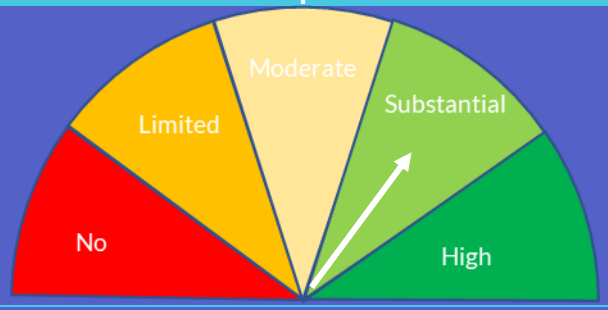
# Mortality Governance Assignment Report 2023/24 (Final)

## The Shrewsbury and Telford Hospital NHS Trust

## 134SATH_2324_803CFWD

**Overall Assurance Opinion**




There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.

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MIAA would like to thank all staff for their co-operation and assistance in completing this review.

This report has been prepared as commissioned by the organisation, and is for your sole use. If you have any queries regarding this review please contact the Engagement Manager. To discuss any other issues then please contact the Director.

# 1 Executive Summary

Overall Audit Objective: To review and assess the robustness of the mortality framework and the Trust's commitment to learning from deaths.

Scope Limitation: This review focuses on the structure and effectiveness of the governance arrangements in place for learning from deaths but does not include testing of clinical reviews.

## Key Findings/Conclusion

Overall our review found that there is a robust system of internal control and governance in place at the Trust in relation to learning from deaths.

The learning from deaths function within the Trust has been subject to significant change and development in recent years, including support from NHS Improvement, and the development of the governance arrangements and review processes. This review found that the governance and control arrangements in place are comprehensive, robust and operating effectively, and that there is a clear organisational commitment to reviewing and learning from deaths within the Trust.

The main areas of particularly good practice related to the development of the role of the Mortality Triangulation Group (MTG), the use of a central pool of reviewers to undertake Structured Judgement Reviews (SJRs), the timeliness of reporting points for learning, the development of the Learning from Deaths Dashboard and the overarching reporting and assurance arrangements in place from the Learning from Deaths Group reporting up to the Board.

One medium level risk recommendation has been raised in respect of the resource required to maintain the high standards achieved and the difficulty in respect of recruitment.

| Objectives Reviewed | RAG Rating |
|---|---|
| Scrutiny and oversight | Green |
| Policies and procedures | Green |
| Governance Arrangements | Green |
| Outcome Reporting | Green |
| Learning Lessons | Green |
| Peer Review | Green |
| **Overall Assurance Rating** | **Substantial** |

| Recommendations | | |
|---|---|---|
| Risk Rating | Control Design | Operating Effectiveness |
| Critical | 0 | 0 |
| High | 0 | 0 |
| Medium | 0 | 1 |
| Low | 0 | 0 |
| **Total** | **0** | **1** |

## Areas of Good Practice

Scrutiny and Oversight

- The governance arrangements at the Trust are compliant with the requirements of the *National Guidance on Learning from Deaths, National Quality Board (March 2017)* and *Implementing the Learning from Deaths Framework: Key Requirements for Trust Boards (July 2017)*.
- Roles and responsibilities are clearly documented and understood, including at an executive and non-executive Board level.
- The Board is provided with quarterly and annual Learning from Death (LfD) update reports that are clear and comprehensive. These report and comment on the SHMI (Summary Hospital-level Mortality Indicator) data, SJR (Structured Judgement Review) data, and any themes, trends or learning identified.
- There are clear governance arrangements in place to assure the quality of case reviews undertaken, and to cascade learning and outcomes internally and externally in a timely manner.

Policies and Procedures

- The Trust has a current, approved LfD Policy in place that is available to staff and the public.
- The policy is clear and comprehensive. Roles and responsibilities are clearly documented, as is the process for reviewing in-patient deaths.
- The policy clearly describes the process for patients who are in scope for SJR, as well as those who are not, and there are clear links to associated policies.
- It was clear that staff have a detailed knowledge and understanding of the policy and processes in place, and there is a clear understanding of the value and importance of the work undertaken.

