The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
13 April 2023

Agenda item	042/23a **APPENDIX A**			
Report Title	How We Learn from Deaths Quarter 3 2022/2023 Full Report			
Executive Lead	Executive Medical Director			
Report Authors	Dr Roger Slater, Fiona McAree, Samantha Carling (Covid update)			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	√
	Our service delivery		Caring	√
	Our partners		Responsive	√
	Our governance	√	Well Led	√
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√		
	For approval	√	Link to risk register: ID435	
Presented to:	Trust Learning from Deaths Group 02 February 2023 Quality Operational Committee 21 February 2023 Quality and Safety Assurance Committee 22 February 2023			
Executive summary:	• There were 629 inpatient and emergency department (ED) deaths in the Trust within Q3 2022/2023, an increase of 126 deaths from Q2 and an increase of 72 from the same quarter 2021/2022. • SJR completion in the Trust remains challenging and significantly below the NHSE recommendation of 15% of all deaths. With only 5 SJRs completed for Q3 2022/2023 to date, it is not possible to share any identified learning specifically from SJRs in this report. • Two serious incident investigations presented to the Trust Review Actions and Learning from Incidents Group (RALIG) in Q3 2022/2023 determined that the death was more likely than due to problems in healthcare and therefore potentially avoidable. • There has been successful recruitment to the Learning from Deaths Clinical Lead post with the appointment commencing 01 Feb 2023. • No Dr Foster Imperial alerts have been received during Q3 2022/2023.			
Appendix	Supporting The Shrewsbury and Telford Hospital NHS Trust (SaTH) to assure their mortality review processes and evidence their learning from deaths. NHSE and NHS Improvement (2023).			
Executive Lead	John Jones			

1.0 Summary of Hospital deaths

1.1 There were 629 inpatient and ED deaths managed by the Medical Examiner Service in the Trust within Q3 2022/2023, an increase of 126 deaths from Q2 and an increase of 72 from the same quarter 2021/2022.

1.2 Fig.1 provides an overview of total deaths across the Trust over the last 12-months. Whilst the figures for inpatient deaths remain stable, a sharp increase of deaths within the Emergency Department (ED) can be noted, from 73 deaths in Q3 2021/2022 to 139 deaths across both sites for the same quarter 2022/2023. Fig.2 compares inpatient and ED deaths for each site. ED deaths at RSH in Q3 2022/2023 have more than doubled for the same quarter 2021/2022.

