

9 January 2018

By email

Wellington House 133-155 Waterloo Road London SE1 8UG

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Dear

Request under the Freedom of Information Act 2000 (the "FOI Act")

I refer to your email of **7th December 2017** in which you requested information under the FOI Act from NHS Improvement. Since 1 April 2016, the patient safety functions of the National Health Service Commissioning Board under Section 13R of the National Health Service Act 2006 have been exercised by the NHS Trust Development Authority, as part of the integrated organisation known as NHS Improvement.

Your request

You made the following request:

"Under FOI please can you provide me with the following statistics for the financial year 2016 -2017.

- 1. The number of avoidable deaths in hospital
- **2.** The ratio of avoidable deaths vs admissions that occur in hospital. Expressed as 1:100 1:1000 etc.
- 3. The total number of Patient Safety Incidents reported in England (HSCIC)
- 4. The number of Never Events?
- 5. The number of injurious falls?
- 6. The number of avoidable pressure ulcers (moderate harm and above)"

Decision

NHS Improvement holds some of the information that you have requested and has decided to release some of the information held and exempt the remainder under section 21 of the Freedom of Information Act 2000.

Response

In relation to questions 1 and 2, NHS Improvement does not hold the information that you have requested. For ONS reports 'avoidable mortality' please see:

https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2015

We would also advise that you refer to local data publication related to 'Learning from deaths' https://improvement.nhs.uk/resources/learning-deaths-nhs/

In relation to question 3, the information requested is exempt under section 21 of the Freedom of Information Act 2000.

Section 21 of the Freedom of Information Act provides an exemption from the right to know if the information requested is reasonably accessible to the applicant through other means. Please refer to NHS Improvement NRLS data publication at:

https://improvement.nhs.uk/resources/national-quarterly-data-patient-safety-incident-reports-march-2017/

In relation to question 4, the information requested is exempt under section 21 of the Freedom of Information Act 2000. Never Events data can be found at:

https://improvement.nhs.uk/resources/never-events-data/

In relation to question 5 (the number of injurious falls) NHS Improvement does not hold this information but you may wish to raise this issue with NHS Digital. We have however conducted a search in the National Reporting and Learning System (NRLS). The table below outlines the number of falls in healthcare services where the date of the incident was recorded as 1st April 2016 to 31st March 2017 and it had been reported to the NRLS by 31st May 2017

	FY 2016/2017		
Degree of harm	English	Welsh	All geographical locations
Low	65,906	5,642	71,548
Moderate	5,021	1,040	6,061
Severe	1,349	103	1,452
Death	143	2	145
Total	72,419	6,787	79,206

In relation to question 6 (the number of avoidable pressure ulcers), we do not hold this data. Please note that categorisation as 'avoidable' or 'unavoidable' is discouraged – see FAQ 5. at https://improvement.nhs.uk/resources/serious-incident-framework/. For this reason we do not believe any other organisation holds information in this respect.

Generally

As set out above some of the information that we have provided is from the National Reporting and Learning System (NRLS). The primary purpose of the NRLS is to enable

learning from patient safety incidents occurring in the NHS. The NRLS was established in late 2003 as a largely voluntary scheme for reporting patient safety incidents, and therefore it does not provide the definitive number of patient safety incidents occurring in the NHS.

All NHS organisations in England and Wales have been able to report to the system since 2005. In April 2010, it became mandatory for NHS organisations to report all patient safety incidents which result in severe harm or death. All patient safety incident reports submitted to the NRLS categorised as resulting in severe harm or death are individually reviewed by clinicians to make sure that we learn as much as we can from these incidents, and, if appropriate, take action at a national level.

The NRLS is a dynamic reporting system, and the number of incidents reported as occurring at any point in time may increase as more incidents are reported. Experience in other industries has shown that as an organisation's reporting culture matures, staff become more likely to report incidents. Therefore, an increase in incident reporting should not be taken as an indication of worsening of patient safety, but rather as an increasing level of awareness of safety issues amongst healthcare professionals and a more open and transparent culture across the organisation.

Review rights

If you consider that your request for information has not been properly handled or if you are otherwise dissatisfied with the outcome of your request, you can try to resolve this informally with the person who dealt with your request. If you remain dissatisfied, you may seek an internal review within NHS Improvement of the issue or the decision. A senior member of NHS Improvement's staff, who has not previously been involved with your request, will undertake that review.

If you are dissatisfied with the outcome of any internal review, you may complain to the Information Commissioner for a decision on whether your request for information has been dealt with in accordance with the FOI Act.

A request for an internal review should be submitted in writing to FOI Request Reviews, NHS Improvement, Wellington House, 133-155 Waterloo Road, London SE1 8UG or by email to nhsi.foi@nhs.net.

Publication

Please note that this letter [and the attached information] will shortly be published on our website. This is because information disclosed in accordance with the FOI Act is disclosed to the public at large. We will, of course, remove your personal information (e.g. your name and contact details) from the version of the letter published on our website to protect your personal information from general disclosure.

Yours sincerely,

NHS Improvement