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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 consistently provide an excellent, globally recognised service |

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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 no patient deaths in Q2 2022/23 that fall 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 NHS Improvement learning from deaths agenda. The Q2 2022/23 data is shown in the table below.

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| **Indicator** | **Q3****2021/22**  | **Q4****2021/22** | **Q1****2022/23** | **Q2****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) | 0 | 1 | 0 | 0 |
| % of cases reviewed under the structured judgement review (SJR) methodology/ reviewed by the Serious Incident (SI) panel | N/A | 1 | N/A | N/A |
| Deaths considered likely to have been avoidable | N/A | 0 | N/A | N/A |

**Learning and improvement opportunities identified during Q2**

During Q2 2022/23 the divisions have continued to implement the actions, and take account of the lessons learned, from the Serious Incident (SI) investigation into the patient death that occurred at Northwick Park in Q4 2021/22. This activity was further enhanced by the information cascaded in five daily scenario-based briefings that were shared during the ‘Safer September deteriorating patients’ week.

Further information will be provided in the Q3 report regarding the learning identified following a patient death that occurred at St George’s, when a patient attended an outpatient appointment, and an SI that has been declared following the death of a patient who had attended for cataract surgery at City Road. As these incidents occurred in Q3, they are not included in the data for this report.

**ME role update**

Two national medical examiner updates have been published by NHS England and NHS Improvement since the Q2 2022/23 report:

* October 2022 [Medical Examiner update - October 2022](https://www.england.nhs.uk/long-read/national-medical-examiner-update/)
* December 2022 [Medical Examiner Update - December 2022](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2019%2F05%2FNational-medical-examiner-bulletin-December-2022.docx&wdOrigin=BROWSELINK)

The statutory medical examiner system will commence on 1 April 2023. The requirement is for medical examiners to provide independent scrutiny of all deaths not taken for investigation by a coroner. To this end, we are in the process of drafting and finalising the policy that will establish University College London Hospitals (UCLH) as the provider of a ME service for City Road services (for any death that occurs on site).

**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;