

Q2 2025/26 Quarterly Report on Learning from Deaths

Public Board
26 March 2026

Presented for:	Assurance
Presented by:	Magnus Harrison, Chief Medical Officer
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Previous Committees:	Mortality Improvement Group 10 February 2026 Quality Assurance Committee 19 February 2026

Link to Strategic Objective	Focus on care quality, effectiveness and patient experience
Link to Provider Capability Assessment	Governance, risk and regulatory
Link to CQC Well-led Statement	Learning, Improvement and Innovation
Regulatory Impact	Regulation 12: Safe care and treatment

Key points	
1. The purpose of this paper is to provide assurance on the Trust's mortality processes and learning from deaths framework including governance, compliance with review processes, key mortality indicators, themes and learning, and the improvement actions taken / planned with quarter two 2025/26.	Assurance
2. The Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratios (HSMR) for Leeds Teaching Hospitals NHS Trust are measuring 'as expected'.	Information
3. In Q2 2025/26, four deaths were escalated for further review through the Trust's patient safety incident escalation processes to agree an method of learning response.	Information

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
External Risk	Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.	Averse	Moving Towards

1. Summary

The purpose of this paper is to provide assurance on the Trust’s mortality processes and learning from deaths framework including governance, compliance with review processes, key mortality indicators, themes and learning, and the improvement actions taken / planned with quarter two 2025/26.

The latest Summary Hospital-level Mortality Indicator (SHMI) published in January 2026 for September 2024 – August 2025 is 1.1137 (decrease from 1.1348 in Q1 2025/26). The Hospital Standardised Mortality Ratios (HSMR) for September 2024 – August 2025 is 115.3 (increased from 113.6 in Q1 2025/26). Both indices will continue to be monitored by the Mortality Improvement Group.

In Q2 2025/26, four deaths were escalated for further review through the Trust’s patient safety incident escalation processes to agree an method of learning response.

2. Review of national indicators

Under the new NHS Oversight Framework Leeds Teaching Hospitals NHS Trust was rated with an average metric score of 2.45 – an improvement of 0.12 from the previous quarter, putting the organisation in segment 3, and improving our rank by 16 places to 80 out of 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 January 2026 Summary Hospital-level Mortality Indicator (SHMI) publication for the 12-month rolling period September 2024 to August 2025 for the Leeds Teaching Hospitals NHS Trust (LTHT) was 1.0978, banded “as expected” and was a decrease from the SHMI published in December 2025; 1.1193, 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

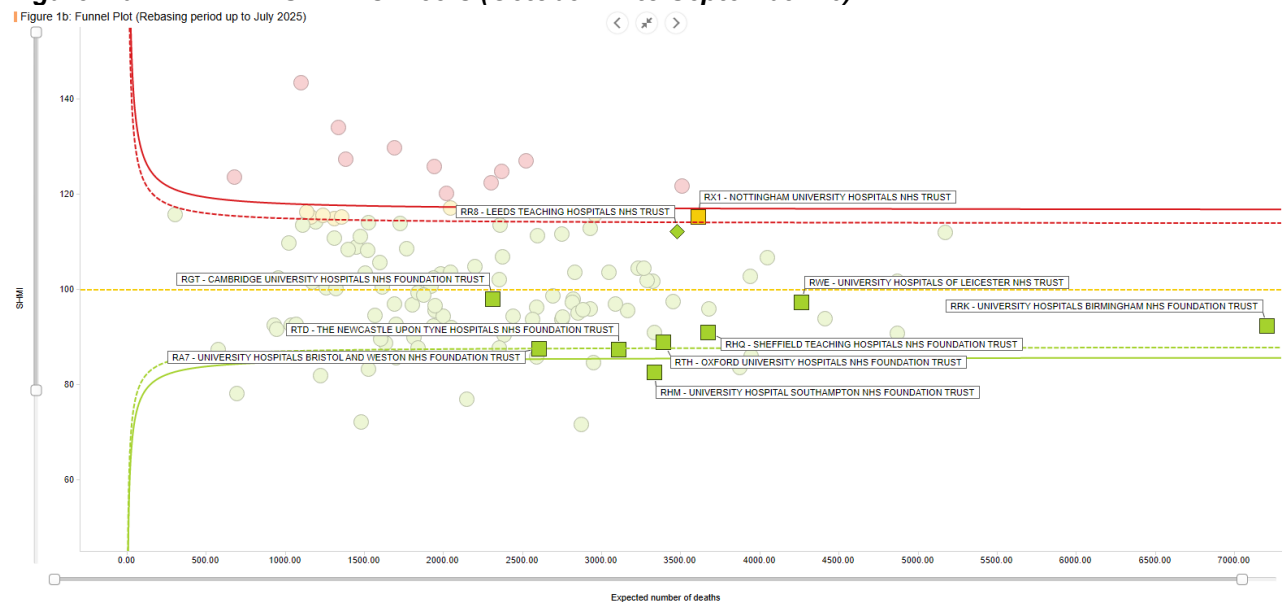
	Figure Publication)	(Jan-26	Banding	Trend
SHMI	1.1137 (Sep 24 to Aug 25)		‘As expected’	
HSMR+ (basket of 56 diagnoses)	114.2 (Sep 24 to Aug 25)		‘As expected’	

