Moorfields Eye Hospital NHS Foundation Trust

NHS

ITEM 10

Report title	Learning from deaths
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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 **zero** patient deaths in Q1 2023/24 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 (ME) role for Moorfields may have small cost implications if 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 Q1 2023/24 data is shown in the table below.

Indicator	Q2 2022/23	Q3 2022/23	Q4 2022/23	Q1 2023/24
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)	0	1	0	0
% of cases reviewed under the structured judgement review (SJR) methodology/ reviewed by the Serious Incident (SI) panel	N/A	100	N/A	N/A
Deaths considered likely to have been avoidable	N/A	0	N/A	N/A

Learning and improvement opportunities identified during Q1

1. <u>Death of a patient following cataract surgery at City Road</u>

An Inquest date is yet to be confirmed, and we remain in the process of submitting evidence to the coroner. The SI investigation report is complete, has been shared with the patient's family and has been reviewed and closed by the ICB. A LIFEline bulletin, or equivalent, will be drafted to help share the learning throughout the organisation. In addition, targeted messages will be shared with specific staff groups. The learning is as below:

- All clinical staff, when considering whether to operate on a patient, must take account of not only the patient's desire for surgery and the immediate anaesthetic and surgical risks of associated with performing the surgery. The social, physical, and psychological risks to patients associated with not undertaking the surgery should also be considered, and the option of the use of adaptations and aids as an alternative should be made clear. Consideration of the appropriateness of surgery for an individual patient must be promoted for discussion.
- The very nature of cataract surgery means that patients requiring the surgery are more likely to be elderly and will have non-ophthalmic medical histories with varying degrees of complexity. It is important that the pre-assessment process is not only comprehensive enough to highlight any risk factors, but also that patients are aware of risk factors so that they can make an informed decision to proceed.
- When a 'decision to admit' a patient for surgery is made, the need for consultant surgeon cover on a theatre list must be carefully considered. Consultant surgeon cover should not be indicated for surgically complex patients only, but should be provided for patients with significant co-morbidities, even if to provide supervision to an experienced surgical fellow who will be completing the procedure.
- Patients with significant co-morbidities ideally should not be transferred from a consultant team and the site of the pre-assessment and added to a pooled theatre

waiting list, although in this case it was necessary because of the patient's pacemaker. Where there is a clinical need to do so, there must be robust mechanisms in place to ensure that the transfer of pre-assessment information is timely and appropriate, and that patients and family members/carer are reassured that the information has been shared.

- Acetazolamide should not be prescribed or administered without first establishing if there are contraindications, even in a low dose in a sight-threatening emergency.
- Immediate consideration must be made regarding the support needs of medical staff involved in an incident such as a patient death. This responsibility must be allocated to an individual consultant.

2. Death of a child, St George's hospital (SGH)

SI panel has twice reviewed the death of a child who died following discharge from the SGH main A&E department. The child underwent ophthalmic review in the Urgent Care Clinic (UCC) prior to being transferred back to the SGH Accident and Emergency department, but subsequently died at home within 12 hours of discharge. The Moorfields safeguarding children and young people team was not notified of the death, and therefore the trust was not represented at the Statutory Joint Agency meeting. The trust has now proactively engaged with the child death review process and learning, including those elements relating to communication, will be identified and shared. The death has not been listed in the Q1 data because the child death review is being led by SGH.

Medical certificate of cause of death (MCCD) update

The Department of Health and Social Care (DHSC) has commissioned the NHS Business Services Authority to develop a new digitised MCCD. It is expected that the new MCCD will be introduced alongside the full set of death certification reforms planned from April 2024. As part of the process for engaging with the medical examiner, following the death of a patient on site, a trust doctor will be expected to complete the MCCD.

Annex 1

Included within the scope of this policy:

1. All in-patient deaths;
2. Patients who die within 30 days of discharge from inpatient services (where the Trust becomes aware of the death);
3. 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;
4. The death of any patient who is transferred from a Moorfields site and who dies following admission to another provider hospital;
5. The death of any patient, of which the trust is made aware, within 48 hours of surgery;
6. All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision by Moorfields;
7. Deaths of which the trust becomes aware following notification, and a request for information, by HM Coroner;
8. Persons who sustain injury as a result of an accident (e.g. a fall down stairs) whilst on Trust premises and who subsequently die;
9. 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:

1. People who are not patients who become unwell whilst on trust premises and subsequently die;