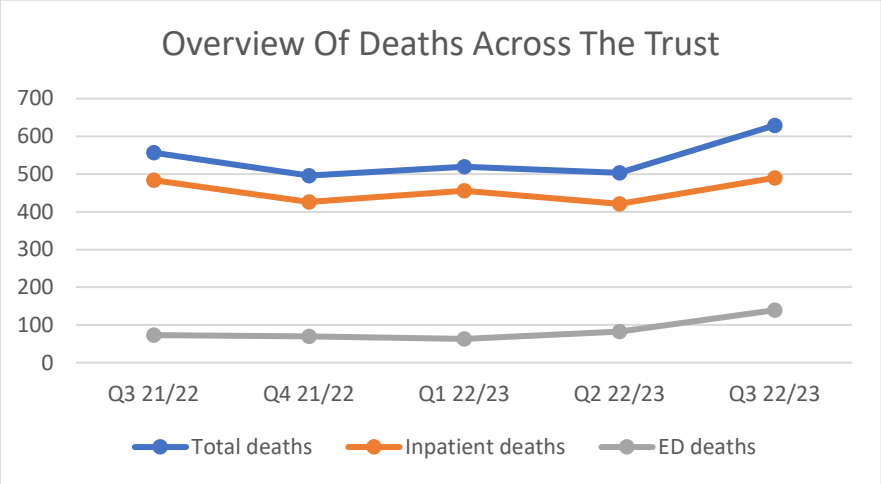

Fig.1

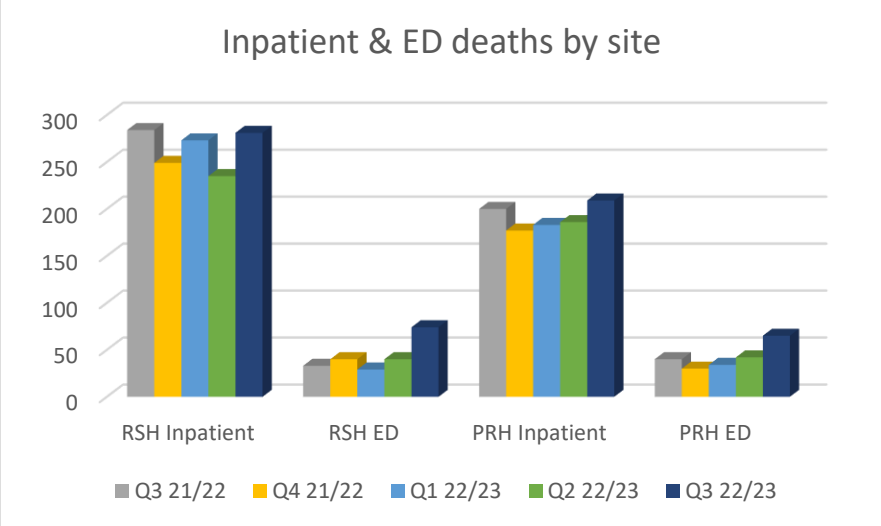

Fig.2

2.0 Learning from Deaths Dashboard

2.1 An overview of the dashboard is provided at Fig.3 highlighting key metrics relating to:

- Context around learning from deaths including SHMI
- Medical Examiner Scrutiny to SJR
- High level details relating to care.

Fig.3

2.2 Context: SHMI – Summary Hospital-level Mortality Indicator

SHMI data includes deaths in hospital and those which occur within 30 days of discharge. The Trust's rolling 12-month SHMI for July 2022 is 1.03 which is within expected range and is favourable to the peer group as seen at Fig. 4 below.

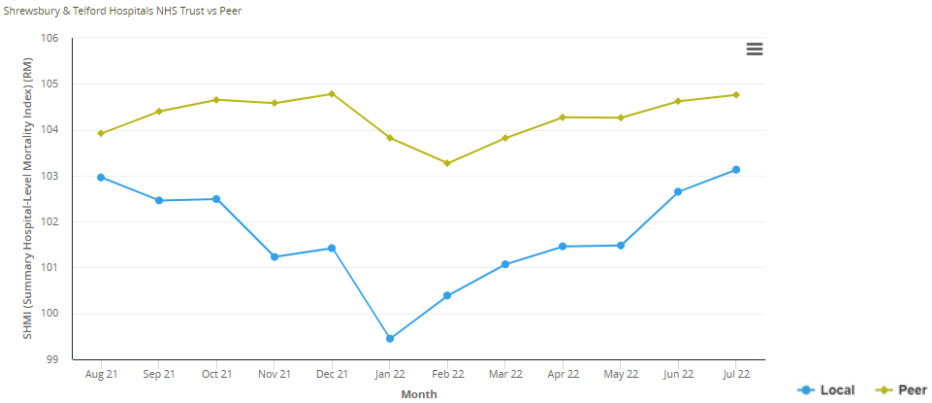

Fig.4 (Source CHKS)

2.3 SHMI Observed versus expected deaths

Comparing observed and expected deaths gives a greater understanding of any changes in the SHMI because it breaks down the two elements of the SHMI calculation – the numerator (observed deaths) and the denominator (expected deaths). A high SHMI value can be caused by a higher number of observed deaths, or a lower number of expected deaths. Expected deaths will be impacted by clinical coding and observed deaths may be impacted by quality of care provided.

The rolling trend for observed versus expected deaths is shown at Fig.5 and is monitored through the Learning from Deaths Dashboard.

