

Q1 2025/26 Report on Learning from Deaths

Public Board
29 January 2026

Presented for:	Information and assurance
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Previous Committees:	Quality Assurance Committee, 4 December 2025 Mortality Improvement Group 25 November 2025

Risk Appetite Framework				
Level 1 Risk	(✓)	Level 2 Risks	(Risk Appetite Scale)	Impact
Clinical Risk	✓	Patient Safety & Outcomes Risk - We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients.	Minimal	Moving Towards

Key points	
1. The purpose of this paper is to provide assurance that the Trust has appropriate processes in place to report on and review patient deaths and ensure that lessons are being learned and improvements outlined in accordance with the national guidance on learning from deaths, published March 2017.	Assurance
2. The Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratios (HSMR) for Leeds Teaching Hospitals NHS Trust are measuring 'as expected'.	To note
3. In Q1 2025/26, two deaths were escalated through the 'potential patient safety incident' reporting processes for review and to agree the method of learning response.	To note
4. The Quality Assurance Committee is asked to review and note the Quarter 1 2025/26 report on Learning from Deaths.	To note

1. Summary

The purpose of this paper is to provide assurance that the Trust has appropriate processes in place to report on and review patient deaths and ensure that lessons are being learned and improvements outlined.

The latest Summary Hospital-level Mortality Indicator (SHMI) published in October 2025 for June 2024 – May 2025 is 1.1348 (decrease from 1.1428 in Q4 2024/25). The Hospital Standardised Mortality Ratios (HSMR) for June 2024 – May 2025 is 113.6 (increased from 109.3 in Q4 2024/25). Both indices will continue to be monitored by the Mortality Improvement Group.

In Quarter 1 2025/26, two deaths were escalated through the 'potential patient safety incident' reporting processes for review and to agree the method of learning response.

2. Background

National Guidance was published by the National Quality Board in March 2017 entitled “A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care”; this guidance was presented to the Quality Assurance Committee in April 2017. Considering this guidance and the previous work of the Mortality Improvement Group, the Trust launched an updated Mortality Review Procedure in June 2017. This was reviewed in 2021 and an updated Mortality Review Policy was approved in January 2022 to include the role of the Medical Examiner, and a revised Structured Judgment Review management and monitoring process.

3. Review of national indicators

Under the new NHS Oversight Framework Leeds Teaching Hospitals NHS Trust was rated with an average metric score of 2.57, putting the organisation in segment 3, and 96/134 in the league table for acute/ acute specialist NHS providers. The domain score for access to services includes the metric of Summary Hospital Mortality Indicator (SHMI) which is monitored through the Mortality Improvement Group and Mortality Improvement Project Group, reporting to the Clinical Effectiveness and Outcomes Group and to Quality Assurance Committee. The SHMI for Leeds Teaching Hospitals NHS Trust is measuring 'as expected'.

The October 2025 Summary Hospital-level Mortality Indicator (SHMI) publication for the 12-month rolling period July 2024 to May 2025 for the Leeds Teaching Hospitals NHS Trust (LTHT) was 1.1348, banded “as expected” and was an increase from the SHMI published in September 2025 1.1236, which was banded “as expected”.

The SHMI continues to be “as expected” at Leeds General Infirmary (LGI) from a previous spell of “above expected” with this change occurring in the data set for June 2025, while remaining “as expected” for St James’ University Hospital (SJUH) site when broken down at site level (other sites do not have sufficient numbers of deaths to be included). All ten of the Diagnosis Group level SHMI were banded ‘as expected’ for this reporting period. The Mortality Improvement Group continues to monitor the Ten Diagnosis Group level SHMI.