Governance Arrangements

- The governance structure is clearly outlined in the policy including the roles of the Mortality Triangulation Group (MTG), the LfD Group, the Quality Operational Committee (QOC), the Quality, Safety and Assurance Committee (QSAC) and the Trust Board.
- Key information is provided at each level including SHMI data and analysis, SJR data, and learning identified.
- Testing of the associated minutes and papers show the current governance reporting arrangements to be operating well.
- The governance support provided by the LfD team ensures concise and consistent presentation of information, especially to MTG, to allow the meetings to run efficiently.
- A pool of corporate reviewers undertake SJRs. This has increased the percentage of SJRs completed overall and has facilitated completion within the 8-week time frame identified within the LfD Policy.
- The role of MTG is to provide oversight of deaths across the Trust. As per the policy, MTG ensures the triangulation of the cases discussed, avoids duplication of reviews, and identifies learning to share internally and externally.

Outcome Reporting

- All in-patient deaths are initially reviewed by the Medical Examiner, and then by MTG where further review action is determined.

- The LfD team has robust arrangements in place to monitor the outcomes from MTG, and any further review actions (e.g. SJR, Datix, potential learning, etc).
- Testing was carried out on a sample of six deaths that were subject to review. In all instances the deaths had been subject to appropriate independent review in accordance with the LfD Policy.
- There are robust governance procedures in place to ensure that case reviews are undertaken in line with the Trust's policy.
- The case review and investigation procedures ensure that the review of cases is independent and undertaken by clinicians not directly involved in the care of the deceased.

Learning Lessons

- There are processes in place at each level of the governance structure to allow for feedback, outcomes and learning to be shared. Learning is shared at the earliest opportunity to allow for timely intervention.

Peer Review

- Testing against the improvement areas highlighted in the peer review confirmed that the majority of areas for improvement were already being addressed at the time of the peer review reporting. Evidence supported that all actions were either completed or are in progress.

## 2 Findings and Management Action

| 1. Resource and recruitment | | Risk Rating: Medium |
|---|---|---|
| Operating Effectiveness | | |
| **Key Finding** – The current team structure was established following a business case in May 2022. This was made in the context of the Getting to Good improvement program and in response to the NHSE/I target for 15% of all deaths to undergo an SJR within eight weeks of the date of death. The proposed resources were benchmarked against two comparable Trusts.<br><br>The investment in the team resource has allowed the development of the current governance arrangements. It is acknowledged that managing the LfD process is quite resource-heavy to maintain the current level of review and scrutiny. Discussions with staff highlighted recent difficulties in recruiting to the team, and sufficient resourcing of the team remains a high-risk area. | **Specific Risk** – Lack of sustained investment and inability to recruit may lead to deterioration in arrangements. | **Recommendation** – Risks in relation to recruitment and resourcing should be monitored and escalated where necessary. |
| **Management Response** – The investment to expand the Learning from Deaths team, facilitated by the approval of the Business Case in May 2022 has enabled the development and maintenance of systems and processes to support the learning from deaths agenda and achieve the robust governance assurance evidenced within this audit report. This is an ongoing programme of improvement which will continue to evolve alongside the requirements of PSIRF and the wider service development, in line with the national and local picture. | | Evidence to confirm implementation – Full complement of staff to meet the service need. |