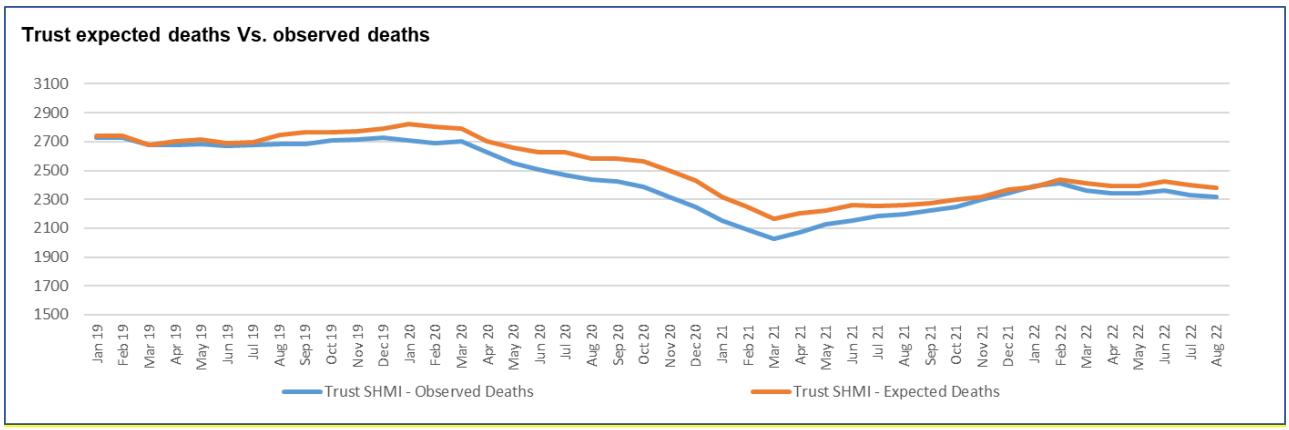

Fig.5

2.4 Mortality by site

SHMI and HSMR indicators have been consistently higher at PRH than RSH. An assurance review has been undertaken to explore this further, the findings of which were presented at the Trust Learning from Deaths Group in January 2023:

- There is a difference in service provision between the two hospitals i.e. higher elective activity with lower associated mortality rates at RSH means that both hospitals are not directly comparable. Further analysis between both sites was made at division and admission types, and at this level, crude mortality was more similar.
- Most deaths at PRH were for non-elective patients in the Medicine and Emergency care Division - SHMI and HSMR was higher at PRH for this cohort of patients. It was identified that for the period of the review, a lower level of clinical coding and palliative care coding is likely to have affected this. Work has been undertaken within Clinical Coding and the End-of-Life and Palliative Care Lead and no concerns were identified.
- Although SHMI and HSMR are higher at PRH during the period under review, both hospitals are comparable or favourable to similar peer trusts, which should provide the Trust with further assurance.
- RAMI was more comparable between both sites than HSMR or SHMI, with non-elective medicine and emergency patients having a lower RAMI at PRH to RSH, in contrast to the other indicators. RAMI make an risk adjustment for the longer lengths of stay recorded at PRH, which helps to mitigate some of the differences on case-mix between both hospitals.
- Crude mortality by bed day rather than by spell shows a similar position at both hospitals.
- Using the RAMI and crude mortality indicators to compare mortality between both sites is suggested as potentially more appropriate for future comparison between both hospitals.
- The review highlights the need to factor in local knowledge of differences in patient case-mix and services provided at each hospital and suggests further comparative analysis on more specific cohorts of patients. Discussion within the Trust Learning from Deaths Group identified that a review of comparison of mortality associated with acute respiratory conditions may be helpful.

2.5 SHMI Details by Condition (Source CHKS)

The conditions with the highest number of 'excess' deaths are:

- Anaemia
- Leukaemia
- Acute and unspecified renal failure

SHMI condition groups are assigned based on the primary diagnosis of the first episode of care.

2.6 Deaths where ‘deficiency and anaemia’ was the primary diagnosis code

The number of patients identified within this cohort were small. A clinical review was undertaken in 2022 as reported through the last paper. No specific concerns were raised within the review although the Clinical Coding team plan to undertake a further audit to determine whether anaemia had been coded correctly for these patients. Feedback to the Trust Learning from Deaths Group is anticipated for February 2023.

2.7 Deaths where the primary diagnosis code was leukaemia

The number of patients within this cohort is small. A preliminary review has been undertaken by the Haematology Lead which is due to be fed back to the Trust Learning from Deaths Group in February 2023.

2.8 Acute and unspecified renal failure

A review of acute kidney injury (AKI) is being undertaken by the renal physicians, including associated mortality related to this condition as per the summary provided in the last paper. Further feedback regarding achievements of AKI Intervention Teams from other Trusts is currently being collated and, on completion will be presented to the Trust Learning from Deaths Group.

2.9 <u>Medical Examiner Scrutiny to SJR</u>

Of the 629 deaths that occurred in Q3, the Medical Examiner (ME) service independently scrutinised 628, with 1 death referred directly to the coroner. 139 deaths were referred to the coroner following ME Scrutiny, the outcomes of which are shown at Fig.6 and Fig.7.