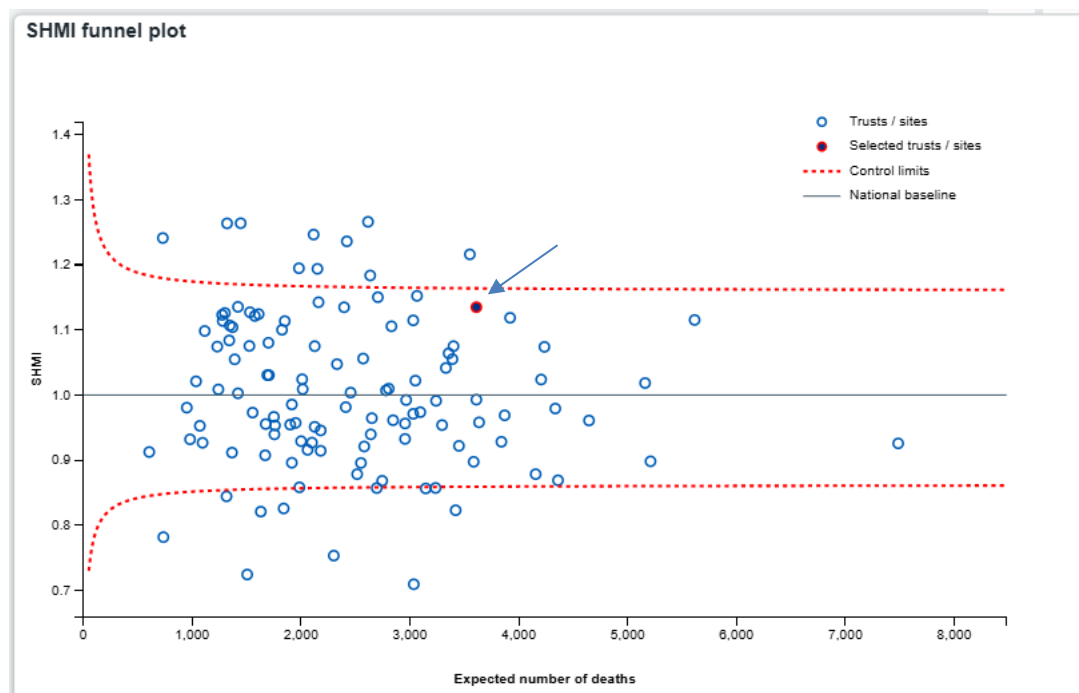
Table 1: National Mortality Indicators

	Figure (July-25 Publication)	Banding	Trend
SHMI	1.1348 (Jul 24 to May 25)	'As expected'	↑
HSMR+ (basket of 41 diagnoses)	113.6 (Jul 24 to May 25)	'As expected'	↑

We expect that LTHT would have a higher number of observed deaths than some other organisations due to being a tertiary centre and Major Trauma Centre (MTC). Expected deaths do not account for patient acuity and instead are based on diagnosis group, which may have an impact on having a lower expected rate despite treating particularly unwell patients. The Mortality Improvement Group continues to monitor the Trust's Mortality Indicators and will continue to undertake coding reviews alongside this process to ensure its quality and accuracy and the accuracy of our Mortality statistics. Structured Judgement Reviews (SJR) will also be requested and monitored through the new SJR storage system provide assurance that the care we are providing is safe and effective.

In September 2025, the contract with Telstra Health UK for the provision of the Dr Foster service subscription was terminated and procurement began for a similar system. The new systems have been reviewed with discussions carried out. The decision has been made to proceed with HED and this system will be implemented as soon as possible. In the meantime, NHS England have begun producing a dashboard that will allow us to continue to monitor our SHMI score using a funnel plot.

Figure 1.0 LTHT NHS England SHMI vs. Peers (Jun 24 to May 25)



4. Update on Mortality Review Process

The National Guidance on Deaths in Care released in March 2017 requires that all Trusts collate and publish specified mortality information on a quarterly basis; within LTHT this included the screening of deaths process. The Trust Mortality Review Policy was updated to outline a revised process for monitoring Mortality Reviews (namely Structured Judgment Reviews) to better enable themes of learning to be identified, and this was approved in January 2022. The Structured Judgment Review (SJR) allocation process is coordinated by the Quality Governance Team and includes cases highlighted for SJR through the Medical Examiners (ME) office; this commenced in May 2022.

4.1 Number of Deaths Eligible for Screening and Compliance

Table 2: Number of Deaths Eligible for Screening as of 31 October 2025.

