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16 October 2017

[redacted]

By email

[redacted]

Dear [redacted]

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

I refer to your email of **18th September 2017** in which you requested information under the FOI Act from NHS Improvement. Since 1 April 2016, the Patient Safety functions under section 13R of the NHS Act 2006 have been exercised by the NHS Trust Development Authority, as part of the integrated organisation known as NHS Improvement.

Your request

Your email, set out in full in the Annex to this letter, contained the following questions:

I would be grateful if you would supply me with the following anonymised information on incidents reported by NHS staff on the *Patient Safety Incident Report Form: Healthcare Staff* since 1st January 2002.

1. The number of patient safety incidents reported by NHS Staff containing the key phrase **"*breast cancer*"** and where the patient was female.
2. The number of these incidents that were identified in **ID03** of the Reporting Form as occurring due to failures in ***clinical assessment*** **(including diagnosis, scans, tests, assessment)**.
3. Of these incidents how many were in each of the 14 **sub-categories of ID03**: 1) assessment – lack of clinical or risk assessment; 2) cross matching error; 3) diagnosis – delay/failure to; 4) diagnosis wrong; 5) scans/x-rays/specimens – inadequate/incomplete; 6) scans/x-rays/specimens – mislabelled/unlabelled; 7) scans/x-rays/specimens – missing; 8) scans/x-rays/specimens – wrong; 9) test results/reports – failure/delay to interpret or act on; 10) test results/reports- fail/delay to receive; 11) test results/reports – missing; 12) Tests -failure/delay to undertake; 13) test results/reports -incorrect; 14) other.
4. In the description of what happened **(ID05)** in how many incidents were the terms "Triple Assessment" or "Triple Assess" or "Triple Test" mentioned?
5. Of the incidents in point 2 above, how many patients were '***harmed***'' (PD 01)?
6. Of the harm done how many incidents were identified in each of the following categories: low harm, moderate harm, severe harm and death?

7. Of the incidents in point 2 above, how many patients experienced a '***near miss***' (PD02)

8. Of the incidents in point 2 above, how many incidents occurred per calendar year (2002-2017)

9. Of the incidents in point 2 above, how many patients were in each of the following four age groups: under 25; 26-40; 41-50; and 51 and older.

I would also be grateful if you would supply me with the following anonymised information on incidents reported by members of the public by eForm, telephone or letter since 1st January 2002.

1. The number of patient safety incidents reported by the public to the NPSA containing the key phrase **"breast cancer**" and where the patient was female.

2. Of these incidents the number that occurred at **diagnosis** (stage 1, question 2 of the patients' eForm).

Finally, I would be grateful if you would supply with the following anonymised information on incidents reported on the *Patient Safety Incident Report Form: General Practice* since 1st January 2002.

1. The number of patient safety incidents reported by General Practice staff containing the key phrase **"*breast cancer*"** and where the patient was female.
2. The number of these incidents identified in Q5 as related to **clinical assessment (including diagnosis, scans, tests, assessment)**.

Decision

NHS Improvement holds the information that you have requested and has decided to release all of the information that it holds.

The information we hold is from the National Reporting and Learning System (NRLS). By way of background, some information about the NRLS may be helpful. 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.

In total 4826 patient safety incidents that contain the term "breast cancer" were reported to the NRLS occurring between 1st January 2002 and 31st July 2017 (based on the date the incident was reported to have occurred) and exported to the NRLS on or before 25th September 2017. These incidents have been further broken down as requested and are held in the attached excel spreadsheet labelled 'Ref 3963 - FOI - [redacted] - Diagnosis Delay'; this spreadsheet also has a section labelled 'Data interpretation' which can provide further context for the data.

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.

NRLS data requests

You may find it helpful to know that NRLS data can also be requested through our data request process via nrls.datarequests@nhs.net. When a data request is made we can help a member of the public, clinical staff or researcher to identify what information might best meet their needs, and discuss the best way to search for it within the NRLS. For example, we can discuss alternative terms and abbreviations that are might be used as synonyms for the issue of interest, and explain that the wording used in incident reports does not always reflect the terms used to describe a set of tests or investigations in more formal clinical literature.