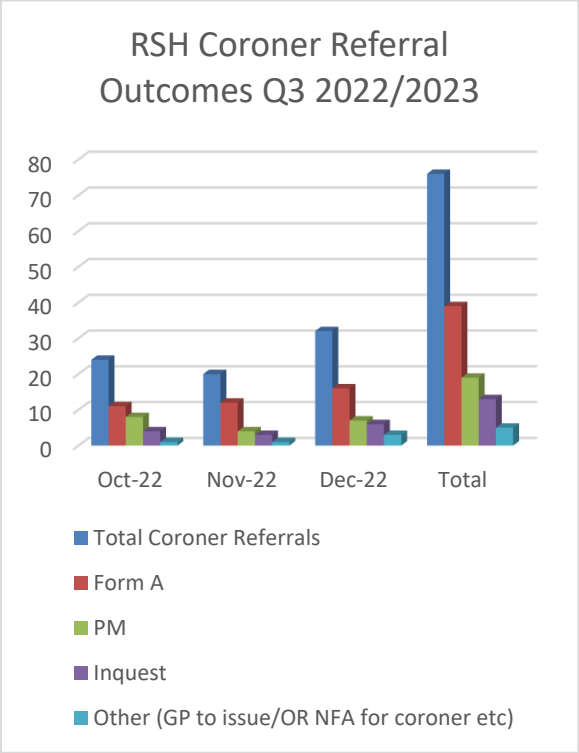

Fig.6

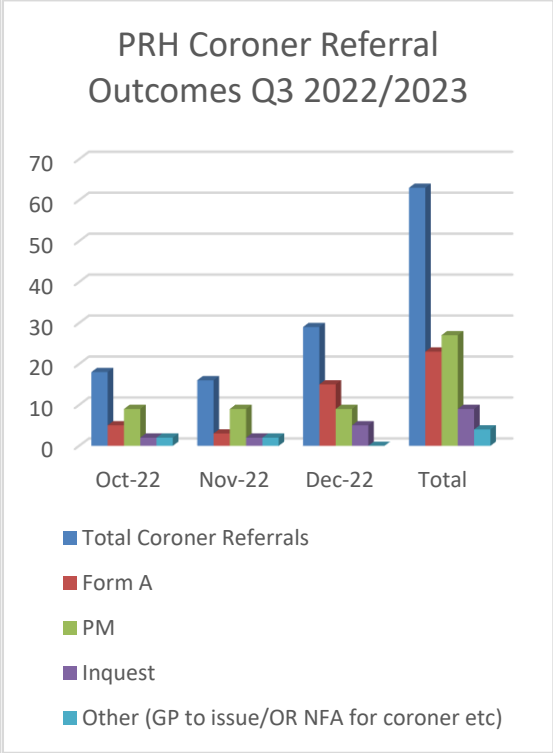

Fig.7

2.10 MCCDs not issued within 3 calendar days

The National ME requires the service to submit quarterly data on the number of MCCDs not issued within 3 calendar days. From the beginning of April 2022, the Medical Examiners stopped writing MCCD's due to the withdrawal of the Emergency Coronavirus Act 2020. Responsibility for this now sits with the treating clinician. Performance in this key metric has deteriorated further from Q1 and Q2 2022/2023 as per Fig.8. The significant pressure treating clinicians are under clinically results in delays in being released from the clinical area to attend the bereavement office to complete the MCCD. The bereavement team support the doctors to facilitate as timely completion as possible and ensure registration services remain appraised of the situation.

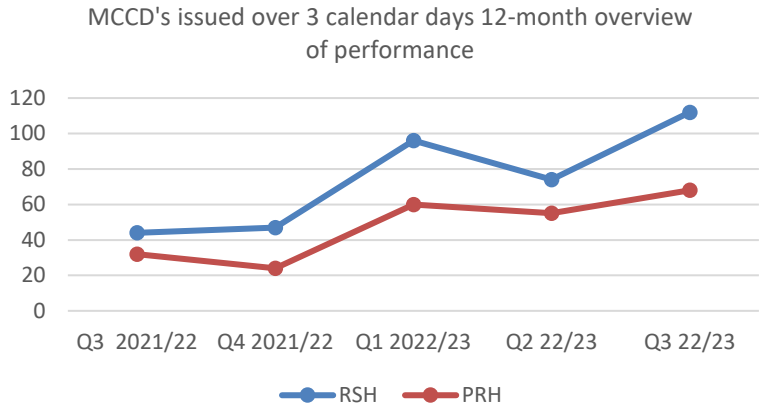

Fig.8

2.11 Deaths where a significant concern about the quality of care is raised with the Medical Examiner by bereaved families and carers

In line with the NQB (2017) guidance, the Trust Learning from Deaths policy recognises the importance of providing bereaved relatives and carers the opportunity to discuss concerns they may have in relation to the quality of care their loved ones received

before they died. A one-to-one conversation is offered to relatives as part of routine Medical Examiner Scrutiny and cases are flagged for detailed SJR accordingly. Relatives are also offered the opportunity to complete a Bereavement Feedback Survey.

