Moorfields Eye Hospital NHS
NHS Foundation Trust

AGENDA ITEM 09 – LEARNING FROM DEATHS (Q3 2018/19)
BOARD OF DIRECTORS 7 FEBRUARY 2019

Report title	Learning from deaths – quarterly update (Q3 2018/19
Report from	Nick Strouthidis, Medical Director
Prepared by	Julie Nott, Head of Risk and Safety
Previously discussed at	Ongoing responsibility of Clinical Governance Committee
Link to strategic objectives	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience

Executive summary

This report provides the trust board with a quarterly update regarding how we learn from deaths that occur within Moorfields defined by criteria (see Annex below) as set out in trust policy. It is a requirement for all trusts to have a similar policy.

The trust has identified 1 patient death in Q3 2018/19 that falls within the scope of the learning from deaths policy.

Quality implications

The board needs to be assured that the trust is able to learn lessons from serious incidents in order to prevent repeat mistakes and minimise patient harm.

Financial implications

There are no direct financial implications from this paper.

Risk implications

If the trust fails to learn from deaths there is clinical risk in relation to our ability to provide safe care to patients, reputational risk, financial risk of potential litigation and legal risk to directors.

Action required/recommendation.

The board is asked to receive the quarterly report for assurance.

For assurance	✓	**For decision**		**For discussion**		**To note**	✓

Learning from deaths – Q3 2018/19

This report satisfies the requirement to provide the trust board with an update regarding compliance with, and learning from, the NHS Improvement learning from deaths agenda. The Q3 2018/19 data, as at 28 January 2019, is shown in table 1 below.

Indicator	Q1 2018/19	Q2 2018/19	Q3 2018/19
Summary Hospital Mortality Indicator (as reported in the IPR)	0	0	0
Number of deaths that fall within the scope of the learning from deaths policy (see annex 1)	1	0	1
% of cases reviewed under the structured judgement review (SJR) methodology/reviewed by the Serious Incident panel	100	N/A	100
Deaths considered likely to have been avoidable	0	0	0

Table 1

During Q3 2018/19 the trust became aware of the death of two patients, although only one has been referenced in the table above because one of the deaths, referred to below as patient 2, did not fall within the scope of the learning from deaths policy. Neither of the deaths involved a patient with a learning disability or mental health needs and neither involved a child.

- **Patient 1:** died within 30 days of discharge from an in-patient service. A review of the care received by the patient has been undertaken and no factors that could have contributed to the patient's death have been identified. The trust is aware that HM Coroner has opened an Inquest into the death of this patient and that the Inquest is scheduled to take place in April 2019. To date, no requests for information have been received from HM Coroner. The trust awaits confirmation of the cause of death.

- **Patient 2:** the death of patient 2, who was a private patient from overseas, does not fall within the scope of the learning from deaths policy as the patient died more than two days after surgery. The patient, who died four days after a surgical procedure, did not pass away on trust premises. A post-mortem examination was undertaken and this has confirmed that the death was not associated with the surgical procedure.

Learning and improvement opportunities identified

Some similarities have been identified in relation to the patient who died in Q1 2018/19 and patient 2; both were private patients who had travelled from abroad to undergo surgery and both died in the UK within a few days of an uncomplicated surgical procedure. The anaesthetists, surgeons and operation types were different and the procedures were months apart (one in Q1 and one in Q3). As requested by the medical director, the clinical governance lead for Moorfields Private has commissioned an independent review, by a consultant anaesthetist, of the private and NHS health records for both of these patients. A specific aim of

the review is to consider the pre-operative assessment procedure and to identify if any action is required to further improve it to the consistently high level of NHS practice. The outcome of the review will be summarised in the Q4 2018/19 report.

Annex 1

Included within the scope of this Policy:

- All in-patient deaths;
- Patients who die within 30 days of discharge from inpatient services (where the Trust becomes aware of the death);
- Mandated patient groups identified by the NQB Learning from Deaths guidance including individuals with a learning disability, mental health needs or an infant or child;
- The death of any patient who is transferred from a Moorfields site and who dies following admission to another provider hospital;
- The death of any patient, of which the Trust is made aware, within 48 hours of surgery;
- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision by Moorfields;
- Deaths of which the Trust becomes aware following notification, and a request for information, by HM Coroner;
- Persons who sustain injury as a result of an accident (e.g. a fall down stairs) whilst on Trust premises and who subsequently die;
- Individual deaths identified by the Medical Examiner or through incident reporting or complaints or as a result of the Inquest process;

Excluded from the scope of this Policy:

- People who are not patients who become unwell whilst on Trust premises and subsequently die;