>
<tr>
<td>This is linked to regulation 28 notifications under the Private and Voluntary Healthcare (England) Regulations 2001.</td>
</tr>
<tr>
<td>Could trigger frequency rules under regulation 15 (1)(b) of the Private and Voluntary Healthcare (England) Regulations 2001, which relates to quality of care – i.e. ‘reflect published research evidence and guidance issued by the appropriate professional and expert bodies, as to good practice in the treatment of the condition from which the patient is suffering’.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Limitations</th>
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<tbody>
<tr>
<td>This is a low volume indicator and may reflect hospital activity instead of identifying issues relating to, for example, the provision of oncology services. If collected quarterly, International Quality Indicator Project® (IQIP), exclusions will apply.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator</th>
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<tbody>
<tr>
<td>Number of inpatient deaths reported in the reporting quarter under regulation 28 of the Private and Voluntary Healthcare (England) Regulations 2001.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominators</th>
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<tbody>
<tr>
<td>Number of inpatients who are discharged.</td>
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<tr>
<td>Number of anaesthetic episodes.</td>
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</table>

Definitions:

Anaesthesia: partial or complete loss of sensation with or without loss of consciousness because of a drug administered by any route.

Inpatient anaesthetic episode: an occasion when an inpatient:
- Is assigned an American Society of Anesthesiologists (ASA) classification.
- Receives anesthetic from anesthesia staff.
- Undergoes one or more inpatient operative procedures within the Office of Population and Census Studies (OPCS) code range of AZ.
2. Return to theatre

<table>
<thead>
<tr>
<th>Summary/benefit</th>
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</thead>
</table>
| Data on the number of cases that have needed to ‘return to theatre’ may imply that there is a problem with the initial surgery or complications following surgery. There is a large volume of data available on return to theatre because surgery is a core function of hospitals in the independent sector. Providers should submit evidence that data on return to theatre are being monitored, that trends are identified, and that each case is thoroughly reviewed. Return to theatre could be linked to the monitoring of surgical site infection (wound debridements) and perioperative mortality. Return to theatre may also link to data on revision from the National Joint Register (NJR). Could trigger frequency rules under regulation 15 (1) (b) of the Private and Voluntary Healthcare (England) Regulations 2001, which relates to quality of care – i.e. “reflect published research evidence and guidance issued by the appropriate professional and expert bodies, as to good practice in the treatment of the condition from which the patient is suffering”.

<table>
<thead>
<tr>
<th>Limitations</th>
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</thead>
<tbody>
<tr>
<td>The return to theatre data set will not include:</td>
</tr>
<tr>
<td>- Patients who are readmitted and taken to theatre.</td>
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<tr>
<td>- Transferred patients who undergo repeat procedures.</td>
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</tbody>
</table>

It does include procedures performed in the ‘operating theatre’ only.

<table>
<thead>
<tr>
<th>Numerator</th>
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<tbody>
<tr>
<td>A return to the operating theatre during the same inpatient admission for complications or untoward outcomes relating to a previous inpatient operative procedure that was performed in the operating theatre, during the reporting quarter. The return was not planned at the time of the previous operative procedure. More than one return can be counted for a single patient. Multiple procedures performed during the same visit are counted only once.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator</th>
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<tbody>
<tr>
<td>Visits to the operating theatre. If a patient dies during the operation, this operation is not included in the denominator.</td>
</tr>
</tbody>
</table>
3. Unplanned transfers

**Summary/benefit**

A common criticism of the independent sector is the lack of provision of critical care services.

Unplanned transfers result from complications that the provider could not clinically deal with during a patient’s episode. Unplanned transfers may indicate a failure in the processes for pre-assessment, failure of the application of the admission criteria or a lack of services in relation to those criteria. The transfer of a critically ill patient can be risky. They should be transferred as soon as possible after the provider recognises that it cannot deal with the complication effectively.

