Reference Number: FOI202122396

From: Private Individual

Date: 09 December 2021

Subject: Patient safety incidents resulting in severe harm or death - 2019/20 and 2020/21

Q1 Please tell me for the years a) 2019/20 and b) 2020/21 the number and, where available, rate of patient safety incidents reported within the trust

A1
a. 5079
b. 5288

The Trust is consistently one of the top incident reporting Trusts in England per 1,000 bed days to the National Reporting and Learning System (NRLS).

Q2 Please provide separately for a) 2019/20 and b) 2020/21 the number and percentage of the patient safety incidents from question 1 that resulted in severe harm or death

For context, I read in this NHS Improvement document on page 20 that trusts are required to record the above information. (https://www.england.nhs.uk/wp-content/uploads/2020/08/De tailed_requirements_for_quality_report_-update.pdf)

A2
a. Zero - 0%
b. Three - 0.056%

Q3 Please provide me with a brief overview of the FIRST FIVE patient safety incidents in 2020/21 that resulted in severe harm or death (i.e. the incidents identified in question 2b above), withholding any identifying information that would run into a Section 40 exemption.

If the information for 2020/21 is not yet available, or if there were zero incidents in 2020/21, please provide me with a summary of the first five incidents from 2019/20 instead.

A3
1. Unnecessary procedure carried out with potential additional treatment required in the long term.
2. Missed opportunities to initiate appropriate treatment.
3. Communication issues, delay in treatment.