Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 11
Learning from deaths report
Board of directors 21 March 2023

Report title	Learning from deaths
Report from	Louisa Wickham, medical director
Prepared by	Julie Nott, head of risk & safety
Link to strategic objectives	We will consistently provide an excellent, globally recognised service

Executive summary

This report provides an 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 **one** patient death in Q3 2022/23 that fell 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

Provision of the medical examiner role for Moorfields may have small cost implications in the event that costs are required.

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 report for assurance and information.

For Assurance	✓	**For decision**		**For discussion**		**To note**	✓

This report satisfies the requirement to provide the trust board with an update regarding compliance with, and learning from, the NHSE learning from deaths agenda. The Q3 2022/23 data is shown in the table below.

Indicator	Q4 2021/22	Q1 2022/23	Q2 2022/23	Q3 2022/23
Summary Hospital Mortality Indicator (as reported in the IPR)	0	0	0	0
Number of deaths that fall within the scope of the learning from deaths policy (see annex 1)	1	0	0	1
% of cases reviewed under the structured judgement review (SJR) methodology/ reviewed by the Serious Incident (SI) panel	100	N/A	N/A	100
Deaths considered likely to have been avoidable	0	N/A	N/A	Pending

Learning and improvement opportunities identified during Q3

In the Q2 report the following two patient deaths, which occurred in Q3, were referenced. Both are reported in more detail below

1. Death of a patient attending an appointment at the St George's outpatient department

An after action review was undertaken following this death, which is deemed to have been unavoidable and which did not fall within the scope of the learning from deaths policy. A review by SI panel was also undertaken. Positive feedback has been received from the St George's Hospital medical emergency team regarding the immediate interventions and actions that had been undertaken by Moorfields staff. Action was taken to ensure the availability of NEWS2 forms in all cubicles and to improve the audibility of the call bell system, which could not be heard throughout the entirety of the department.

2. Death of a patient following cataract surgery at City Road

A patient attended for cataract surgery, under the glaucoma service. Post-operatively the patient became unwell and, approximately 3 hours after the onset of symptoms, the patient was transferred via emergency ambulance to the Royal London Hospital (RLH). The patient passed away just over 48 hours after admission to RLH.

The death is being investigated as a serious incident (SI) and an inquest date has been set for 10 May 2023. The cause of death has not yet been communicated to the trust. The SI investigation is on-going therefore learning will be shared in the Q4 report.

ME role update

The statutory ME system will commence on 1 April 2023. By 31 March 2023 all NHS organisations should have processes in place to facilitate the work of MEs. The central quality & safety team is in the process of finalising the process by which deaths occurring on trust premises will be referred to the ME service at University College London Hospitals NHS Foundation Trust, who will be providing the ME service for Moorfields.

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;