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25/04/2017

[redacted]

By email

[redacted]

Dear [redacted]

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

I refer to your email of **07 April 2017** in which you requested information under the FOI Act from NHS Improvement. Since 1 April 2016, Monitor and the NHS Trust Development Authority (the "TDA") are operating as an integrated organisation known as NHS Improvement and the Patient Safety functions under section 13R of the NHS Act 2006 have been exercised by the TDA, as part of NHS Improvement.

For the purposes of this decision, NHS Improvement means the TDA.

Your request

You made the following request:

'Could you please respond to the following request for information under the Freedom of Information Act.

For your reference, the number of patient safety incidents reported in England is published on NHS Improvement's website (https://improvement.nhs.uk/resources/national-quarterly-data-patient-safety-incident-reports/).

As such, can you please provide the number of maternity related patient safety incidents reported in England for the following years:

- *2010*
- *2011*
- *2012*
- *2013*
- *2014*
- *2015*
- *2016 (if available)*

I look forward to hearing from you by Wednesday 10 May 2017 (which is 20 working days following this request)'

Decision

NHS Improvement holds the information that you have requested.

NHS Improvement 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 recent search of the NRLS was carried out for all patient safety incidents reported as occurring in an Obstetrics or Community midwifery speciality reported as occurring between 01 January 2010 and 31 December 2016 if these had been uploaded to the NRLS by 11 April 2017. Whilst we have chosen these specialities in good faith as most likely to identify requested incidents we cannot guarantee that there are not additional relevant incidents that an alternative strategy might have found.

Table 1 below provides the results of the search broken down by year.

Table 1: Total incidents from Obstetrics or community midwifery specialities reported to the NRLS in England for the period 01 January 2010 to 31 December 2016 uploaded by 11 April 2017

Year	Total
2010	96,346
2011	105,549
2012	112,396
2013	119,982
2014	129,750
2015	134,747
2016	143,526

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 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