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26 April 2018

[redacted]

By email
[redacted]

Dear [redacted],

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

We refer to your email of 27 March 2018 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:

"Under the Freedom of Information Act, please could you provide me with information on the number of reports made under the National Reporting and Learning System where:

(a) The reports were for ambulance services; and
(b) The incident type was 'Access, admission, transfer, discharge (including missing patient)'

And could the number of incidents be broken down by 'degree of harm' (in the same format and with the same headings used in the NaPSIR workbook.

Please could the information be provided in each for the years 2014/15, 2015/16, 2016/17, and 2017/18 (to the latest date for which figures are available)."

You clarified you request on 28 March 2018 as follows:

"I would like to request data for calendar years."

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.

Table 1
Number of reported incidents where Care Setting equals Ambulance Services and Incident type equals Access, admission, transfer, discharge (including missing patients) by reported degree of harm by financial year
Base: Incidents reported as occurring between 1st January 2014 and 31st March 2018 and exported to the NRLS by the 24th April 2018

Care Setting of Occurrence	Incident Category (level 1)	Degree of Harm	2014	2015	2016	2017	2018*	Total
Ambulance service	**Access, admission, transfer, discharge (including missing patient)**	**No Harm**	1,644	2,134	2,309	2,859	659	**9,605**
		Low	556	853	1,066	742	182	**3,399**
		Moderate	203	147	100	145	65	**660**
		Severe	97	50	47	61	24	**279**
		Death	31	23	15	39	15	**123**
Total			**2,531**	**3,207**	**3,537**	**3,846**	**945**	**14,066**

*Note: Figures for 2018 are not complete.

In relation to the above table, reporting of degree of harm in the NRLS is intended to record the actual degree of harm suffered by the patient. However due to large number of organisations/people reporting to the NRLS this is not always the case. Some incidents may be coded based on the potential for severe harm to the patient, rather than the actual harm. In other cases, the patient may have died, but not as a result of a patient safety incident: even following investigation, the relationship between any incident which occurred and the

outcome for the patient is often unclear, especially when incidents happen during the care of patients with life-threatening illnesses.

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