In Q3 2022/2023, 22 cases were referred by the Medical Examiner for an SJR based on significant concerns raised by the bereaved. The number of significant concerns raised by bereaved families has increased significantly to the previous quarters. Two of these cases has been investigated by the relevant division and two are subject to a Coroner's inquest, the learning of which will feedback through the Legal Team. 6 cases are progressing through the formal complaints process at the time of this report.

2.12 Completion of Structured Judgement Reviews (SJRs)

SJRs may currently be triggered in the Trust through ME Scrutiny, online mortality screening or following case discussions within the weekly Mortality Triangulation Group operational meeting. Random sampling will be introduced to provide additional assurance for the Trust, although this has been delayed due to the current resource limitations within the Divisions to complete SJRs within the 8-week timeframe specified within the Learning from Deaths Policy.

Whilst the SJR completion rate for Q4 2021/2022 is near to the NHSE target of 15%, there has been a significant deterioration over the last three quarters as seen at Fig.9 below.

12-month overview of SJR completion	SJRs completed as percentage of overall deaths in the Quarter (629)	Comments
2021/22 Q4	14.5%	69 completed
2022/23 Q1	4%	21 completed
2022/23 Q2	3%	15 completed
2022/23 Q3	0.8%	5 completed

Fig.9

The reason for the deterioration in SJR completion is believed to be multi-faceted:

- Resource challenges within the divisions to undertake SJRs due to current clinical workload and insufficient SJR reviewers.
- The vacant corporate Clinical Lead for Learning from Deaths post required to support the divisions with SJR completion, especially relating to training requirements and quality assurance. This post has now been filled on a one-year tenure with an allocation of 2 Programmed Activities (PA). The successful applicant commenced in post 01 February 2023.
- Migration to a new online SJR platform in December 2022, requiring the provision of new logs on details and training for users.
- The number of cases flagged for SJR was nearly 8.9% in Q3 as seen at Fig.10 below, and just over 8% for Q1&2 combined. It is important to increase the number of cases appropriately selected for SJR, to make the completion target rates achievable. Case selection figures will increase when random sampling has been introduced.

TOTAL SJRS ALLOCATED FOR COMPLETION IN Q3		
ME flagged confirmed SJRs	44	
ME flagged 'Learning' upgraded to SJR	7	
Mortality screening flagged SJRs	4	
SJRs triggered from other sources	1	
Total SJRs raised in Q3	56	8.9% of all deaths flagged for SJR

Fig.10

The Learning from Deaths team are working collaboratively with the Trust Improvement Hub team to develop a programme of work over the next 12 months to improve SJR completion rate compliancy. Seven workstreams have been identified, each of which will require a nominated workstream lead and the involvement of key stakeholders. The workstreams have been identified as:

- Workstream 1: Resources, roles and responsibilities.
- Workstream 2: Data management (Divisional and Corporate).
- Workstream 3: Education and Training, to include quality assurance measures.
- Workstream 4: Culture, Communications and Public Relations.
- Workstream 5: Triangulation and Learning, to include Learning from Deaths representation at appropriate Divisional / Trust forums.
- Workstream 6: Notes management
- Workstream 7: Learning from Deaths integration with PSIRF.

2.13 Overview of Care

A high-level overview of care is provided on the dashboard at Fig.3, summarising learning identified in the SJRs completed year to date 2022/2023. More detailed analysis of Q1&2 learning from SJRs was detailed in the Q1 and Q2 2022/2023 How We Learn from Deaths report.

There have been insufficient SJRs completed in Q3 to enable any credible analysis of the identified learning and detailed inclusion in this report.

3.0 Learning identified through the wider Learning from Deaths processes in the Trust

3.1 An audit of deaths within the Trust where an ambulance offload delay was experienced by the patient, has been undertaken over the last 6 months using the SJR methodology. Through this work, assurance has been provided that any death where the ambulance offload delay may have impacted adversely on the outcome, was already being managed through the patient safety framework.

3.2 Themes noted through MTG within Q3 2022/2023:

- Patients declared medically fit for discharge (MFFD) but then diagnosed with a hospital acquired infection and dies. These cases are now being monitored through MTG and further review / cluster review is being planned to identify any specific learning.

- Concerns raised by the family or through ME Scrutiny where there have been problems with a recent discharge prior to the death of the patient within the Trust.
- End-of-Life care – improvement work continues as detailed within the Q1&2 2022/2023 report.