| | |
|---|---|
| To sustain this specialist work even at the current level and ensure the Trust continues to achieve robust governance around mortality it is imperative that recruitment to full establishment is achieved. Even within the existing template of staff following the expansion of the team, any interruption to availability of team members for example during periods of annual leave or sickness, exposes a fragility which risks compromising assurance around the operational and strategic focus of work. This is no 'flex' within the system.<br><br>Recruitment to the current vacancies and attracting applicants with the specialist skillset required and who are comfortable to deal with this sensitive agenda, is proving to be a significant challenge. This further increases the risk within the service. Staff recruited to these specialist roles require a detailed orientation and support period to fully appreciate the complexities of the learning from deaths agenda and be able to fully contribute and respond to the demands of the role.<br><br>In summary, the management response to the specific risk identified with this audit recommends:<br><br>1. A review of the current staff template to provide an appropriate level of cover especially administrative support to maintain and develop the service irrespective of staff absence including annual leave, sickness, staff development and mandatory training. The review of the staff template needs to accommodate appropriate succession planning within the team.<br>2. Vacancies within the team are ring-fenced to prevent delays within the recruitment process.<br>3. Explore alternative ways to attract appropriate candidates with the right skillset to the team.<br><br>Responsible Officer – Head of Learning from Deaths and Clinical Standards, and Senior Clinical Lead, Learning from Deaths<br><br>Implementation Date – June 2024 | |

## Appendix A: Detailed Findings

### Objective One: There is Board leadership in respect of scrutiny and oversight of mortality.

The role of the Trust Board with regards to LfD is set out in the *National Guidance on Learning from Deaths, National Quality Board (March 2017)* and *Implementing the Learning from Deaths Framework: Key Requirements for Trust Boards (July 2017)*. The governance arrangements at the Trust were compared with the specific leadership requirements outlined in the national guidance and were found to be fully compliant.

The Trust has a LfD Policy in place (April 2022) which outlines the key roles and responsibilities throughout the Trust in relation to LfD. The current Medical Director has overall responsibility for the LfD agenda, and there is a nominated Non-Executive Director with the responsibility for oversight of implementation of the LfD process. To deliver the LfD service, there is a Head of Learning from Deaths and Clinical Standards and a supporting team in place, along with Senior Clinical Lead, Clinical Lead and a pool of central SJR reviewers. Detailed job descriptions are in place for each of these roles.

The Board is provided with quarterly and annual reports covering LfD and the Medical Examiner/Bereavement Service. These reports summarise the in-patient deaths that have occurred at the hospital, any themes and trends identified, and breakdown and analysis of the Trust's SHMI (Summary Hospital-level Mortality Indicator). It also reports on the SJRs completed compared to the NHSE recommended target of 15%.

Quality governance arrangements are outlined in the LfD policy providing assurance to the Board that case reviews and investigations are carried out to a high quality standard. Arrangements to ensure quality include:

- The LfD policy is clear and comprehensive regarding the roles and responsibilities of individuals, and the organisational arrangements for reviewing care.
- The governance reporting framework outlined in the policy.
- The use of corporate reviewers to undertake SJRs.
- The case management undertaken by the LfD team to track the completion of SJRs and record and track learnings and outcomes.
- The use of the standardised SJR*Plus* online tool for all SJRs.
- The mandatory initial training program in place for SJR reviewers, and the establishment of the SJR forum.
- The LfD assurance statement included in the Trust's annual Quality Account.

Monthly MTG Themes and Trends reports are reported through the governance route, including to QSAC, Serious Incident update reports are also reported through the governance route, with a monthly report taken to QSAC.

The arrangements for internal and external reporting and dissemination of learning are outlined in the LfD policy. All learning is shared at the earliest opportunity with the relevant division/officer and through divisional governance teams. Learning for external partners is shared with the relevant organisation and copied into the ICS. All learning is recorded and tracked by the LfD team on their case tracker spreadsheet, and themes database. A summary of the learning shared is included in the monthly MTG report which filters up through the quarterly LfD reports taken to QOC, QSAC and the Board.

The LfD team have worked closely with the Commissioners and received intensive support from NHSE to develop the team and governance arrangements. LfD was included in the Trust's improvement plan and updates are included in the Getting to Good regular update reports to the Board.

### Objective Two: Policies and procedures relating to mortality are comprehensive, up to date and clear regarding roles, responsibilities, and accountability at all levels.