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 SJR storage system to provide assurance that the care we are providing is safe and effective.

In 2025/26 we have ended the contract with Dr Foster and Telstra Health and are in the process of onboarding a new system called HED; Healthcare Evaluation Data (HED) which is an online benchmarking solution developed by University Hospitals Birmingham NHS Foundation Trust.

Figure 1.0 HED LTHT SHMI vs. Peers (October 24 to September 25)



3. 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 September 2025.

CSU	Number of Deaths Eligible for Screening Q2 2025/26	Number Screened Q2 2025/26	Number Triggered Q2 2025/26
Specialty & Integrated Medicine	181	172	30
Cardio-Respiratory	87	76	21
Oncology	77	68	19
Abdominal Medicine and Surgery	76	59	29
Centre for Neurosciences	59	50	18
Trauma and Related Services	33	21	10
Urgent Care	67*	13	7
Head and Neck	0	0	0
Chapel Allerton Hospital	0	0	0
Women's	21	N/A	N/A

*Includes Emergency Department deaths that are screened differently.

Figure 2.0: Trust wide Compliance with Mortality Screening Tool

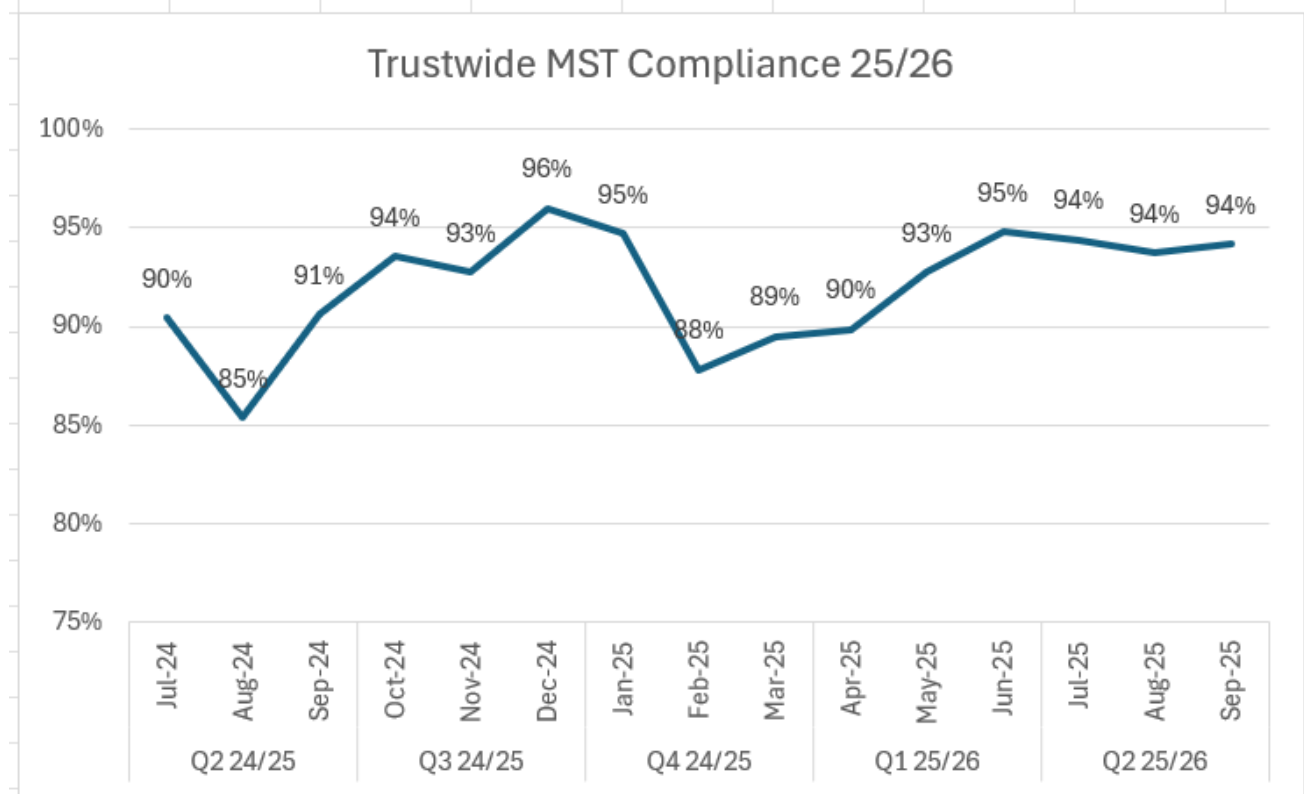


Figure 3.0: Percentage of Reviews Triggered from Screening process

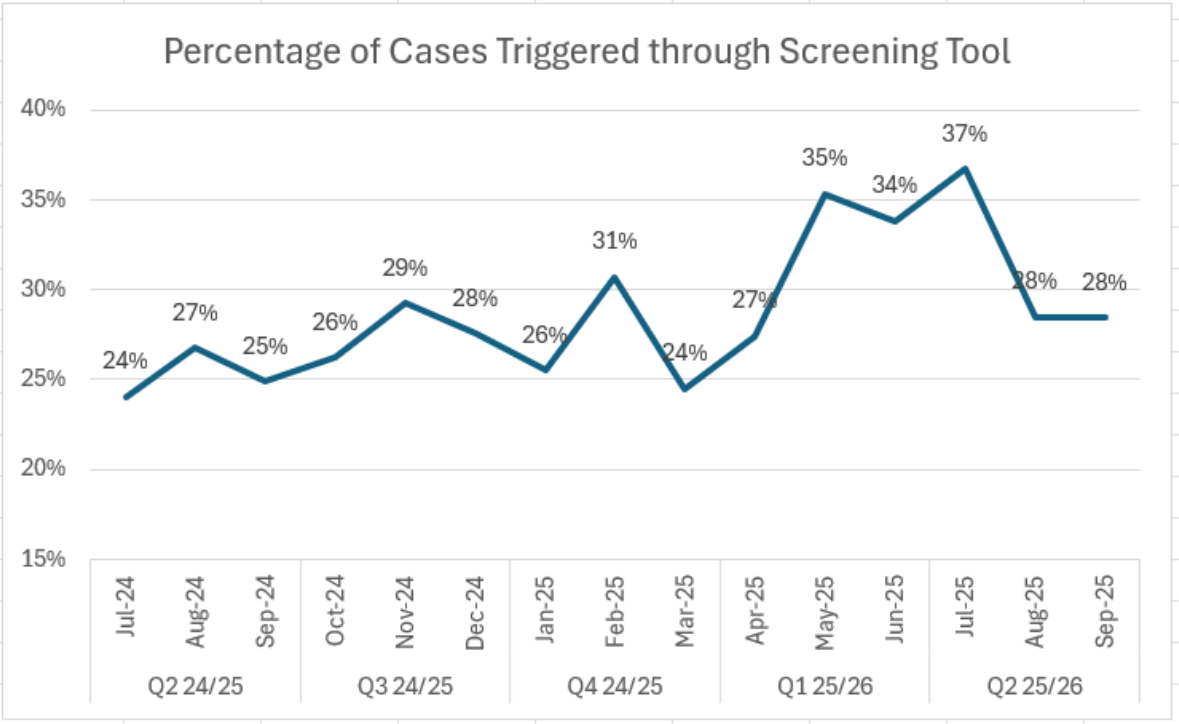
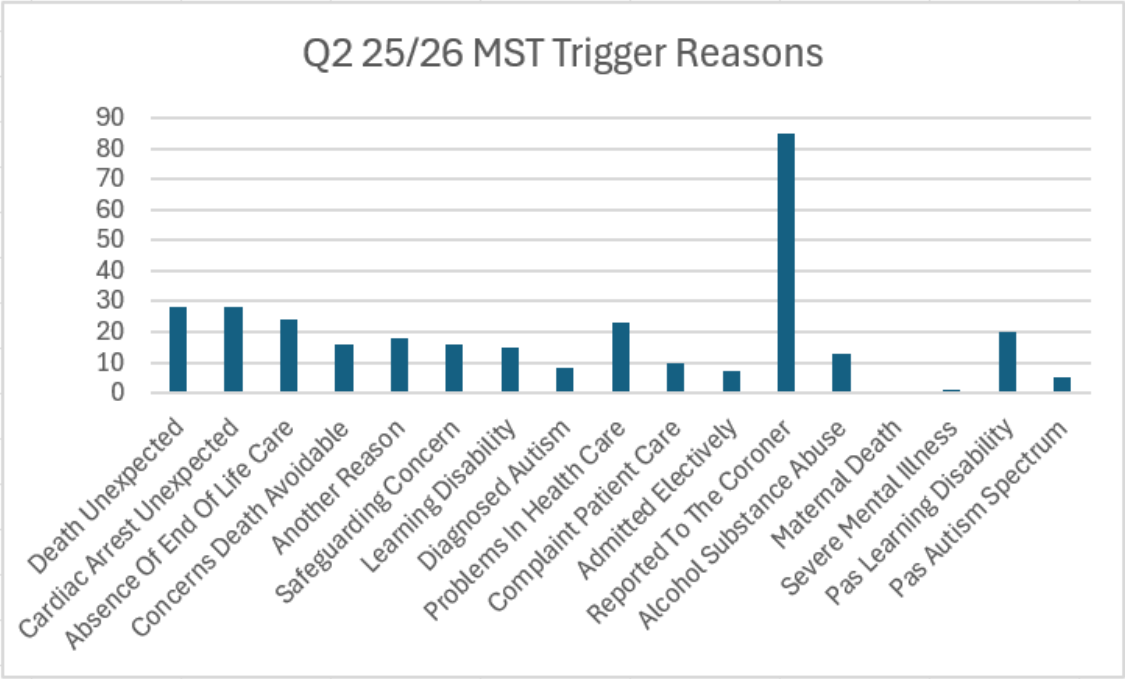


Figure 4.0: Mortality screening tool trigger reason



4.2 Completion of Clinical Reviews

In Q2 2025/26, 179 SJRs were completed on the online system, this excludes all patient deaths in the Leeds Children's Hospital, Maternity Department , Emergency Department, and the Major Trauma Centre which are subject to alternative review methodology, however the learning from those deaths are included within the report. 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 are defined within our Patient Safety Incident Response Plan 2024-26. Identified deaths are escalated via the Trust's 'potential patient safety incident investigation' (PPSII) reporting processes and are discussed at the Weekly Quality Meeting where, supported by the Patient Safety Incident Response Plan 2024-26, a decision is made as to the type of incident review required. Incidents that are escalated are as

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 Incident Response Group prior to CSU sign off and sharing with the family/carers.

This report includes all information obtained from Datix in Quarter 2 2025-2026 from 01/07/2025 up to and including 30/09/2025.

During this period: Four deaths were escalated via a PPSII. No falls resulting in death have required escalation. Table 4 below provides details of these incidents, and the level of review recommended following discussion at the Weekly Quality Meeting. Two cases 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	Q2 2025/26
0	5	7	4	2	4

Table 4 - Details of deaths identified via the incident escalation function - Quarter 2 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, Patient Safety Learning Hub and Quality Assurance Committee.

