Moorfields Eye Hospital NHS Foundation Trust

Agenda item 10
Learning from deaths Q4 18/19
Board of directors 2 May 2019

Report title	Learning from deaths – quarterly update (Q4 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 0 patient deaths in Q4 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 arising 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

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 Q1 to Q4 2018/19 data, as at 23 April 2019, is shown in table 1 below.

Indicator	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
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	1	0
% of cases reviewed under the structured judgement review (SJR) methodology/reviewed by the Serious Incident panel	100	0	100	0
Deaths considered likely to have been avoidable	0	0	0	0

Table 1

Learning and improvement opportunities identified

The Q3 2018/19 report recorded that:

- the outcome of a review of the private patient pre-operative assessment procedure, and actions required to improve it to the consistently high level of NHS practice, would be included in the Q4 2018/19 report. The outcome of this review is not yet available therefore an update will be provided in the Q1 2019/20 report;
- an Inquest had been opened into the death of patient who had died within 30 days of discharge from an in-patient service. The head of risk & safety attended the Inquest on 23 April 2019 and is able to confirm that the Inquest did not identify any element of the patient's care from which the trust is able to learn.

Medical examiner role

Acute trusts in England have been asked to begin setting up medical examiner offices to initially focus on the certification of all deaths that occur in their own organisation. The purpose of the medical examiner system is to:

- provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths;
- ensure the appropriate direction of deaths to the coroner;
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased;
- improve the quality of death certification;
- improve the quality of mortality data.

In April 2019 NHS England/NHS Improvement issued an update in relation to the role of medical examiners, specifically following the appointment of a national medical examiner. The points below are of note:

- Medical Examiner systems to review all hospital deaths must be in place by April 2020. There will be funding available, the extent and nature of this will be clarified by the Department of Health and Social Care within the next few weeks;
- The head of risk & safety has initiated a conversation with Islington CCG regarding the approach to be adopted by trusts, such as Moorfields, who will not be in a position to appoint a trust employed medical examiner. It is most likely that there will be a formal agreement, with one or more trusts in the North Central London STP, to host a 24/7 service that can be accessed if required. The medical director is required to initiate discussions with medical directors at other acute trusts.

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;