CSU	Number of Deaths Eligible for Screening Q1 2025/26	Number Screened Q1 2025/26	Number Triggered Q1 2025/26
Specialty & Integrated Medicine	201	190	35
Cardio-Respiratory	80	60	18
Oncology	83	39	15
Abdominal Medicine and Surgery	100	81	45
Centre for Neurosciences	54	43	30
Trauma and Related Services	53	28	19
Urgent Care	65*	8	4
Head and Neck	2	2	1
Chapel Allerton Hospital	0	N/A	N/A
Women's	13	N/A	N/A

*Includes Emergency Department deaths that are screened differently.

Figure 2.0: Trust wide Compliance with Mortality Screening Tool

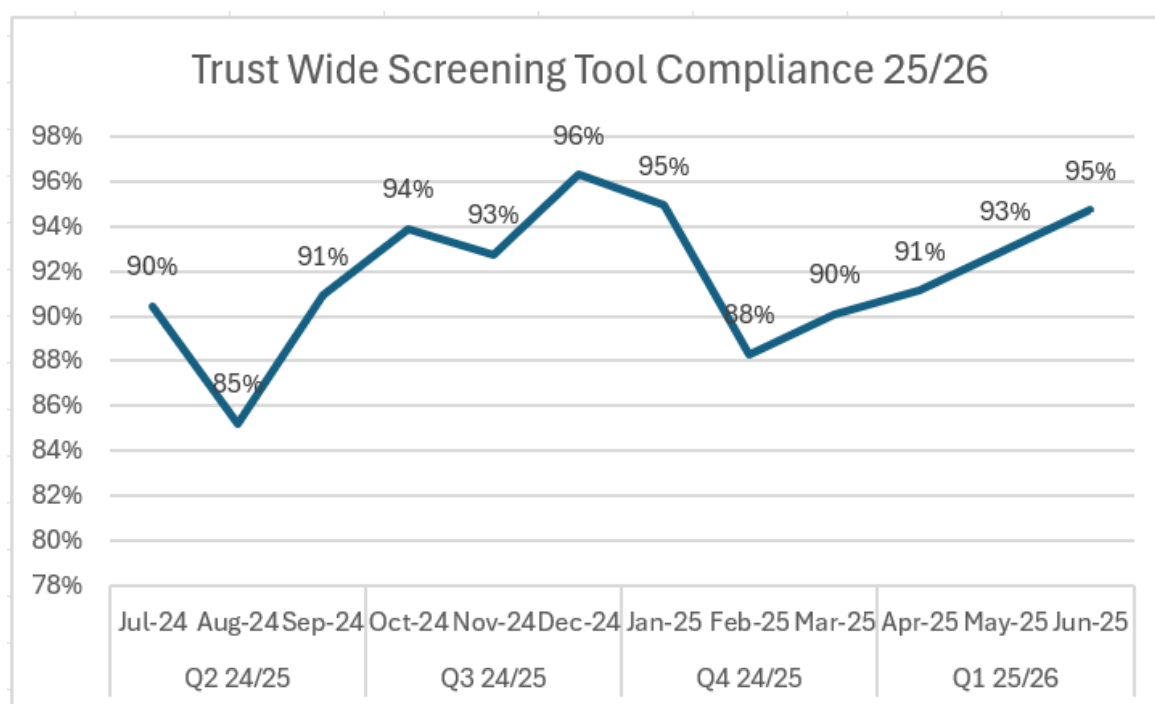


Figure 3.0: Percentage of Reviews Triggered from Screening process

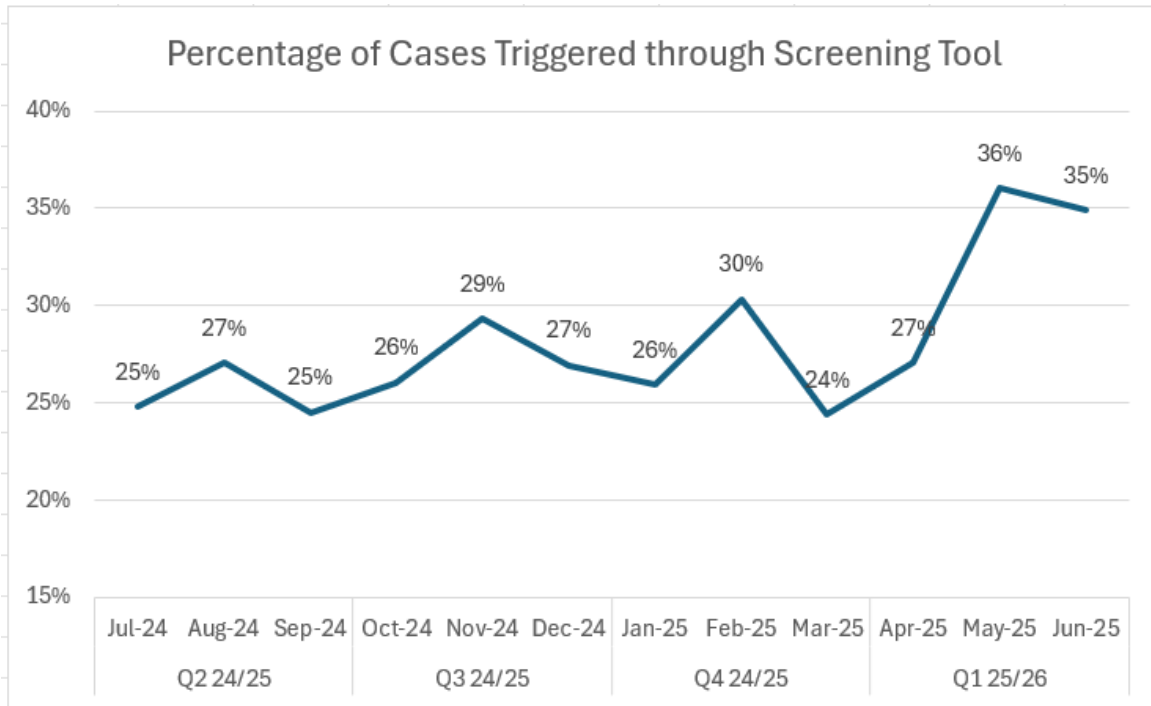
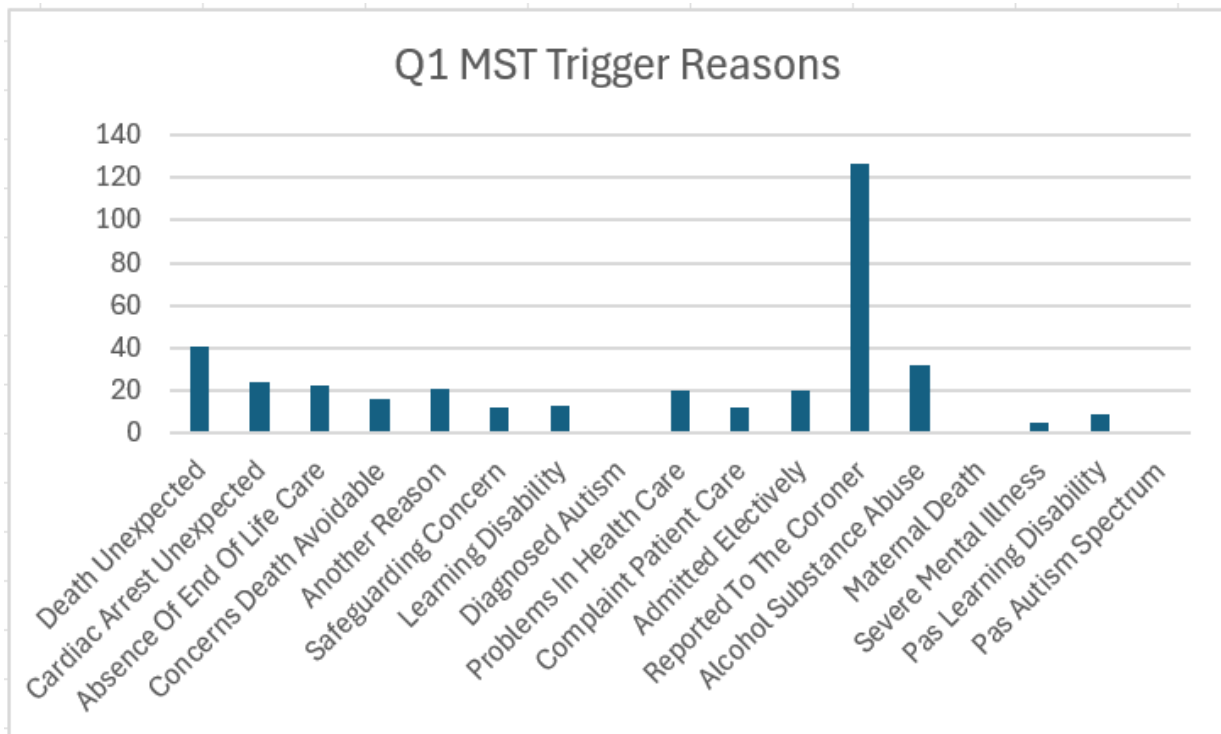