The 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 is an active partner in the WYATT shared learning group. 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.

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 Investigations Procedure and aligned to PSIRF.

Table 5 - Details of completed reviews.

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

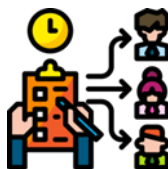
	Communication & Collaboration Good multi-disciplinary team approach was a frequent theme highlighted, as was good communication and engagement with families and patients.
	Clinical Management Themes of good practice in clinical management were identified including early recognition, prompt advice from 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.
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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.

Themes and trends remained largely the same as in previous iterations of the report, suggesting more work should be carried out on what appear to be long term areas for improvement.

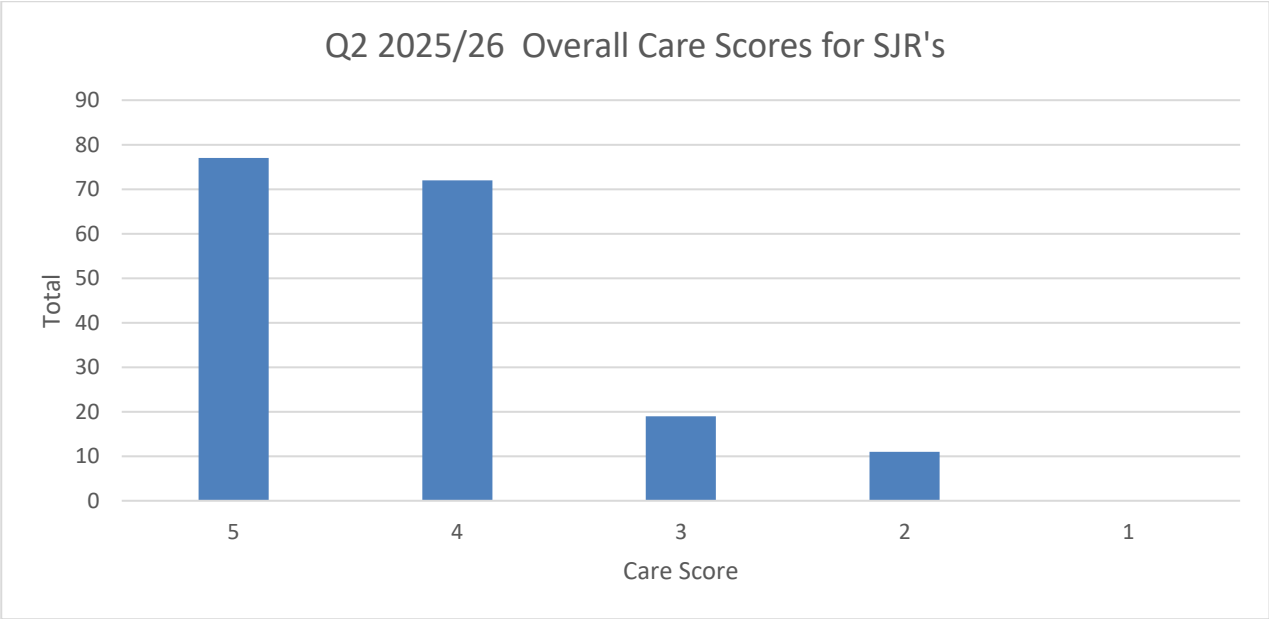
6.2 Themes from SJRs

In Q2 2025/26, 179 SJRs were completed on the online SJR system. In 11 reviews the overall score given by the initial reviewer was 2 (poor care), no reviews resulted in care graded as 1 .

Learning was identified in relation to:

- Ensuring face to face patient reviews are carried out in a timely manner.
- 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.
- Importance of adequate training to spot abnormalities and refer appropriately.
- Ensure clinical reviews are document on time to ensure adequate transfer of care.

