



Request under Freedom of Information Act 2000

Thank you for your request for information which we received on 21 June 2021.

I am pleased to confirm the following.

1) Please tell me <u>separately</u> for 2019/20 and 2020/21 the number of patients who have died during the reporting period

2019/2020 - 1108 **2020/2021** - 1150

2) The number of deaths included in 2019/20 and 2020/21 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient

2019/2020 - 252 **2020/2021** - 261

3) An estimate of the number of deaths in 2019/20 and 2020/21 for which a case record <u>review</u> or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.

2019/2020 - 4 **2020/2021** - 4 + 20 (Hospital acquired COVID pt died *of* COVID and *not with* COVID)

4) Please provide me with a brief overview of the FIRST FIVE incidents (in 2020/21 preferably or from 2019/20 if this is not yet available) identified in question 3 (i.e. cases of deaths that were more likely than not caused by problems in care), withholding any identifying information that would run into a Section 40 exemption.

Financial year 2020 – 2021 we reported 3 Serious Incidents associated as 'deaths:

1/2020 – Inpatient suicide

- 2/2020 Oesophageal intubation
- 3/2020 IUD Intrauterine death

As a teaching hospital, we conduct education and research to improve healthcare for our patients. During your visit students may be involved in your care, or you may be asked to participate in a clinical trial. Please speak to your doctor or nurse if you have any concerns.

5) Finally, can you please summarise what the Trust learnt and what actions have been taken as a result of the aforementioned cases/investigations.

1/2020 (brief summary of learning and actions)

- Raising staff aware of ligature risk
- Environmental risk assessments in collaboration with Estates and Health & Safety Advisor
- Joint policy document between Central North West London and Milton Keynes University Hospital that supports better communication particularly when highlighting concerns around risk of self-harm, absconding or suicide attempts
- Effective use of the eCARE (electronic patient record) mental health management plan

2/2020 (brief summary of learning and actions)

- Human factors training
- Wider shared learning on interpretation of capnography traces
- Availability of cognitive aids in anaesthetic rooms and wider training
- Standardisation of configuration of capnography monitoring
- Position statement anaesthetic practitioner roles and responsibilities

3/2020 (brief summary of learning and actions)

- Use sFIT/PIGF ratio to identify those women at very low or very high risk of imminently developing Pre-eclampsia
- Review of local policies
- Shared learning re escalation

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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

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