The Trust has an approved LfD policy in place that was issued in May 2022. The Policy has a review date of May 2027, and is made available to staff on the Trust's document library, and the public on the Trust's website.

The Policy clearly describes key roles and responsibilities at Board, executive level, and throughout the organisation and these descriptions are detailed and comprehensive. The Policy also clearly describes which patients are in and out of scope for an SJR, including those who qualify for a LeDeR review, and those diagnosed with an SMI. Children and young people, including infant and child deaths, are out of scope for SJR. Perinatal and maternal deaths are also out of scope and are reported to MBRRACE-UK.

The Policy also outlines the internal and external reporting and dissemination of learning by category, outlining the different arrangements for different categories of patient.

The Policy and the Trust's approach to LfD was discussed at length with staff. This included the Head of Learning from Deaths and her team, the Senior Clinical Leads, SJR reviewers, the Assistant Director of Nursing and the nominated Non-Executive Director. It was clear from discussions that staff have a detailed knowledge and understanding of the policy and processes in place, and there was a clear understanding of the value and importance of the work undertaken.

In addition to this, one of the weekly MTG meetings was observed. The meeting was efficient and concise, covering a large number of reviews. All included in the meeting were clear of their role, and of the processes in place. Meeting attendees were engaged, and there was room for professional debate and discussion regarding cases.

The LfD process is outlined in the policy and details the three stages of review as:

- ME scrutiny – The ME completes initial independent scrutiny of all inpatient and ED (Emergency Department) adult deaths within seven days of the date of death and may flag the need for potential learning or an SJR. If an incident is identified that requires reporting, this will be done through the Trust's Datix system.
- Mortality Screening – This is an online tool developed by SATH to determine whether there were any issues in the care provided. These may also result in the recommendation for an SJR or identify positive examples of care.
- SJR - This is to identify positive or negative learning and is to be completed within eight weeks of the date of death.

The policy lists all associated policies, guidelines and SOPs, and this includes the Duty of Candour Policy, the Clinical Incident Management Policy, the Policy on the Management of External Reviews and Assurances, and polices relating to the deaths of specific categories of patients.

Within the policy it outlines the different ways care provided to patients is to be graded, and the specific criteria where it would be deemed a significant incident to be reported through the Trust's Datix system.

The methodology for case reviews, specifically SJRs follows the national methodology set out by the Royal College of Physicians. All SJRs are completed through the online SJR*Plus* system which ensures a comprehensive and consistent approach to reviews.

### Objective Three: Governance arrangements and processes are embedded and consistent within the Trust to give due focus to the review and reporting of deaths.

The governance structure for reporting on LfD into the Trust Board is clearly detailed in the policy and is as follows:

Mortality Triangulation Group (MTG)

- MTG meet weekly to discuss and review all deaths, including those cases identified for SJR. The group is accountable to, and reports to, the LfD Group, and is co-chaired by the Senior Clinical Lead and the Clinical Lead for LfD.
- There are detailed and comprehensive terms of reference in place which are subject to annual review and were last updated in May 2023.
- The LfD team prepare for the meeting using the MTG meeting workbook in accordance with the terms of reference. This categorises deaths, and ensures all deaths are subject to review and consideration. There is also a checklist in place to ensure all pre- and post-meeting actions are carried out. "Patient on a page" summaries are produced for those deaths flagged for potential learning, SJR and those who have been referred to the Coroner.
- There are robust records in place to record and monitor the cases discussed and actions agreed upon. Those selected for review are monitored by the LfD team.
- The meeting of the 10th January 2024 was observed. The meeting was well attended, efficiently run and seemed well established. Due to the preparation, organisation and structure of the meeting, a significant number of cases were covered. The meeting is held over teams to facilitate screen sharing when reviewing documentation.
- The meeting workbooks and supporting documents were observed during and after the meeting and were found to be robust and comprehensive.