Figure 4.0: Mortality screening tool trigger reason



4.2 Completion of Clinical Reviews

The Quality Governance Team were notified of 218 mortality reviews completed during Q1 2025/26. In Q1 2025/26, 184 SJRs were completed on the online system. The majority of specialties provided a return outlining the completion of reviews and subsequent learning identified. Engagement with mortality leads will be strengthened ahead of the quarter 2 report in order to identify learning across every specialty. There had been some delays with Oncology due to not having a mortality lead in place for some time, however this post has now been recruited into and so we should observe an improvement with the learning from deaths process.

All patient deaths are subject to alternative review methodology in the Leeds Children's Hospital, Emergency Department, and the Major Trauma Centre. This approach has been agreed by the Mortality Improvement Group to account for the regulatory and service specific requirements in these areas.

5. Summary of investigations and learning following a patient death

The Trust is required to report quarterly on the number of deaths reviewed through the Patient Safety Incident Response Framework (PSIRF). These deaths are identified via the Trust's 'potential patient safety incident' (PPSII) reporting processes and are discussed at the Weekly Quality Meeting where the learning response is agreed. Incidents that are escalated are as defined within our Patient Safety Incident Response Plan 2024-26.

All in-patient falls resulting in moderate harm or above undergo a Falls Improvement Review (FIR). When a patient dies following a fall, if the fall or sustained injury is listed within the medical cause of death (MCCD) the FIR will be reviewed via the Patient Safety Response Group prior to CSU sign off and sharing with the patients family.

This report includes all information obtained from Datix in Quarter 1 2025-2026 from 01/04/2025 up to and including 30/06/2025. The quarterly trend of deaths reported is displayed in Table 3.

During this period: Two deaths were escalated via a PPSII. There have been no falls resulting in death. Table 4 below provides details of these incidents, and the learning review commissioned following discussion at the Weekly Quality Meeting. Both deaths escalated were referred to the Coroner.

Where reviews have concluded from previous reports, the outcome and learning are included below in Table 5.

Table 3 - Deaths escalated - Quarterly trend

Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
0	5	7	4	2

Table 4 - Details of deaths identified via the incident escalation function - Quarter 1 2025/26

This table has been redacted from submission to Public Board to ensure anonymity to patients and their families. Full detail has been received and considered at the Quality Assurance Committee.

Findings and actions from Completed Reviews

Findings and actions from all Patient Safety Incident Investigations are discussed at various Quality meetings including the Trust Quality Governance Forum, Quality and Safety Assurance Group and Quality Assurance Committee.

Since July 2024 a Patient Safety Learning Hub has been developed. The meeting encourages representatives from all CSUs to attend to discuss how lessons learned from incidents, audits, safety alerts and other sources can be shared effectively across the Trust and in a manner where the learning can be retained.

The Trust has led on the establishment of a shared learning group involving WYATT Trusts. The purpose of this is to set up a network to discuss common challenges relating to quality and safety, focusing on sharing key learning points and themes arising from Patient Safety Incident Investigations and Never Events, reporting to the WYAAT Medical Directors group.

Key topics for sharing learning and ideas from across the West Yorkshire region on locally reported Patient Safety Incident Investigations and Never Events have been discussed, in addition to a review of regular incident reporting profiles.

An overview of completed learning review outcomes following the death of a patient are summarised in the table below. The table includes details of key findings, lessons learned, identified improvements and actions to address the care and service delivery issues identified.

Learning reviews are conducted in line with the Trust's Patient Safety Incident Response Plan and the Investigations Procedure with the focus being on learning to avoid reoccurrence of incidents.

