Great Ormond Street Hospital for Children
NHS Foundation Trust

Date: **17 March 2020**

Our reference: **FOIRQ5717**

Dear Sir/Madam,

Thank you for your request for information processed under the Freedom of Information Act 2000. Please see our response to your following request for information:

Your Request and Our Response (in bold)
Please see our response to your following request for information from Great Ormond Street Hospital for Children NHS Foundation Trust (the 'Trust'):

1. *The figures published quarterly, as required by the The National Health Service (Quality Accounts) (Amendment) Regulations 2017, and directed by the National Quality Board National Guidance on Learning from Deaths, on the number of deaths in the Trust that were subjected to a case record review and were judged more likely than not to have been due to problems in care, for each quarter that they have been published.*

   In March 2017, the National Quality Board (NQB) published national standards for the review of inpatient deaths and learning from the care provided to patients. The guidance requires that Trusts share information on learning from deaths at a public board meeting.
   "From April 2017, Trusts will be required to collect and publish, on a quarterly basis, specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards). This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care." This was published in advance of guidance that was being written for the review of the deaths of children, and has since been published.

The first Great Ormond Street Learning from Deaths report to Trust Board was received September 2017, and covered the period 1st January 2017 to 30th June 2017. Prior to this national guidance the Trust had a process to review learning from death reports at the Trust Patient Safety and Outcomes Committee (PSOC). The Mortality Review Group (MRG) had been established in 2012 to review the deaths of inpatients at Great Ormond Street Hospital (GOSH). The reports from cases record reviews from the MRG were reported to the PSOC, and then following the NQB requirement to Trust Board.

The term "problems in care" is not used for reviewing and reporting on child deaths. Mortality reviews for children may highlight 'modifiable factors' instead of 'problems of care' in accordance with recommendations included in HM Government Child Death Review Statutory Guidance (2019). Modifiable factors are defined as factors, which by means of nationally or locally achievable interventions could be modified to reduce the risk of future child deaths .This is also recognised in the NQB guidance "In child mortality review, professionals have moved away from defining 'avoidability' to instead using the language of 'a preventable death' where the latter is defined as a death in which 'modifiable factors may have contributed to the death and which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Reporting at GOSH using the reporting format aligned to the NQB requirements, noting "modifiable factors" instead of "problems in care" commenced for deaths from Q3 2017/2018. The figures are included in the GOSH Learning from Deaths Reports. These reports are included in the public Trust board meeting papers and can be found via the following link: https://www.gosh.nhs.uk/about-us/who-we-are/our-organisational-structure/trust-board/trust-board-meetings

Report	Trust Board meeting discussed at
Report of deaths in Q2 2019/20	On the agenda for 11th April 2020
Report of deaths in Q1 2019/20	Wednesday 27 November 2019
Report of deaths in Q4 2018/2019	Thursday 18th July 2019
Report of deaths in Q3 2018/19	Wednesday 22nd May 2019
Report of deaths in Q2 2018/19	Thursday 7 February 2019
Report of deaths in Q1 2018/19	Wednesday 5 December 2018
Report of deaths in Q4 2017/2018	Wednesday 25 July 2018

These are as reported at the time they were written and reported (as in some cases reviews may not have been concluded at the time the

reports were written). All deaths in the periods covered in the reports have now been reviewed.

2. *If no figures have been published please provide an explanation regarding why the Trust believes it has complied with The National Health Service (Quality Accounts) (Amendment) Regulations 2017.* **This is not relevant as the figures have been provided.**

3. *Whether the Trust uses the Learning from Deaths Dashboard issued with the National Guidance.*

   We do not use the suggested dashboard, as it is not relevant for reporting on child deaths. This is because the measures relate to "adult inpatient deaths" and also refer to "problems of care" which is not aligned to the Child Death Review Guidance on reporting modifiable factors. The Learning from Deaths dashboard is to report "The Structured Judgement Review methodology, for use in relation to adult acute inpatient deaths" At GOSH the proportion of cases with modifiable factors are reported on and monitored over time in the Learning from Deaths reports, this is in order to detect any clear trends or patterns.

Please note:
The information we have provided under the Freedom of Information Act 2000 is the information held on the date your request was received by the Trust.

We hope the information provided is sufficient and helpful in answering your questions, issues or concerns. Should you have any further queries in relation to this request, please do not hesitate to contact the FOI Team and quote the above reference number on any related correspondence.

Re-use of information

Great Ormond Street Hospital for Children
NHS Foundation Trust

Yours sincerely

Freedom of Information team
Great Ormond Street Hospital for Children NHS Foundation Trust
Email: foiteam@gosh.nhs.uk

[Enclosed – Your rights – see next page]

Your Rights

Should you have any questions relating to the response you have received to your request for information, please do not hesitate to contact the FOI Team. Alternatively, you are entitled to make a request for an internal review within two months from the date of receiving our final response to your original request. You can also write to the Head of Quality & Safety at the following address:

Quality & Safety team
Great Ormond Street Hospital
LONDON
WC1N 3JH

If, however, you remain dissatisfied with the outcome of the internal review then you have the right to appeal to the Information Commissioner as the final stage of the FOI process. You can contact the Information Commissioner's Office at the following address:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

Telephone: 0303 123 1113
Fax: 01625 524510