Could trigger frequency rules under regulation 15 (1)(b) of the Private and Voluntary Healthcare (England) Regulations 2001, which relates to quality of care – i.e. “reflect published research evidence and guidance issued by the appropriate professional and expert bodies, as to good practice in the treatment of the condition from which the patient is suffering”.

**Limitations**

Transfers can occur for reasons that are not related to the capabilities of the provider and may be outside of the provider’s control.

For example, if a patient’s insurance funds are exhausted, they may be transferred to the NHS for further care. Contractual arrangements may result in a patient being moved back to the service from which they were referred. For example, when work is being undertaken as a spot purchase arrangement from a local Commissioner, a treating consultant may prefer to have a patient transferred to a location closer to their normal workplace if the patient’s condition requires more attention than originally anticipated.

A transferred patient may subsequently die and the provider may not know this outcome.

New models of care, for example, when an establishment in the independent sector leases facilities from an NHS trust, may require a different approach for this indicator.

Only covers inpatient transfers out of hospital and excludes day cases.

**Numerator**

Number of unplanned transfers of inpatients to another hospital (NHS or independent sector) for medical, surgical, obstetrical care or for clinical management. This does not include the transfer of patients from one ward to another or transfers for treatment that do not require the patient to be admitted to another hospital.

It does include the transfer of patients to hospitals owned by the same company.

**Denominator**

Number of inpatients who have been discharged, excluding deaths.
4. Unplanned readmissions

**Summary/benefit**

Unplanned readmission can indicate that patients are being discharged prematurely and that there is poor control over admission and problems with care following discharge or discharge information.

For surgery, in particular, unplanned readmissions may relate to earlier complications, such as surgical site infections which require debridement or dislocation of hip.

Could trigger frequency rules under regulation 15 (1)(b) of the Private and Voluntary Healthcare (England) Regulations 2001, which relates to quality of care – i.e. “reflect published research evidence and guidance issued by the appropriate professional and expert bodies, as to good practice in the treatment of the condition from which the patient is suffering”.

**Limitations**

Depends on the reporting capabilities of the establishment. The number of unplanned transfers may be high for the hospital but low for individual consultants.

The timescale of the indicator will be 29 days from independent sector treatment centres and non-IQIP participants, and 31 days from IQIP participants.

This indicator could be severely limited in establishments that do not receive their own readmissions, or where the patient is readmitted without the original hospital being made aware of the readmission.

**Numerator**

Number of readmissions to the same hospital for the same or a related condition that was not planned at the time of discharge. This excludes:

- Readmission for unrelated condition.
- Readmissions for false/actual labour and delivery.

**Denominator**

Number of inpatients who are discharged excluding discharges for death.
5. Surgical site infection hip/knee arthroplasty

**Summary/benefit**

Hospital acquired infection causes anxiety and discomfort, complicates illness and can delay recovery. In some cases, it is a cause of morbidity for patients following surgery. Standards to ensure ‘asepsis’ (that is, to remove bacteria, fungi and other causes of disease) in operating theatres are the key to minimising the risk of infection. However, infection or disease cannot always be prevented. The likelihood of a surgical site infection depends upon a number of factors relating to the patient and the surgical procedure. In particular, the risk of developing a surgical site infection varies according to the type of surgery being carried out, the general health of the patient at the time of operation and the length of the operation.

The Health Protection Agency runs a national surgical site infection surveillance service. Indicator 2a from the quality indicator project matches the definitions of the Health Protection Agency for diagnosis and risk.

Adjusting for risk can identify hospital caseload and mix and this could be used to analyse the hospital's profile of patients.

It could trigger frequency rules under regulation 15(6) of the Private and Voluntary Healthcare (England) Regulations 2001, which states: “The registered person shall make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff (including medical practitioners with practising privileges)”.

**Limitations**

Reports only include surgical site infections that are identified during a patient’s stay in hospital. This is particularly relevant where providers are trying to reduce the length of stay for orthopaedic procedures, or where contractual arrangements mean that care after a patient leaves hospital is carried out by another hospital.

A greater number of older patients may increase a hospital’s rate of surgical site infection.