3.3 A case was reviewed where a patient died who had presented to ED with a dossette box. Concerns were identified through ME Scrutiny. The case was reviewed by the Trust Medicine Safety Officer who highlighted limited national guidance on the use of dossette boxes, despite the complexity of the issue being recognised. Work is now in progress by the Medicines Safety Officer in collaboration with the Integrated Care System to support a cross system approach to dossette box use.

3.4 Following concerns raised through ME Scrutiny regarding a patient who was admitted following accidental overdose of morphine in the community, focused work is now underway in collaboration with the Integrated Care System to develop a system-wide approach to high-risk opioid prescribing. Locally, the policy for managing opioid overdose has been updated and shared with clinical teams.

3.5 Following the death of a patient who presented with clostridium difficile infection after receiving two courses of antibiotics in the community following a dog bite, the Trust Medicine Safety Officer has reviewed the case and is sharing findings with the Integrated Care System as an opportunity for further learning to be identified.

4.0 Deaths of patients with a confirmed Learning Disability

4.1 In Q3 2022/2023 there were 3 patients with confirmed learning disabilities, who died in the Trust either as an inpatient or in the ED. These cases have been reported to the service improvement programme for people with a learning disability and autistic people (LeDeR). SJRs are currently in progress for these patients.

4.2 An additional death for Q1 2022/2023 of a patient with confirmed Learning Disabilities has been identified, bringing the total number of deaths in Q1 from 4 as reported in the last quarter, to 5. There is currently no robust process in place to facilitate the accurate identification of patients with learning disabilities who have died in the Trust without the support of Midlands Partnership Foundation Trust personnel. This has been escalated to the Trust Mental Health and Learning Disability Lead for further development.

5.0 Deaths of Patients with a Serious Mental Health Condition:

5.1 To facilitate appropriate recognition of patients who have died in the Trust with a serious mental health condition and consequently initiate a mandated review of care in line with national guidance (NQB 2017), a review of the internal processes to support this is underway in collaboration with the Trust Mental Health and Learning Disability Lead. There is currently no nominated mental health specialist to support mandated SJRs for this group of patients within the Trust. Until appropriate resource can be identified SJRs for patients who have died with a diagnosed serious mental health condition will be managed through the divisional clinical teams.

5.2 In Q3 2022/2023 there were 3 deaths identified of patients with a serious mental health condition. SJRs remain outstanding for these patients.

6.0 Maternal, Neonatal and Infant mortality

6.1 Nationally, all deaths of pregnant women and women up to one year following the end of the pregnancy irrespective of where or how the woman dies, are notified to MBRRACE-UK – 'Mothers and Babies: Reducing Risk though Audits and Confidential Enquiries across the UK'.

6.2 In addition to MBRRACE-UK reporting requirements, all direct or indirect maternal deaths of women while pregnant or within 42 days of the end of the pregnancy are reported to the Healthcare Safety Investigation Branch (HSIB). Direct deaths include those resulting from obstetric complications of the pregnancy, from interventions, omissions, incorrect treatment or from a chain of events resulting from any of these. Indirect deaths include those from previous existing disease that developed during pregnancy, and which was not the result of direct obstetric causes, but which was aggravated by the physiological effects of pregnancy in the perinatal period (during or within 42 days of the end of the pregnancy).

6.3 There have been no maternal deaths in the Trust in Q3 2022/2023.

6.4 The Perinatal Mortality Review Tool (PMRT) available through MBRRACE-UK is used by the Trust. The tool supports high quality standardised reviews across NHS maternity and neonatal units in England, Scotland and Wales of the care leading up to and surrounding each stillbirth and neonatal death, and the death of babies who die in the post-neonatal period having received neonatal care.

6.5 Perinatal and infant deaths are reported to MBRRACE-UK according to the following criteria:

Term	Definition	SaTH Q3 data
Stillbirths	Baby delivered from 24+0 weeks gestation showing no signs of life	2
Early neonatal deaths	Death of a live born baby (20 weeks gestation or later) occurring before 7 days of life	2
Late neonatal deaths	Death of a live born baby occurring between 7 and 28 completed days after birth	0
Terminations of pregnancy	All terminations of pregnancy after 22+0 and all terminations from 20+0 weeks which resulted in a live birth resulting in a neonatal death	1

6.6 There were no serious incidents relating to maternal deaths but 2 serious incidents relating to perinatal mortality which were reported to the Strategic Executive Information System (StEIS) during Q3 2022/2023. These remain are under investigation.

