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11 November 2016

[redacted]

**By email**

[redacted]

Dear [redacted]

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

I refer to your email of 16 October 2016 in which you requested information under the FOI Act from NHS Improvement. Since 1 April 2016, Monitor and the NHS Trust Development Authority (TDA) have been operating as an integrated organisation known as NHS Improvement. For the purposes of this decision, NHS Improvement means TDA.

## Your request

You made the following request:

> *"Can you please give me details of medical incidents that led to a patient's death that were reported to NHS Improvement in the financial year 2015/16 at the following three hospital trusts?*
>
> *Brighton and Sussex University Hospitals NHS Trust*
>
> *Western Sussex Hospitals NHS Trust*
>
> *East Sussex Healthcare NHS Trust.*
>
> *I am aware patient safety incidents are available online but these are only numbers, I am looking for further details about the type of incidents that took place."*

## Decision

NHS Improvement holds information relevant to your request. 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.

From your request I believe you are aware of the NRLS data contained within our recently published Organisation Patient Safety Incident Reports at https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-28-september-2016/.

In response to your request we recently carried out a search of the NRLS of all incidents reported by Brighton and Sussex University Hospitals NHS Trust, Western Sussex Hospitals NHS Trust and East Sussex Healthcare NHS Trust as occurring between the dates 1st April 2015 to 31st March 2016 if these had been uploaded to the NRLS by 20th October 2016 and the original reporters had reported the degree of harm as death. The results of this search have been provided in Table 1 below. The table contains the number of incidents broken down by the additional detail of the categories that are held within the NRLS database, specifically the incident category, as reported by the original reporters at Brighton and Sussex University Hospitals NHS Trust, Western Sussex Hospitals NHS Trust and East Sussex Healthcare NHS 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,

**Patient Safety Team NHS Improvement**

**Table 1:** Incidents reported as degree of harm = death for three chosen organisations, by Incident Category Level 1 and Level 2, broken down by Financial Year

| Organisation Name | Org Code | Incident Category Level 1 | Incident Category Level 2 | Incident Category Free Text as reported by the original Reporter | Total |
|---|---|---|---|---|---|
| BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST | RXH | Access, admission, transfer, discharge (including missing patient) | Transport - delay / failure | | 1 |
| | | Treatment, procedure | Treatment / procedure - inappropriate / wrong | | 1 |
| | | Other | Other | Other | 1 |
| EAST SUSSEX HEALTHCARE NHS TRUST | RXC | Access, admission, transfer, discharge (including missing patient) | Discharge - inappropriate | | 1 |
| | | Documentation (including electronic & paper records, identification and drug charts) | Appointment recording error | | 1 |
| | | Infection Control Incident | Infection - cross / healthcare associated | | 1 |

| | | | | | |
|---|---|---|---|---|---|
| | | Implementation of care and ongoing monitoring / review | Delay or failure to monitor | | 2 |
| | | | Other | Monitoring - Lack of/delay in observations/inadequate assessment of patient | 1 |
| | | Treatment, procedure | Treatment / procedure - inappropriate / wrong | | 1 |
| | | | Other | Access - No availability to or delay in provision of service, care or treatment | 2 |
| | | | | Labour - Paediatric Resuscitations | 1 |
| | | | | Monitoring - Unexpected Death | 4 |
| | | | | Treatment - Incorrect treatment or procedure carried out or recommended | 1 |
| | | | | Treatment - Unexpected complication during or after an operative procedure | 2 |
| | | Other | Other | Labour - Still Birth | 1 |
| WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST | RYR | Clinical assessment (including diagnosis, scans, tests, assessments) | Diagnosis - delay / failure to | | 1 |
| | | | Other | Diagnosis - other | 1 |
| | | Implementation of care and ongoing | Other | Implementation & ongoing monitoring/review - other | 1 |

| | | | | | |
|---|---|---|---|---|---|
| | | monitoring / review | | | |
| | | Medication | <No Level 2> | | 1 |
| | | Patient accident | Slips, trips, falls | | 2 |
| | | | Other | Accident of some other type or cause | 1 |
| | | Self-harming behaviour | Suspected suicide (actual) | | 1 |
| | | Treatment, procedure | Other | Treatment, procedure - other adverse event | 1 |
| | | Other | Other | Neonatal death | 2 |
| | | | | Other | 3 |