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11 August 2017

[redacted]

By email
[redacted]

Dear [redacted]

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

I refer to your email of **27 July 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

You made the following request:

"Can you please provide the following information under the Freedom of Information Act.

· *The number of serious incidents which were reported between January 2010 and December 2016. Can you please break down your response by the number of such reports in each year (i.e. 2010, 2011, 2012, 2013, 2014, 2015, 2016).*

For your reference, the serious incident framework sets out when a serious incident must be declared. This document is available on your website at https://improvement.nhs.uk/resources/serious-incident-framework/."

Decision

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

By way of background you may find it useful to know that the information we hold is from 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.

Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. The Serious Incident Framework describes the circumstances in which such a response may be required. In summary this includes, acts or omissions in care that result in: unexpected/ potentially avoidable death, unexpected/ potentially avoidable injury resulting in serious harm (including those where the injury required treatment to prevent death or serious harm), abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. More detailed guidance is included within part one, section one of the SI framework available from: https://www.england.nhs.uk/patientsafety/serious-incident/

With regards to STEIS modules, this system has evolved over the years it has been in operation (which exceeds more than 15 years) and new fields and categories have been added over time to reflect changing reporting behaviours as well as structural/ organisational changes. The reason Module 2 was created was due to the changes within the NHS landscape in 2013 which resulted in the closure of the Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) which had overseen SI investigations until this point. STEIS was amended so that Clinical Commissioning Groups and NHS England could take on the role of investigation monitoring and oversight.

STEIS Module 3 was introduced to support better implementation of the revised Serious Incident Framework (published March 2015). This included updating and rationalising incident categories (which had accumulated over many years to produce an excessive and overlapping list) and amending reporting timeframes to align more closely with expectations outlined within the SI framework.

In total 165094 Serious incidents were reported to StEIS, as of extraction date 3rd August 2017. **Table 1** shows the breakdown of these incidents by year for the period 2010 - 2016.

	Total number of SI's reported on STEIS
2010	13283
2011	18288
2012	22703
2013	28340

2014	31634
2015	27513
2016	23333
Total	165094

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