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NHS
Milton Keynes University Hospital
NHS Foundation Trust

Request under Freedom of Information Act 2000

Thank you for your request for information which we received on 13 December 2021.

I am pleased to confirm the following.

1) 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

2019/20: 9833
2020/21: 9631

2) 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

2019/2020: incident with outcome of Major/Catastrophic harm (inc death) 27/9833 = 0.27%
2020/2021: incident with outcome of Major/Catastrophic harm (inc death) 31/9631 = 0.32%

3) 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.

Incident 1: Patient presented to the Emergency Department (ED) in January with worsening shortness of breath after being diagnosed with COVID 19 in the community. Patient was seen and discharged from ED. Patient re-presented eight days later acutely unwell. The patient had a cardiac arrest and sadly died. Diagnosis of acute myeloid leukaemia was made.

Incident 2: Admitted with Addisonian's crisis. Patient has a background of pan-hypopituitarism as a resultant of post-surgery for craniopharyngioma. Patient was not discharged with their regular medications including steroid replacements. As a result, they did not take their steroid replacement leading to an admission with adrenal crisis.

Incident 3: Patient admitted from ED for emergency laparoscopic appendicectomy. Anaesthetic induction performed. Post induction whilst in the Anaesthetic room, oxygen saturations dropped. Patient then had a cardiac arrest.

Incident 4: Patient was scanned at InHealth Diagnostic Centre in November and urgent findings not flagged nor patient sent to Emergency Department for urgent follow up. Reporting radiologist immediately informed the oncology department and the MRI manager.

Incident 5: Patient arrived in Resus following cardiac arrest, No pre-alert from paramedics prior to arrival. Member of resus team was in the area and heard the LUCAS machine (Chest Compression System) alert.

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If you are unhappy with the information received in response to this request, please address your complaint to the Patient Affairs Office at Milton Keynes Hospital NHS Foundation Trust, Standing Way, Eaglestone, Milton Keynes MK6 5LD If, after exhausting our internal process, you are still unhappy with the information received, you may write to the Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF.

If you need any further assistance, please do not hesitate to contact us at the address above.

Yours sincerely,

Freedom of Information Co-ordinator
For and on behalf of Milton Keynes Hospital NHS Foundation Trust