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8 January 2018

[redacted]

By email

[redacted]

Dear [redacted]

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 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 (the numbering has been inserted by NHS Improvement for ease of reference):

1. *"I would like to know how many patients have been kept alive against their wishes/ against their 'living will', under the Mental Capacity Act between 01/01/2012 – 01/12/2017 (or as close to those dates as possible)? Thank you.*
2. *Please can you also tell me how much has been paid out to these individuals in compensation?*
3. *If you're able to break the figures down by county and hospital I would be most grateful- thank you. If you're unable to give me details for the whole of England, please can I have the figures, for the above, for a) Kent, b) Sussex and c) Surrey?"*

Decision

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

Response

Please note that the information that we have provided 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.

A search of the NRLS was carried out on 28th December 2017 of all incidents reported as occurring between 1st January 2012 and 30th December 2017, uploaded to the NRLS by 3rd January 2018 and where the free text description of the incident contained *'Advanced Directive* or *Living Will* or related terms including misspellings, and also contained the terms *'Kept alive, lost, mislaid, mis-laid, missed, misfiled, mis-filed, failed to comply, or failure to comply'*. Whilst we have chosen key word searches in good faith as most likely to identify requested incidents we cannot guarantee that there are not additional relevant incidents that an alternative keyword search strategy might have found.

For the information you requested we also made a search using the Strategic Executive Information System (StEIS). StEIS is a database used for the notification of appropriate parties that Serious Incidents have occurred and to manage progress of investigations, as set out in the Serious Incident Framework 2015, please note it does not hold the full investigation report for Serious Incidents. The revised Serious Incident Framework published in March 2015 builds on previous guidance that introduced a systematic process for responding to serious incidents in NHS-funded care. It replaces, the National Patient Safety Agency (NPSA) National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (2010) and NHS England's Serious Incident Framework (March 2013). The framework takes account of the changes within the NHS landscape and acknowledges the increasing importance of taking a whole-system approach, where cooperation, partnership working, thorough investigation and analytical thinking is applied to ensure organisations identify and learn what went wrong, how it went wrong and what can be done to minimise the risk of the incident happening again. A search of StEIS was carried out on 18h December 2018 for incidents occurring between 1st January 2012 and 1st December 2017 using the free text search terms of "advanced directive" "advance directive" and "living will" but no relevant Serious Incidents were found.

We found one incident in the NRLS that may be relevant to your request. It describes one dose of intravenous antibiotics given in hospital to a patient whose 'living will' stated they

would not wish to receive these. However, it is unclear whether the single dose affected the patient's survival.

We found five further incidents that may have some relevance to your request. Three described unsuccessful attempts at cardiopulmonary resuscitation of people living in their own home, where family members contacted emergency or urgent care services, but where the family members could not initially locate their relative's 'living will' to show healthcare staff. One related to an unsuccessful attempt at cardiopulmonary resuscitation of a patient in hospital; after their death a relative reported the patient had a living will but it was unclear if the hospital had previously been informed of this. One related to an unsuccessful attempt at cardiopulmonary resuscitation of a patient just admitted to hospital; resuscitation was stopped as soon as the patient's notes from a previous admission, including their advance directive, were obtained.

In regard to your second question "*how much has been paid out to these individuals in compensation?"* NHS Improvement does not hold this information and we would advise that you approach the NHS Litigation Authority for the data that you require at: http://www.nhsla.com/OtherServices/Pages/Accessing-Information-about-the-NHS-LA.aspx

In regard to your third question, the organisations that reported incidents which were either relevant or had some relevance to your request were:

- University Hospitals Coventry and Warwickshire NHS Trust
- Welsh Ambulance Services NHS Trust
- North Bristol NHS Trust
- Wirral University Teaching Hospital NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust

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