Yours sincerely,

NHS Improvement

Annex 1:

[redacted]

Freedom of Information Officer
NHS Improvement

18th September 2017

Dear Freedom of Information Officer,

This is a request under the Freedom of Information Act.

I am aware that NHS Improvement collects information about adverse events and near misses as part of its remit to ensure that the NHS learns from mistakes, and that this continues the work of the National Patients Safety Agency and the NHS Commissioning Board Special Health Authority. I am currently investigating how many adverse events and near misses since 2002 have involved individuals diagnosed or subsequently diagnosed with breast cancer. I am particularly interested in failures to carry out the Triple Assessment.

I would be grateful if you would supply me with the following anonymised information on incidents reported by NHS staff on the *Patient Safety Incident Report Form: Healthcare Staff* since 1st January 2002.

8. The number of patient safety incidents reported by NHS Staff containing the key phrase **"*breast cancer*"** and where the patient was female.
9. The number of these incidents that were identified in **ID03** of the Reporting Form as occurring due to failures in ***clinical assessment*** **(including diagnosis, scans, tests, assessment)**.
10. Of these incidents how many were in each of the 14 **sub-categories of ID03**: 1) assessment – lack of clinical or risk assessment; 2) cross matching error; 3) diagnosis – delay/failure to; 4) diagnosis wrong; 5) scans/x-rays/specimens – inadequate/incomplete; 6) scans/x-rays/specimens – mislabelled/unlabelled; 7) scans/x-rays/specimens – missing; 8) scans/x-rays/specimens – wrong; 9) test results/reports – failure/delay to interpret or act on; 10) test results/reports-fail/delay to receive; 11) test results/reports – missing; 12) Tests -failure/delay to undertake; 13) test results/reports -incorrect; 14) other.
11. In the description of what happened **(ID05)** in how many incidents were the terms "Triple Assessment" or "Triple Assess" or "Triple Test" mentioned?
12. Of the incidents in point 2 above, how many patients were '***harmed***' (PD 01)?
13. Of the harm done how many incidents were identified in each of the following categories: low harm, moderate harm, severe harm and death?
14. Of the incidents in point 2 above, how many patients experienced a '***near miss***' (PD02)

8. Of the incidents in point 2 above, how many incidents occurred per calendar year (2002-2017)
9. Of the incidents in point 2 above, how many patients were in each of the following four age groups: under 25; 26-40; 41-50; and 51 and older.

I would also be grateful if you would supply me with the following anonymised information on incidents reported by members of the public by eForm, telephone or letter since 1st January 2002.

2. The number of patient safety incidents reported by the public to the NPSA containing the key phrase **"breast cancer**" and where the patient was female.
2. Of these incidents the number that occurred at **diagnosis** (stage 1, question 2 of the patients' eForm).

Finally, I would be grateful if you would supply with the following anonymised information on incidents reported on the *Patient Safety Incident Report Form: General Practice* since 1st January 2002.

3. The number of patient safety incidents reported by General Practice staff containing the key phrase **"*breast cancer*"** and where the patient was female.
4. The number of these incidents identified in Q5 as related to **clinical assessment (including diagnosis, scans, tests, assessment)**.

If you have any queries at all about the information required please do not hesitate to contact me for further clarification. I can be contacted on [redacted] or at [redacted]

Please note that I am a private individual and am not employed by a commercial organisation. I am aware that any data received from you must be interpreted with caution because incident reporting is voluntary and not all events will be reported accurately or in a timely fashion. If you are unable to supply data from 1st January 2002, please supply data from as far back in time as you can.

I would prefer to receive the required information by email.

I look forward to hearing from you promptly, as required by the legislation, and in any case within 20 working days.

Thank you for your time.

Yours faithfully,

[redacted]