Table 5 - Details of completed reviews. – Quarter 1 2025/26

This table has been redacted from submission to Public Board to ensure anonymity to patients and their families. Full detail has been received and considered at the Quality Assurance Committee.

6. Sharing learning

Identification of good practice and areas for improvement in care following a patient's deaths are an integral element of the mortality process within LTHT; this is inclusive of potentially avoidable deaths and learning identified following an investigation, as well as learning outlined following SJR.

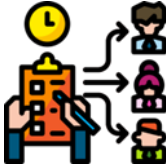
6.1 Learning highlighted by the CSUs

Table 6: Trends in Relation to Good Practice



Communication & Collaboration

Good multi-disciplinary team approach was a frequent theme highlighted, as was good communication and engagement with families and patients.



Clinical Management

Themes of good practice in clinical management were identified including early recognition, prompt advice from other specialties, assessments, and early senior review.



Early Recognition and End of Life Care

Multiple specialties continue to highlight good practices relating to end of life care including early recognition of a dying patient, involvement of the palliative care team, exploring patients' wishes and providing good bereavement support and compassionate care to families and patients.

Table 7: Trends in relation to areas for improvement



ED wait times

Some specialties highlighted issues in relation to long wait in ED including delays in assessment, treatment and transfer to a ward. This has been an ongoing area for improvement highlighted in Q4 2024/25.



Discussions related to interventions

Several specialties highlighted cases where more in depth discussion of surgical and non-surgical procedures with patients and/or families could have been considered. Of note were cases of aspiration or obstruction requiring intubation.



Unnecessary Patient Movements

Specialties highlighted the often inappropriate and significant bed waiting times as well as patients being moved unnecessarily leading to detrimental impact on the care received.

We have observed consistent trends relating to areas for improvement over previous iterations of this report. The Mortality Improvement Group has discussed the need for an improved process

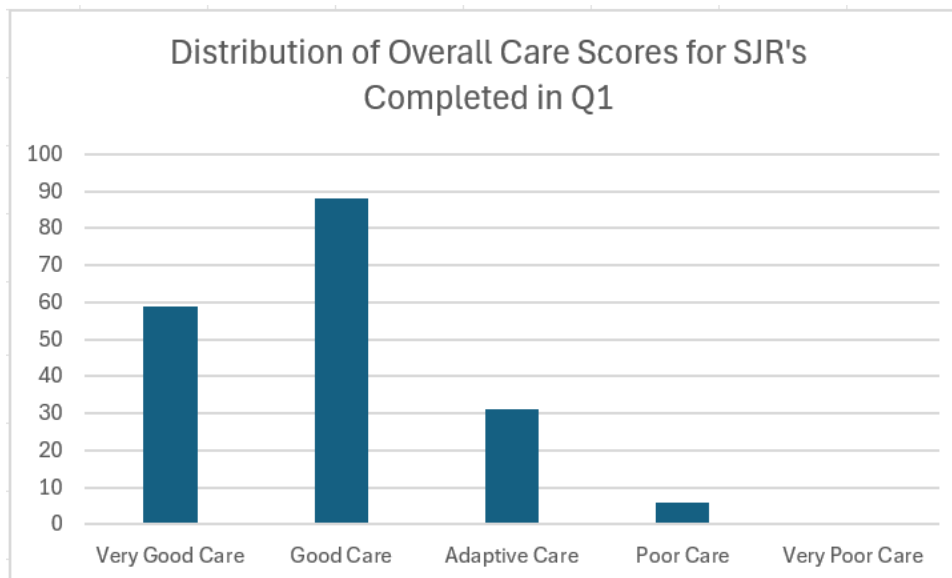
within Clinical Service Units for the implementation of action and improvement work following mortality review, particularly where there are prevalent and consistent themes. There is an internal audit of the mortality review process due to take place within Q3-Q4 2025-26 and the Group is working closely with internal auditors to identify actions for improvement and a more robust cycle of learning for improvement embedded into the governance and mortality review structures.