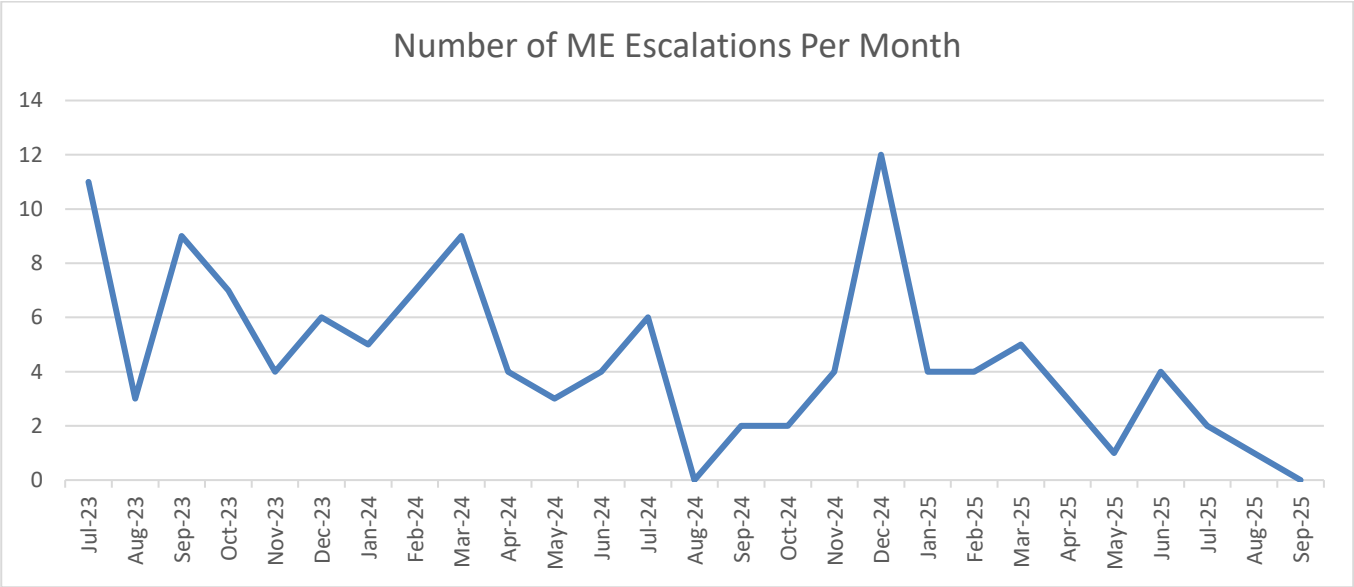
Figure 5 Distribution of overall care scores for SJRs completed in Q2 25/26



6.3 Themes from escalations from the Medical Examiner service

In Quarter 2 2025/26 3 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. We have not received any alerts from the CQC

in this period in relation to mortality outliers, we will be able to set up our own outlier alerts via the HED system now that this is in place.

8 Mortality Work Programme

In Quarter 2, the presentations at Mortality Improvement Group covered the implementation of the new HED Analysis system to replace Dr.Foster, as well as the mortality indicators review and Coding KPI updates for Q1.

8.1 HED Analysis System

During Q2, the Healthcare Evaluation Data (HED) System was procured to strengthen the Trust's use of data to support quality improvement, patient safety, and operational performance. The system provides access to nationally benchmarked datasets through interactive dashboards, enabling LTHT to monitor clinical outcomes, identify variation, and compare performance against peer organisations. Its introduction supports both strategic oversight and detailed service-level analysis, aligning with existing performance management and governance arrangements.

Prior to and during implementation, discussions took place across clinical, operational, and corporate teams to agree priorities and ensure the system met the Trust's needs. These discussions were supported by structured training sessions tailored to different user groups, including senior leaders, clinicians, and analysts. Training focused on understanding the dashboards, interpreting metrics, and applying insights to improvement activity. Together, these engagement and training activities supported the effective embedding of HED into routine performance review and quality improvement processes at LTHT.

In Q3 2025/26 specialty presentations will cover mortality in patients with learning disability and autism and well as presentations from Gastroenterology. 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 is exempt from publication under Section 22 of the Freedom of Information Act 2000, as it contains information which is in draft format. This report will be made available following ratification at the Quality Assurance Committee on 19 February 2026.

14 Recommendation

Public Board are asked to review and approve the Quarter 2 2025/26 report on Learning from Deaths.

15 Supporting Information

Not applicable.

Simon Brookes
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February 2026