

Learning from Deaths Report Q4 2025/26

Public Board
24 September 2026

Presented for:	Assurance
Presented by:	Elizabeth Garthwaite, Interim Chief Medical Officer
Author:	Katie Middleton Tansley, Clinical Effectiveness and Compliance Manager
Previous Committees:	Clinical Effectiveness and Outcomes Group 11 August 2026 Quality Assurance Committee, 26 August 2026

Link to Strategic Objective	People – we make LTHT a brilliant place to work for everyone in order to deliver excellent, safe, and sustainable care for every patient, every time.
Link to Provider Capability Assessment	Quality of care
Link to CQC Well-led Statement	Learning, Improvement and Innovation
Regulatory Impact	Regulation 12: Safe care and treatment

Key points	Purpose
1. This report provides an update on Quarter 4 Learning from Deaths activity, including Structured Judgement Reviews, mortality screening, Medical Examiner escalations, mortality indicators and learning from specialist review processes.	Assurance
2. A total of 176 Structured Judgement Reviews were recorded in Quarter 4 2025/26, with the majority of reviews reflecting good or excellent care. Five reviews recorded an overall care score of 2. Full detail is contained within the report.	Information
3. Key learning themes relate to timely recognition and escalation of deterioration, clinical monitoring and senior review, delays in access to treatment or specialist input, documentation and handover, communication with patients and families, and care coordination for complex or frail patients. Several reviews highlighted the impact of wider system pressures, including prolonged waits in ED, outlier ward care, delayed transfers and challenges in maintaining continuity of review for patients awaiting discharge or managed outside the usual specialty area.	Information
4. Following the internal audit of the Mortality Framework, an improvement plan is in place to strengthen the quality, consistency and assurance of Structured Judgement Reviews, including use of the SJR tool, action tracking, reviewer training and quality assurance processes.	Assurance
5. The Committee is asked to receive the report and take assurance from the Learning from Deaths activity undertaken during Quarter 4 2025/26, including mortality screening, Structured Judgement Reviews, Medical	To note

Examiner escalations and specialist mortality review processes. The Committee is also asked to note the key learning themes identified and the improvement actions being taken through the Mortality Framework Improvement Plan to strengthen the quality, consistency and assurance of the review process.	
---	--

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

1. Summary

This report provides an update on Learning from Deaths activity during Quarter 4 2025/26, including Structured Judgement Review (SJR) outcomes, mortality screening, Medical Examiner escalations, mortality indicators, and learning identified through specialist mortality review processes.

During Quarter 4 2025/26, 176 SJRs were completed. The majority of reviews identified care as good or excellent, with 81 cases scoring overall care as good and 66 as excellent. Five cases recorded an overall care score of 2 (poor care).