**Numerators (see below for definitions)**

- Number of hip arthroplasty surgical site infections by risk in the reporting quarter.
- Number of knee arthroplasty surgical site infections by risk in the reporting quarter.

**Denominators (see below for definitions)**

- Number of primary and revision hip replacement surgeries by risk index.
- Number of primary and revision knee replacement surgeries by risk index.
Numerator definitions

Further information can be found at on the Health Protection Agency’s website at www.hpa.org.uk.

Skin or subcutaneous infection: this occurs within 30 days of surgery. It involves the skin or subcutaneous tissue of the incision and meets at least one of the following criteria:

- Purulent drainage from the superficial incision.
- The superficial incision yields organisms from the culture of aseptically aspirated fluid or tissue, or from a swab and pus cells are present.

At least two of the following symptoms and signs arise:

- Pain or tenderness.
- Localised swelling.
- Redness.
- Heat.

One of the following arises:

- The superficial incision is deliberately opened by a surgeon to manage the infection, unless the incision is culture-negative.
- The clinician diagnoses a superficial incisional infection.

Organ/space infection: this occurs within 30 days of surgery involving the deep tissues (i.e. fascial and muscle layers) within a year, if an implant is in place and the infection appears to be related to the surgical procedure, and meets at least one of the following criteria:

- Purulent drainage from the deep incision but not from the organ/space component of the surgical site.
- The deep incision yields organisms from the culture of aseptically aspirated fluid or tissue, or from a swab and pus cells are present.
- A deep incision that spontaneously dehisces or is deliberately opened by a surgeon when the patient has a least one of the following symptoms or signs:
  - fever (higher than 38 degrees celsius)
  - localised pain or tenderness, unless the incision is culture-negative
  - an abscess or other evidence of infection involving the deep incision that is found by direct examination during the follow up operation, or by histopathological or radiological examination
  - diagnosis of a deep incisional surgical site infection by an attending clinician.

An infection that involves both superficial and deep incision is classified as deep incisional surgical site infection.
Identifying risk index

The risk index is calculated based on a patient's ASA score, wound classification, and the time of their operation.

ASA classification of physical status: the preoperative ASA score is an assessment by the anaesthetist of the patient’s preoperative physical condition according to the ASA classification.

The preoperative condition is scored as:

Class 1: Normal healthy patient.
Class 2: Patient with mild systemic disease caused either by the condition to be treated surgically or by other pathophysiological processes.
Class 3: Patient with severe systemic disease that is not incapacitating.
Class 4: Patient with an incapacitating systemic disease that is already life-threatening, and not always correctable by operation.
Class 5: Moribund (dying) patient who has little chance of survival.

Wound class: surgical wounds can be classified according to the likelihood and degree of wound contamination at the time of operation. This should be done at the time of surgery by the surgeon. If this information is not available, the Health Protection Agency provides the minimum wound class for each surgical procedure (available on the Health Protection Agency’s website). The final classification of wound contamination must be confirmed in consultation with the surgeon, or by checking the patient's records using the definitions below.

Clean wounds: uninfected operative wounds, which are not inflamed, which have not entered the respiratory, gastrointestinal, genital or urinary tracts or the oropharynx, and where there is no break in aseptic technique. In addition, clean wounds must be primarily closed and, if there is drainage, this must be closed. Operative wounds that follow non-penetrating trauma, such as a fractured neck or femur, should be included in this category if they meet this criteria.

Clean-contaminated wounds: operative wounds in which the respiratory, alimentary, genital or urinary tracts are entered under controlled conditions and without unusual contamination, providing that there is no evidence of infection or a major break in aseptic technique.

Contaminated wounds: operations on fresh, open traumatic wounds, where there is a major break in aseptic technique; or in which there is gross spillage from the gastrointestinal tract or acute inflammation without pus.

Dirty or infected wounds: operations in which acute inflammation with pus is encountered or in which perforated viscera are found; operations on traumatic wounds that have retained devitalised tissue, foreign bodies or faecal contamination, or where the operation on the traumatic wound has been delayed. Operations included in this class are those in which the organisms causing post-operative infection are likely to have been present in the operative field before surgery.
**Duration of operation**: this is the time in minutes from skin incision to skin closure. The duration of operation is a measure of the length of exposure to potential contamination.