6.2 Themes from SJRs

In Q1 2025/26, 184 SJRs were completed on the online SJR system. In six reviews the overall score given by the initial reviewer was 2 (poor care). Learning was identified in relation to:

- Monitoring patients after sedation.
- Ensuring patients receive consultant reviews after long stays in ED
- Ensure bloods are carried out before discharge in patients presenting with cellulitis and confusion.
- Ensuring patients receive adequate IV fluids whilst waiting long periods in ED.
- Ensuring patients do not have long periods of waiting in ED.
- Prompt reviews and diagnosis in patients with temperature or diagnostic spikes.
- Ensure patients are monitored correctly whilst in ED with proper documentation in place.

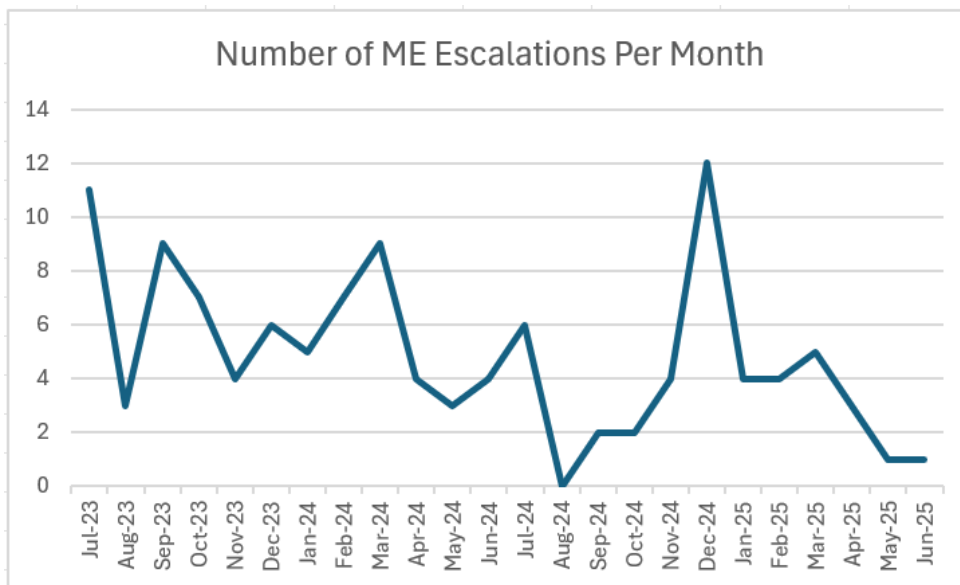
Figure 5 Distribution of overall care scores for SJRs completed in Q1 25/26



6.3 Themes from escalations from the Medical Examiner service

In Quarter 1 2025/26 five cases were escalated by the Medical Examiner service for review. A majority of the cases included patients with disability needs.

Figure 6 Number of ME escalations per month



7 Mortality Outlier alerts

Mortality outlier alerts are reviewed and monitored at the Trust's Mortality Improvement Group (MIG), chaired by the Associate Medical Director (Risk Management). The MIG reports into the Clinical Effectiveness and Outcomes Group, and any safety items for escalation would be discussed at the Quality and Safety Assurance Group. There are currently no open Mortality Outlier Alerts.

8 Mortality Work Programme

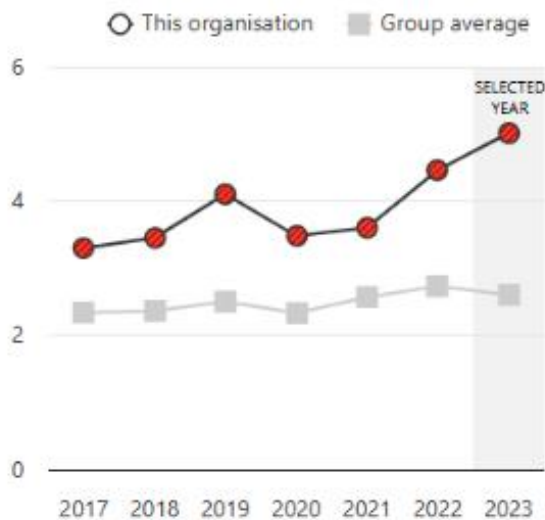
In Quarter 1, the presentations at Mortality Improvement Group covered the MBRRACE Neonatal data collection and an in-depth report regarding the quality of the data collected, as well as the mortality indicators review, Coding KPI updates for Q4 and an update from Neurosurgery and Congenital Cardiology regarding service improvements and risk reducing measures in the onset of increased capacity.