Learning from Deaths Group

- The LfD Group meet monthly and are accountable to, and report to, QOC and the Trust Board. The purpose of the group is to provide assurance that good practice is being established, and to ensure there is a coordinated and effective approach in place to understand and learn from deaths.
- There are detailed terms of reference in place dated October 2022. Draft updated terms of reference were presented to the February 2024 meeting and will be presented to the March meeting for approval following further feedback.
- Meetings follow a detailed, standing agenda with additional items added where applicable. The minutes for the previous three meetings (October, November and December) were reviewed. This showed a good level of attendance where quorate was confirmed.

The minutes for each meeting evidenced detailed discussion and scrutiny for each item presented.

- Standard items that are covered include a detailed action log, the LfD Dashboard and the monthly MTG Themes and Trends reports.
- Different specialist case reviews are selected for additional focus for each meeting, and any specific learning actions requiring additional focus are reviewed.

Quality Operational Committee (QOC), Quality and Safety Assurance Committee (QSAC) and Trust Board

- QOC reports into QSAC and both of these meetings are held monthly. QSAC reports in turn to the Board, who meet bi-monthly. The papers and minutes for each of these for the year to date (April to November) were reviewed. This evidenced detailed consideration and discussion of the reports presented.
- The review confirmed that there is clear evidence that the LfD reporting route is working in operation.
- LfD cuts across a number of other items reported and discussed, and is specifically mentioned in the QSAC dashboard, Perinatal Mortality Review Tool (PMRT), MBRRACE updates, the risk register, Getting to Good action plan update, and LeDeR reports.
- SHMI data with breakdown and commentary is included in both the LfD update reports, and in the QSAC dashboard. Serious Incident Overview reports are reviewed and include LfD on a case-by-case basis where applicable. Examples were seen where particular specific issues relating to LfD were separately reported on, for example the review of excess deaths in ED.

In terms of the capacity and capability of the Trust in relation to LfD, there are two main roles to consider, that of the LfD team who manage and facilitate the Trust's overall arrangements for LfD, and that of the clinical leads and SJR reviewers.

The current team structure was established following a business case in May 2022. This was made in the context of the Getting to Good improvement program and in response to the NHSE/I target for 15% of all deaths to undergo an SJR within eight weeks of the data of death. The proposed resources were benchmarked against two comparable Trusts.

The investment in the team resource has allowed the development of the current governance arrangements. It is acknowledged that managing the LfD process is quite resource-heavy to maintain the current level of review and scrutiny. Discussions with staff highlighted recent difficulties in recruiting to the team, and sufficient resourcing of the team remains a high-risk area.

A change was made during 2023 to use a corporate pool of reviewers to undertake the SJR reviews with the objective of increasing the number completed. There is now a pool of three corporate reviewers, supported by the clinical lead who also undertakes SJRs, who have specific job descriptions and dedicated PA time to complete the reviews, and their caseload is tracked and monitored by the LfD team. Where second reviewers are needed these are sought from the applicable specialty.

The LfD Policy is clear on the range of independent investigation routes for reviewing deaths at the Trust. The role of MTG is to provide oversight of all deaths across the Trust. As per the policy, MTG ensures the triangulation of cases discussed, avoids duplication of reviews, and identifies learning to share internally and externally. Where such reviews are taking place, these are recorded and tracked by the LfD team.

The commissioners played an active role in the initial development of the Trust's approach to LfD through intensive support as part of the Getting to Good program. Bi-monthly Getting to Good action plan updates are taken to QSAC, and the most recent update reviewed (November 2023), showed progress to be "on-track", and within the program highlights section it reports that SJRs continue to exceed the NHSE recommended target of 15%.

**Objective Four: Outcomes from case records, mortality reviews and investigations are formally reported internally through the Trust.**

All in-patient deaths at the Trust are scrutinised by the Medical Examiner (ME), which incorporates discussion with the clinical team and the bereaved and may on occasion require the death to be referred to the Coroner. The ME Service produce a summary document of this scrutiny. This will identify patients where concerns in care are noted.