6.7 Learning identified through completed perinatal mortality reviews and Healthcare Safety Investigation Branch (HSIB) reviews:

- A partogram was not completed for a lady in labour who had suffered a pregnancy loss. ACTION taken – this information has now been included in the Midwives Mandatory Day 2 Training for Bereavement.
- A patient with two risk factors for pre-eclampsia, did not receive aspirin. Review of care identified that the risk assessment completed at booked did not correctly identify the two risk factors of first pregnancy and multiple

pregnancy, and therefore the lady was incorrectly identified as 'low risk'. The reviewers were unclear however if the patient did receive aspirin and there was a documentation error or whether the aspirin was missed. ACTION taken - a reminder was sent to all midwives to ensure risk factors are checked and to refer to the appropriate Aspirin standard operating procedure.

- Patient with fibroids had a plan for serial growth scans made from 32 weeks gestation. Local guidance and RCOG guidance stated from 28 weeks although it was noted that the plan was made before the updated guidance was implemented 18/11/22. Learning shared within division.
- Need to ensure appropriate escalation where there is uncertainty in clinical diagnosis, especially when blood pressure is raised, and protein is in the urine.

7.0 Paediatrics

7.1 There were 3 inpatient / ED deaths of children under the age of 18 in Q3 2022/2023.

7.2 One serious incident relating to a child death was reported by the Trust to StEIS during Q3 2022/2023. This investigation remains open.

7.3 A thematic review is currently in progress to maximise learning opportunities, with a specific focus on escalation and recognition on the unwell child.

8.0 Potentially Avoidable Deaths

8.1 A potentially avoidable death is defined within the National Quality Board (2017) guidance as any death that has been clinically assessed using a recognised methodology of case record review and determined more likely than not to have resulted from problems in healthcare. The methodology used to assess potentially avoidable deaths in the Trust is the serious incident framework.

8.2 On completion of an investigation, serious incidents are presented to the Trust Review Actions and Learning from Incidents Group (RALIG), chaired by the Executive Medical Director for approval prior to submission to Shropshire, Telford, and Wrekin Integrated Care System (STW ICS) for final review and approval. Deaths deemed to be potentially avoidable following the serious incident investigation are reported to the Board of Directors once final approval has been provided by the STW ICS to ensure transparency, consistency, and accuracy of reporting. A detailed summary of these cases is provided in the monthly Incident Overview Report presented to the Quality and Safety Assurance Committee and the Quarterly Learning from Incidents Report presented to the Quality and Operational Committee.

8.3 In Q3 2022/2023, there were 6 serious incidents relating to patients who have died, reported externally to the Strategic Executive Information System (StEIS). Following serious incident investigation, two deaths within the Trust presented to RALIG in Q3 2022/2023 were deemed more likely than not to have been due to problems in healthcare and therefore to have been potentially avoidable. Duty of Candour is completed by the Divisional Quality Governance Teams. Learning from serious incidents is shared as described at section 8.2.

9.0 Covid Update

9.1 To the end of December 2022 a total of 1060 patients have died within the Trust and have also tested positive for Covid-19 infection on PCR. The significant majority of these have been determined to be pre-hospital admission contact for the virus. However, there is a proportion that have been identified as Trust acquired (nosocomial), some of whom have been identified as dying 'of' Covid -19 (1a, 1b or 1c on their death certificate) and others 'with' covid (part 2 of the death certificate).

9.2 During the third wave to date, there has been a change in the content of death certificates; while a patient may have been screened as being positive for Covid-19 infection on PCR, where they are asymptomatic (or very mild symptoms), Covid does not feature on the death certificate (this is consistent for both Community and Trust acquired cases). The timing of this is likely linked to the vaccination regime.

- 667 patients have Covid-19 recorded on parts 1a, 1b, or 1c of their death certificate
- 154 patients have Covid-19 recorded on part 2 of their death certificate
- 192 patients who tested positive for Covid-19 do not have this recorded on either part of their death certificate
- 9 patients who tested positive are cases which went for fast-track inquest and the cause of death has not been readily available (where they meet the criteria for inclusion in the Trust's nosocomial probable/definite related deaths, they have been included in the numbers below)
- The remaining cases are awaiting outcome of their Cause of Death or as they are not nosocomial in nature have not been included in the count

9.3 The main focus of the Trust review continues to identify all cases where patients have died of/with Covid-19 in the 'probable/definite' section using the criteria advised by NHSE noted below.

