

22 March 2017

Wellington House  
133-155 Waterloo Road  
London SE1 8UG

T: 020 3747 0000  
E: [nhsi.enquiries@nhs.net](mailto:nhsi.enquiries@nhs.net)  
W: [improvement.nhs.uk](http://improvement.nhs.uk)

By email  
[REDACTED]

Dear [REDACTED]

## **Request under the Freedom of Information Act 2000 (the “FOI Act”)**

I refer to your email of 23<sup>rd</sup> February in which you requested information under the FOI Act from NHS Improvement. Since 1 April 2016, Monitor and the NHS Trust Development Authority are operating as an integrated organisation known as NHS Improvement. For the purposes of this decision, NHS Improvement means Monitor and the TDA.

### **Your request**

You made the following request:

*“Data from the Health and Social Information Centre spreadsheet of primary diagnoses summaries showed that 156 people were admitted to hospital for the reason referred to in the subject - 'acute reaction to foreign substance accidentally left during a procedure' in 2014-15. It also showed that 'foreign body accidentally left in body cavity or operation wound following a procedure' occurred 797 times in the same period. This is reference T81.6 and T81.5 respectively.*

*I would like to request the following information:*

- 1. I would like a breakdown of where these incidents occurred by county.*
- 2. I would like details of which foreign bodies and substances were left in the patient's bodies.*
- 3. I would like details of how these incidents occur in as much detail as possible.*
- 4. I would like details of what happens to the foreign bodies once removed. I would like to receive the information in spreadsheet form by email.”*

### **Decision**

NHS Improvement holds information relevant to your request and has decided to withhold it on the basis of the applicability of the exemptions in section 12 and 21 of the FOI Act as explained below. We've outlined below our response to the questions you asked.

#### **Question 1 – a breakdown by county**

NHS Improvement holds this information but has decided to withhold it on the basis of the applicability of the exemption in section 21 of the FOI Act.

## *Section 21 – information accessible by other means*

Under section 21 information is exempt from disclosure if it is reasonably accessible to the applicant by other means. Information may be reasonably accessible to the applicant even though it is accessible only on payment.

The Hospital Episode Statistics data you have asked for is provided to NHS Improvement by NHS Digital for a fee. As part of its publication scheme, NHS Digital operates a Data Access Request Service (DARS) for HES data and other health datasets that it gathers. We consider that the data you have requested is reasonably accessible to you by application and payment of a fee through DARS and is therefore exempt from disclosure under the FOI Act. Further information about DARS, including how to make an application, is available on NHS Digital's website via the following link: <http://content.digital.nhs.uk/DARS>.

## **Questions 2-6 – details of the incidents**

We have not been able to progress this part of your request, because to do so would exceed the cost limit under section 12 of the FOI Act.

### *Cost Limit under section 12 of the FOI Act*

Under section 12(1) of the FOI Act, NHS Improvement is not required to comply with any request that potentially exceeds the relevant cost limit. The relevant cost limit is £450, which is set out in The Freedom of Information and Data Protection (Appropriate Limit and Fees) Regulations 2004. This equates to a period of approximately eighteen hours in which to locate, retrieve and extract the information that you have requested.

This information is not contained within the Hospital Episode Statistics data provided to NHS Improvement by NHS Digital but may be contained within the National Reporting and Learning System (NRLS) and/or the Strategic Executive Information System (StEIS), which NHS Improvement operate but it would take more than 18 hours to locate and collate that information. This is because not all of the categories of incidents you have outlined align with the categories used in these systems so a clinician would need to review a large number of incident data to assess which incidents recorded on the system were relevant to your request, and to extract the information requested about those incidents.

Further information about the two systems is set out below together with details of information publicly available, which may be relevant to your request

### The National Reporting and Learning System

The NRLS was established in late 2003 as a largely voluntary scheme for reporting patient safety incidents, and therefore does not provide definitive information about 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 but providers can voluntarily report patient safety incidents resulting in no harm, low harm or moderate harm. 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.

Every six months national statistics are published about the patient safety incidents reported to the NRLS. This information is available on our website via the following link: [click here](#).

### 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.

As of April 2014, provisional never events data is published monthly throughout the financial year and each year a final whole-year report which supersedes the monthly provisional reports is published. This information is available on our website via the following link: [click here](#).

### *Advice and Assistance provided under section 16 of the FOI Act*

Under section 16 of the FOI Act, NHS Improvement is required, as a public authority, to provide advice and assistance so far as is reasonable, to individuals who have made a request to it under the FOI Act.

Given NHS Improvement's indication above of the volume of documentation that would need to be reviewed to locate the information sought, NHS Improvement would provide the following indications to assist you to make a request that can be complied without the time limits in section 12 becoming applicable. You may wish to:

- narrow your request to information contained within particular datasets held by NHS Improvement, for example, the NRLS or StEIS;
- consider how incidents are categorised in the datasets held by NHS Improvement and limit your request to specific categories of information; and/or
- consider what information is already in the public domain.

Details of the categories of information on the StEIS and NRLS are available on our website in the links contained above.

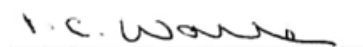
### **Review rights**

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](mailto:nhsi.foi@nhs.net).

Yours sincerely,



**Iain Wallen**

Director of Information and Analytics