All in-patient deaths are then reviewed by MTG, and these are grouped into cases highlighted for potential learning or SJR, Coroner referrals, any mortality screenings, including those which have triggered an SJR, and all other deaths. The LfD team produce a summarised "patient on a page" document for those flagged for review.

MTG will review the ME scrutiny. In specific instances the recommendations may be amended due to alternative reviews or investigations that may already be in progress, for example a case already being managed through the patient safety process. They will also review all other deaths to identify any other cases of concern and select random cases for review.

The outcomes from MTG are recorded and processed by the LfD team. Where potential learning is identified this is cascaded to the relevant area, including the relevant divisional governance team for action. SJRs are allocated to a reviewer, either from the corporate pool or to be undertaken by a divisional reviewer. The LfD team track and monitor all SJRs undertaken corporately and maintain oversight of those allocated to the divisions through the divisional governance teams.

The outcomes are added to the MTG triage database that records all deaths and is updated as the notes for each case are triaged as to where they need to be sent. This process is managed by a member of the LfD team who retrieve the notes from Clinical Coding after each MTG to ensure they are sent to the appropriate place to facilitate any next stage reviews. The LfD team use a series of standardised front sheets that direct where the notes are to go, instruct the recipient on the actions required, and where to then return the notes.

Testing was carried out on a sample of six deaths that were subject to review, and each case was tracked through from initially being recorded on the bereavement spreadsheet, through review and proposed action at MTG, recording on the LfD databases, the case review undertaken (e.g. SJR, Datix, Serious Incident), to recording and disseminating learning.

In all cases it was evidenced that the death had been subject to appropriate independent case review in line with the LfD Policy, and that any outcomes/learning were disseminated at the earliest opportunity.

The governance procedures in place ensure that case reviews and investigations are undertaken in line with the Trust's policy. This includes standardised ME reports, standardised Patient on a Page reports, use of the standardised mortality screening tool, use of the online SJR*Plus* system (using the RCP methodology), and management of the process using the LfD team databases.

The case review and investigation procedures in place ensure that the review of care is independent and undertaken by clinicians not directly involved in the care of the deceased. This includes:

- Independent ME scrutiny
- Independent case review at MTG
- SJRs completed by corporate and divisional reviewers

For the sample of cases reviewed, there was evidence of different stages of independent review in all cases.

There are also wider Trust arrangements for independent review, including the arrangements for incident management and patient safety review.

**Objective Five: Any actions from mortality reviews are communicated and implemented to support shared learning.**

There are processes in place at each level of the governance structure to allow for feedback, outcomes and learning to be shared and reported. The objective is to share any learning at the earliest opportunity to allow for timely intervention. In practice this works as follows:

- MTG – This is the forum where all deaths are reviewed. Where learning is immediately identified this is recorded and disseminated by the LfD team following the meeting to either the relevant team within the Trust, or the external partner. This is also copied to the relevant divisional governance team.
- LfD Team – Where SJRs are identified, these are recorded and tracked by the LFD team. Outcomes are recorded by the team and reported to the appropriate forum.
- Themes – MTG and the LfD team are also aware of any themes under review at the Trust, and any cases identified that fit these themes are recorded and reported to the relevant area.
- MTG reports to LfD Group – A review of the monthly reports prepared for the LfD Group was carried out. These reports follow a standard format each month and are clear, concise and easy to understand. Anonymised case level detail is given for each point detailing the issues identified and the outcomes. This includes key themes, Datix reviews, referrals to specialist teams within SATH, referrals to other agencies, etc. It also details positive learning identified. These reports are timely and typically the period reported on is six weeks prior to the meeting date.
- QOC/QSAC/Trust Board – The quarterly reports summarise any key themes, outcomes and learning identified for the quarter. Specific high-risk areas, or key themes are covered in specific detailed reports. For the period reviewed this included an urgent review of neonatal deaths, review of child deaths and a review of excess deaths in ED.

