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| **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 pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience |

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| **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 Q4 2021/22 that falls within the scope of the learning from deaths policy. This death is being investigated as a Serious Incident (SI) and the duty of candour process has been initiated with the next of kin and the patient’s son. | | | | | | | |
| **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 NHS Improvement learning from deaths agenda. The Q4 2021/22 data, on 13 May 2022, is shown in the table below.

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| **Indicator** | **Q1**  **2021/22** | **Q2**  **2021/22** | **Q3**  **2021/22** | **Q4**  **2021/22** |
| 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 | 0 | 0 | 1 |
| % of cases reviewed under the structured judgement review (SJR) methodology/ reviewed by the Serious Incident (SI) panel | N/A | N/A | N/A | 1 |
| Deaths considered likely to have been avoidable | N/A | N/A | N/A | 0 |

**Learning and improvement opportunities identified during Q4**

An SI was declared in February 2022, following the death of a patient who had attended Northwick Park as an outpatient. An after action review (AAR) was undertaken 3 days after the event and the outcome of this informed the SI investigation. The AAR and interviews conducted as part of the SI investigation process were used as an opportunity to confirm with staff the actions that should have been taken on the day. A Section 42 referral was made, and this investigation (led by an external stakeholder) has run in parallel with the SI investigation. The host trust supported the trust investigation through the provision of relevant information (e.g., access to CCTV). The investigation into this incident concluded during Q1 2022/23 and the learning includes:

* A NEWS chart should be completed immediately for all patients who attend in poor health or who are recognised as starting to deteriorate.
* Administrative staff should receive an orientation of the emergency call bells, telephones and cardiac arrest trolley as part of their local induction.
* It should be a mandatory requirement for administrative staff to undertake BLS training and know what to do in the event of an emergency.
* Registered staff, in a standalone ophthalmic facility, should undertake annual ILS training. At the very least there should be one member of the nursing team with ILS training on every shift.
* Clear leadership during a medical emergency is essential to ensure that the necessary equipment is made available promptly and optimum resuscitation conditions are achieved, including positioning of the patient.
* Doctors need to participate in safety huddles.

**ME role update**

Two national medical examiner updates have been published by NHS England and NHS Improvement since the Q3 report:

* February 2022 <https://www.england.nhs.uk/wp-content/uploads/2019/05/National-medical-examiner-bulletin-February-2022.pdf>
* April 2022 <https://www.england.nhs.uk/wp-content/uploads/2019/05/national-medical-examiner-bulletin-april-2022.pdf>

**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;