**Classification of risk**
Scores on the NNIS risk index range from zero (0) to three (3). A risk index point is assigned when one of the following applies:

- ASA assessment of three, four or five
- A class three contaminated wound or class four dirty or infected operative wound
- The operative procedure lasts longer than two hours

For example:

<table>
<thead>
<tr>
<th>ASA</th>
<th>Wound</th>
<th>Procedure time</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clean</td>
<td>Less than two hours</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>Clean</td>
<td>Less than two hours</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Contaminated</td>
<td>More than two hours</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Dirty</td>
<td>More than two hours</td>
<td>3</td>
</tr>
</tbody>
</table>
6. Staphylococcus Aureus Bacteraemia

**Summary/benefit**

Staphylococcal infection and bacteraemia, particularly methicillin resistant Staphylococcus aureus (MRSA), is an important public health issue. Providers should demonstrate that they are monitoring life threatening infections and rate of infection.

The Health Protection Agency runs a surveillance scheme for MRSA and methicillin sensitive Staphylococcus aureus (MSSA). Data should be collected in line with this scheme.

It could trigger inspection under regulation 15(6) of the Private and Voluntary Healthcare (England) Regulations 2001, which states that “the registered person shall make suitable arrangements to minimise the risk of infection and toxic conditions and the spread of infection between patients and staff (including medical practitioners with practising privileges)”.

**Limitations**

Reporting on positive blood cultures does not necessarily indicate that there is an infection.

Certain patients are at higher risk of developing infections, which means that a hospital’s caseload could affect its rate of infection.

Rates of MRSA are higher among hospitals that receive patient transfers. It is likely that there will be low volume of incidence due to the type of patient being admitted, pre-admission screening and the nursing regime in individual rooms.

**Numerators**

Number of blood culture results that were reported as positive for MRSA.

Number of blood culture results that were reported as positive for MSSA.

Total number of episodes of MRSA positive blood culture – episodes in the same individual within 14 days of the first reported episode are considered part of the original episode and should not be reported. Episodes that are more than 14 days after the first reported episode should be reported, as these are considered separate episodes.

Total number of repeated episodes of positive blood culture.

Total number of episodes of Staphylococcus aureus blood culture – episodes in the same individual within 14 days of the first reported episode are considered part of the original episode and should not be reported. Episodes more than 14 days after the first reported episode should be reported, as these are considered separate episodes.

**Denominator**

Total number of ‘bed days’ – calculated by the number of inpatients in the hospital at midnight.
### 7. Serious injury

<table>
<thead>
<tr>
<th><strong>Summary/benefit</strong></th>
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| Regulation 28 of the Private and Voluntary Healthcare (England) Regulations 2001 covers information that has already been submitted by providers. Reports of serious injury may indicate failings in the service that have resulted in harm to patients.  

Reports of serious injury provide an opportunity for the provider to assess its processes for reporting incidents and sharing information, analysing and learning from adverse incidents, and implementing and monitoring remedial actions.  

A large number of reports of ‘near misses’ are usually synonymous with an open and safety conscious culture. Incidents that result in serious injury are likely to be the result of a failure of safety mechanisms. The Care Quality Commission is developing definitions relating to serious injury and will provide further guidance at a later date. |

<table>
<thead>
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<th><strong>Limitations</strong></th>
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| To date, the indicator of 'serious injury' has been largely undefined. There may be different thresholds for reporting serious injury in regional structures or between providers.  

‘Near miss’ reporting will not be measured. |

<table>
<thead>
<tr>
<th><strong>Numerator</strong></th>
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<table>
<thead>
<tr>
<th><strong>Denominators</strong></th>
</tr>
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</table>
| Total number of ‘bed days’ – calculated for the number of inpatients in the hospital at midnight.  

Number of inpatients who have been discharged. |