9.4 Hospital onset Covid-19 infection definitions:

- Community onset – a positive specimen less than or equal to 2 days after hospital admission or hospital attendance.
- Hospital onset ***(Indeterminate)*** – a positive specimen 3-7 days after hospital admission
- Hospital onset ***(probable)*** – a positive specimen date 8-14 days after hospital admission
- Hospital onset ***(definite)*** – a positive specimen date 15 or more days after hospital admission

9.5 There have been 185 patients who have died with definite/probable hospital onset COVID-19. Over the past 12 months these correlate to an average of just over 4 patients per month who have died in relation to nosocomial infection where Covid-19 is on the death certificate. Prior to the vaccination roll out, this was significantly higher.

9.6 While the focus of the Trust's Serious Incident review complies with the requirement to investigate those patients who died due to probable/definite acquired Covid-19 infection, a holistic approach is being taken to the management of Covid-19 across the organisation and consideration given to internal, external, and human factors which have affected this.

9.7 Monitoring of patients who test positive for Covid-19 infection within the Trust continues. This includes a group of patients who, with treatment for their symptoms, survived the infection. These patients are also part of the duty of candour process

where their infection has been determined to be hospital acquired (probable or definite).

9.8 While there is evidence that there may be some lapses in Infection, Prevention and Control (IPC) compliance in some areas which may have contributed to the outbreaks, which can lead to subsequent deaths of patients, this is not the only factor. Other factors may include:

- An aging estate with insufficient side-rooms with the ability to isolate patients for the advised incubation period is a significant factor. Patients are often isolated for a brief period, which does not extend to the possible incubation period of the virus but only until they have a negative swab.
- Research into airflow around wards has indicated that even with closed doors, these have to open and close for staff and patient access. Viral particles have been shown to travel a ward within 24hours even with basic measures.
- Mask efficacy: Government guidelines for the majority of care management was with standard surgical masks which are approximately 75% effective. Linked with the prevalence of asymptomatic carriers being between 1:3 and more recent statistics of 1:2 people, the risk of transfer remains. FFP3 masks remain effective to a higher degree (95% +).
- More recently, there is evidence that the reintroduction of visitors has had an impact on the number of patients contracting Covid-19.
- Since the Government advised that admission screening of patients is no longer required unless specific criteria are met, there is an increased frequency of outbreaks of Covid-19 within the organisation, although there has not been an increase in the average number of deaths during this time.

9.9 General information relating to Covid-19 deaths

Average age of patients	77 years
Youngest patient	2 years
Oldest patient	100 years
Female	41.5% (remains constant)
Male	58.5% (remains constant)

10.0 Formal feedback from onsite NHSE external assurance review completed December 2022

10.1 An external peer review of the quality of the Trust's SJRs and the way it can use these to learn from deaths and improve care was undertaken in December to assure the Trust about SJR skills and processes and identify any areas for improvement. The formal report received at the end of January 2023 did not highlight any concerns or potential areas for improvement that the Learning from Deaths team had not already identified and started to address.

10.2 In summary the findings concluded that:

- The Trust has made significant improvements in the way it learns from deaths. It was noted that the Trust now uses an electronic SJR and has several reviewers trained to use it, thus providing consistency of approach as well as a method for identifying and reporting on learning.
- The Trust should review case selection for SJR to prevent duplication, especially relating to Coronial investigations and existing datix reviews that are

in progress. Widening the scope of cases for SJR is likely to increase review of 'everyday care' provided to a broader spectrum of patients and therefore avoid missed opportunities for learning due to biased selection.

- In general, SJRs are well done, and reviewers are comfortable describing poor or good care and experience.
- There is the potential to increase capture of lessons learned, positive and negative, from reviews. Areas for improvement could be addressed through training / masterclasses, as well as multi-disciplinary discussion of cases.

10.3 The full report can be found at Appendix A.

11.0 Risk register

11.1 There is one risk on the Trust Risk Register relating to recruitment within the Learning from Deaths.

11.2 The Trust has agreed to recruit at risk to clinical and non-clinical roles within the corporate Learning from Deaths team and additional PA sessions to support the Learning from Deaths Clinical Lead and completion of SJRs across all specialities. Recruitment is in progress and once the additional resource is in post and fully established, it is anticipated that the risk will close.

11.3 Appropriate office space accommodation has not yet been identified to house the expanded Learning from Deaths team.

Trust Senior Clinical Lead for Learning from Deaths
Head of Learning from Deaths and Clinical Standards
January 2023