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29 March 2018

[redacted]

By email

[redacted]

Dear [redacted],

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

We refer to your email of 2 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 requested the following information (numbering inserted by NHS Improvement):

"Please send us the following information:

1. *How many accidents have been reported resulting from ceiling hoist failures since 1st January 2009?*

2. *How many incidents where a person has been injured, died or had a near miss through ceiling hoist mechanical failures have been reported since 1st January 2009?*

3. *Have any mechanical failures been reported in respect of the Guldmann GH2 since 1st January 2009?*

4. *If so, how many and what were the failure complained of? If too many, please identify the category of failures.*

5. *Did any of those failures result in the occupant of the hoist being injured or killed?"*

Decision

NHS Improvement holds some of 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.

A search of the NRLS was carried out on 23 March 2018 of all incidents reported as occurring between 1 January 2009 to 31 December 2017 (based on the date the incident was reported to have occurred) and exported to the NRLS on or before 22 March 2018. We have undertaken different specific searches within these date ranges to answer your questions as far as possible, and the additional detail of each search approach is described alongside each data table below. The approach we have taken will pick up many appropriate incidents however we cannot guarantee that there are not additional relevant incidents that an alternative search strategy might have found.

Question 1

The information requested is not held.

We were not able to supply data specific to ceiling hoists using the categorical data collected by the NRLS. The NRLS has a device type of 'Patient hoists' but no sub-category for ceiling hoists, therefore, we cannot determine how many incidents reported involve ceiling hoists.

Table 1 provides the overall numbers for the medical device incident category of 'patient hoists'.

Table 1: Number of reported incidents where device type equals 'Patient hoists' and Incident type equals 'Medical device/equipment', by year

Year	2009	2010	2011	2012	2013	2014	2015	2016	2017	Total
Reported numbers	**628**	**602**	**698**	**650**	**697**	**755**	**696**	**744**	**640**	**6,110**

Question 2

The information requested is not held.

We were not able to supply data specific to mechanical failure related to 'Patient hoists' but in Table 2a have supplied data from the NRLS category of 'Failure of device/equipment'. This category includes mechanical failure, but would also include other types of equipment failure, such as battery failure/battery not charged, and issues with hoist slings.

Table 2a: Number of reported incidents where device type equals 'Patient hoists' and Incident type equals 'Medical device / equipment', and incident category equals 'Failure of device/ equipment' by year (note this is a sub-set of the numbers in Table 1)

Year	2009	2010	2011	2012	2013	2014	2015	2016	2017	Total
Reported numbers	223	213	257	210	227	248	232	245	234	**2,089**

Table 2b: Number of reported incidents where device type equals 'Patient hoists' and Incident type equals 'Medical device / equipment', and incident category equals 'Failure of device/ equipment' by reported degree of harm (note this is the same data as in Table2a, but divided by reported degree of harm instead of by year)

Reported degree of harm	No Harm	Low	Moderate	Severe	Death	Total
Reported numbers	1,834	218	34	2	1	2,089

Within the data used for Tables 2a and 2b, we undertook an additional search for any incidents where the free text of the incident included the word 'ceiling' or 'overhead'. Please note the reporter is unlikely to always state which kind of hoist was involved when describing what happened, so this will not identify all reports that related to ceiling hoists. Additionally, the use of these terms could be incidental e.g. a report that described having to move a patient to a ceiling hoist because the portable hoist had failed. The findings from this search are shown in Table 3.

Table 3. Number of reported incidents with the term 'ceiling' or 'overhead' used in the free text incident description where device type equals 'Patient hoists' and Incident type equals 'Medical device/equipment', and incident category equals 'Failure of device / equipment' (note this is a sub-set of Tables 2a and 2b)

Reported degree of harm	No Harm	Low	Moderate	Severe	Death	Total
Reported numbers	150	11	2	0	0	163

Questions 3, 4 and 5

Within the data used for Tables 2a and 2b, we undertook an additional search for any incidents where the free text description of the incident included the word 'Guldmann'. Please note the reporter is unlikely to always state which brand of hoist was involved when describing what happened, so this will not identify all reports that related to 'Guldmann' hoists.. The findings from this search are shown in Table 4.

Table 4. Number of reported incidents with the term 'Guldmann' used in the free text where device type equals 'Patient hoists' and Incident type equals 'Medical device/equipment', and incident category equals 'Failure of device / equipment' (note this is a sub-set of Tables 2a and 2b)

Reported degree of harm	No Harm	Low	Moderate	Severe	Death	Total
Reported numbers	11	0	0	0	0	11

We reviewed these eleven incident reports. Of these:

- five describe battery failure or battery not charged
- two describe tears or rips to the hoist sling
- two relate to adjusting the length of the emergency cord when a patient self-operates the hoist. The text of the two incidents is very similar and these may represent duplicate submission of a single incident
- one describes a hoist referred to as "Guldmann?" suggesting reporting staff are not certain of the make, and describes *"equipment supplier were on site at patient home installing a gantry hoist . The motor device for the gantry hoist came apart. As this motor could not be used a second one was delivered approx. 1 hour later. This second motor was not charged and the gantry hoist could not be used."* The remainder of the incident report is mainly concerned with delay and discomfort caused to the patient and carers by the need to use a portable hoist in the interim. one states *"Both leg loops sprung out of ceiling track hoist lifting bar (Guldmann GH3) when client was hoisted above the bed by OT . Parent present . . . Hoist company revised their information. Team members advised. Hoist company assessed that careful placement and monitoring was sufficient. Team members advise accordingly."*

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.

Other information sources

It may be helpful to note that the key source of information on mechanical failures of medical devices is the Medicines and Healthcare products Regulatory Agency (MHRA). We routinely share NRLS data relating to medical devices with them, and they also operate their own Yellow card reporting scheme. See https://www.gov.uk/guidance/contact-mhra

It may also be helpful to know that the NRLS is a system focused on NHS-funded care. Deaths or serious injury in certain circumstances outside NHS-funded care (e.g. in care homes) are reported directly to the Care Quality Commission.

Publication

Please note that this letter 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