8.1 Neonatal Mortality Data MBRRACE

The neonatal service had conducted a review of data in relation to the MBRRACE report and neonatal mortality report. They had explored with the perinatal leadership fellow management the quality of the data presented and discussed that the best outcome would be to create a subgroup with the premise of approaching MBRRACE about data quality from other tier 3 units, including LTHT. The neonate team stipulated that in addition to a review of internal deaths from within Leeds they also reviewed cases of death where infants are transferred to other hospitals or hospices, as well as where infants are also transferred to Leeds from other sites. This was then discussed at QSAG as well as escalated to the board as part of a larger infant mortality review at LTHT.

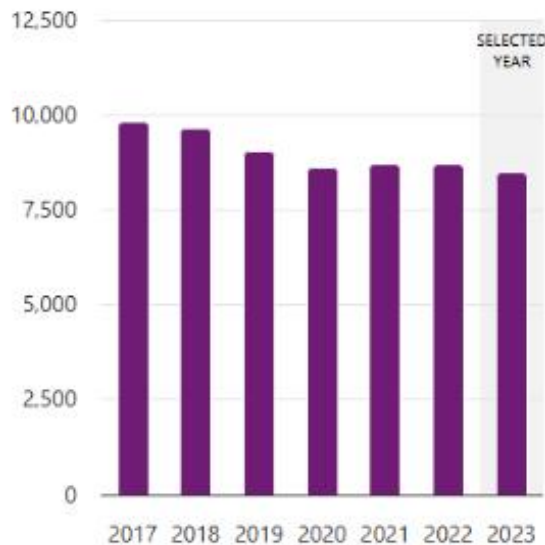
Mortality rates, by year

Stabilised & adjusted neonatal mortality rate per 1,000 live births



Births, by year

Total number of births



8.2 Neurosurgery Deaths and SJR Update report

Data presented from Dr Foster and Referapatient as well as other sources suggested that patterns of admission were emerging in Emergency Care in regard to Neurosurgery. These patterns were discussed and checked on a regular basis in order to ensure that the most efficient approach to dealing with surges was implemented.

Data further suggested that there had been an increase in admissions over time and that this had led to an increase in risk, leading to a statistically significant increase in risk as admissions increase. However, neurosurgery remained within expected parameters for risk, compared to other hospitals of the same level.

Risk management remained stable over the reported time period, even with an increase in deaths for specific neurosurgery related complaints. The team demonstrated swift response to mitigate risks and provide excellent care for patients, even against ever increasing demands on the service.

The SJR structure in Neurosurgery was good, with a clear and concise use of the SJR system that worked in tandem with the reviews completed on a monthly basis. All deaths were discussed in monthly governance with rolling consultant attendance to ensure adequate input and discussion.

In Q2 2025/26 specialty presentations will cover mortality in patients with learning disability and autism, as well as presentations from Vascular Surgery as well as updates from the Neonatal team regarding PICANET data collection. The Coding team and Quality Governance Analyst continue to work with specialties to monitor and review mortality indicators and coding data as required.

9 Financial Implications

There are no financial implications with this report.

10 Risk

The Quality Assurance Committee provides assurance oversight of the Trust's most significant risks, which cover the Level 1 risk categories (see summary on front sheet). Following discussion at the Quality Assurance Committee meeting there were no material changes to the risk appetite statements related to the Level 2 risk categories and the Trust continues to operate within the risk appetite for the Level 1 risk categories set by the Board.

11 Communication and Involvement

The Mortality Improvement Group works in collaboration with the Clinical Service Units Mortality Leads, Corporate Services and Medical Examiner. There is senior medical management oversight of learning from deaths activities by the Associate Medical Director (Risk Management). This work is monitored by the Quality and Safety Assurance Group.

12 Equality Analysis

The Mortality Review Policy – Learning from Deaths supports a comprehensive approach to ensuring safe and effective patient care has taken place through a robust mortality review process; particularly in relation to patients with a Learning Disability or Autism

13 Publication Under Freedom of Information Act

This paper has been made available under the Freedom of Information Act

14 Recommendation

The Quality Assurance Committee is asked to review and note the Quarter 1 2025/26 report on Learning from Deaths.

15 Supporting Information

Not applicable.