**Objective Six: Learning from the external peer review has been taken forward and embedded into practice.**

A peer review of the Trust's LfD arrangements was carried out by NHS England and NHS Improvement. The review was completed in two parts with an off-site review of the SJR process in October 2022, followed by an on-site desktop review of SJRs and hospital records in December 2022. When the review was undertaken, the Trust had recently moved to the online SJR*Plus* system, therefore the sample of SJRs reviewed were a mix of the new approach and previous paper-based SJRs.

The review found the Trust had made significant improvements in the way it learns from deaths. It didn't make explicit recommendations but highlighted potential areas for improvement. The peer review was presented to the Trust Board on 13th April 2023 as part of the LfD Q3 report. Prior to this the report had followed the normal governance route through the LfD group, QOC and QSAC. This reported that the peer review did not highlight any concerns or potential areas for improvement that the LfD team had not already identified and started to address.

Testing was undertaken to review progress and supporting evidence against the improvement areas highlighted in the peer review. It was evident that the majority of the areas for improvement were already being addressed at the time of the peer review report, and were addressed by the move to *SJRPlus,* and through the role of MTG.

## Appendix B: Engagement Scope

### Scope

The purpose of this audit was to undertake a review of the effectiveness of frontline to Board governance arrangements for identifying, investigating, and reporting on mortality,

The scope of this review focussed on the following control objectives:

- There is Board leadership in respect of scrutiny and oversight of mortality,
- Policies and procedures relating to mortality are comprehensive, up to date and clear regarding roles, responsibilities, and accountability at all levels.
- Governance arrangements and processes are embedded and consistent within the Trust to give due focus to the review and reporting of deaths,
- Outcomes from case records, mortality reviews and investigations are formally reported internally through the Trust.
- Any actions from mortality reviews are communicated and implemented to support shared learning.
- Learning from the external peer review has been taken forward and embedded into practice.

### Scope Limitations

The review is limited to the controls detailed above.

### Limitations

The matters raised in this report are only those which came to our attention during our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required. Whilst every care has been taken to ensure that the information in this report is as accurate as possible, based on the information provided and documentation reviewed, no complete guarantee or warranty can be given with regards to the advice and information contained herein. Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system

## Appendix C: Assurance Definitions and Risk Classifications

| Level of Assurance | Description |
|---|---|
| High | There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed. |
| Substantial | There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently. |
| Moderate | There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk. |
| Limited | There is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls puts the achievement of the system objectives at risk. |
| No | There is an inadequate system of internal control as weaknesses in control, and/or consistent non- compliance with controls could/has resulted in failure to achieve the system objectives. |

| Risk Rating | Assessment Rationale |
|---|---|
| Critical | Control weakness that could have a significant impact upon, not only the system, function or process objectives but also the achievement of the organisation's objectives in relation to:<br>• the efficient and effective use of resources<br>• the safeguarding of assets<br>• the preparation of reliable financial and operational information<br>• compliance with laws and regulations. |
| High | Control weakness that has or is likely to have a significant impact upon the achievement of key system, function or process objectives. This weakness, whilst high impact for the system, function or process does not have a significantimpact on the achievement of the overall organisation objectives. |
| Medium | Control weakness that:<br>• has a low impact on the achievement of the key system, function or process objectives;<br>• has exposed the system, function or process to a key risk, however the likelihood of this risk occurring is low. |
| Low | Control weakness that does not impact upon the achievement of key system, function or process objectives; however implementation of the recommendation would improve overall control. |

## Appendix D: Report Distribution

| Name | Title |
|---|---|
| John Jones | Executive Medical Director |
| Roger Slater | Senior Clinical Lead, Learning from Deaths |
| Mary Aubrey | Programme Director, Getting to Good |
| Fiona Richards | Head of Learning from Deaths and Clinical Standards |
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## Public Sector Internal Audit Standards

Our work was completed in accordance with Public Sector Internal Audit Standards and conforms with the International Standards for the Professional Practice of Internal Auditing.