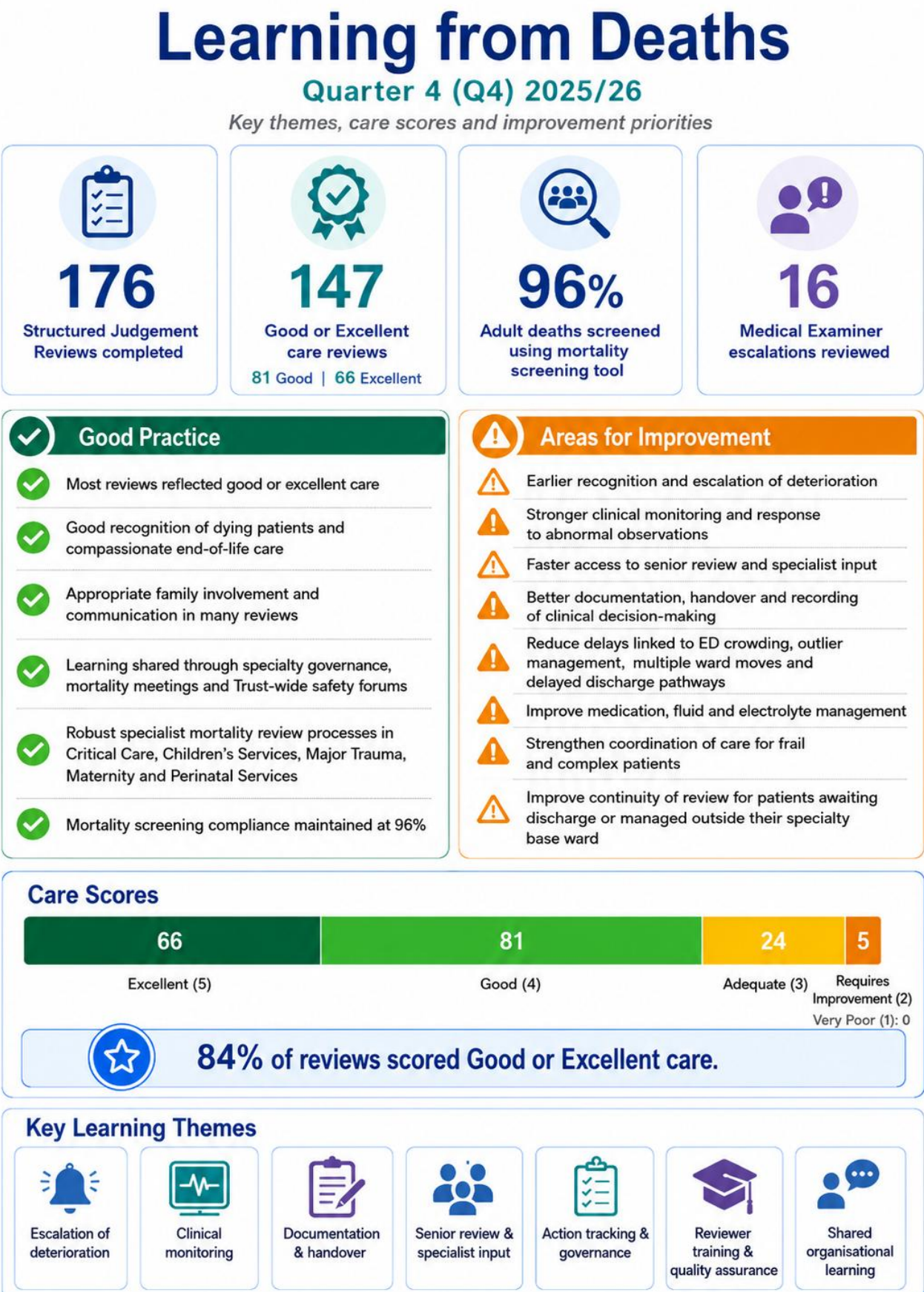
The reviews scoring overall care as 2 identified recurring themes relating to recognition and escalation of deterioration, timely access to senior or specialist review, delays in treatment or re-review, and gaps in clinical monitoring. Issues included delayed escalation to Critical Care outreach, delay in medical review, delays in observations, prolonged ED stay, and missed opportunities to prescribe appropriate treatment. These cases have been managed through the Trust Incident Reporting Process and a learning response is being conducted.

Across the wider Q4 SJR cohort, key learning themes related to clinical monitoring, documentation and handover, medication and fluid management, timely access to treatment or specialist input, and coordination of care for complex or frail patients. Several reviews also highlighted the impact of system pressures, including prolonged waits in ED, outlier ward care, delayed transfers, multiple ward moves and reduced continuity of review for patients awaiting discharge. While many cases reflected appropriate care in the context of advanced illness, frailty or multimorbidity, the reviews identified opportunities to strengthen escalation, senior review, communication with families and documentation of clinical decision-making.

The report provides assurance that learning from adult, paediatric, Emergency Department, Critical Care, Major Trauma, maternity and perinatal mortality review processes is being identified, shared and acted upon through established governance arrangements.

Actions arising from mortality reviews include strengthened communication with clinical teams, reinforcement of documentation and escalation expectations, specialty-specific

learning through mortality and morbidity meetings, and ongoing monitoring of improvement actions through clinical governance processes.



2. Learning from Deaths

The NHS Learning from Deaths programme requires trusts to review deaths systematically, identify learning and improvement actions, and provide Board-level assurance that care quality and patient safety are continually improving. Learning from Deaths is central to national patient safety policy and the Care Quality Commission's assessment of organisational leadership and safety culture.

This report outlines the Trust's Learning from Deaths activity for Quarter 4 2025/26, including Structured Judgement Review outcomes, thematic learning, and actions taken. It provides assurance that deaths have been reviewed proportionately, learning has been identified and shared, and improvement actions are being tracked through established governance arrangements.

A total of 175 Structured Judgement Reviews (SJRs) were recorded in Quarter 4. Three patients were subject to more than one SJR linked to their NHS number, though the alternative SJRs were not recorded within this quarter.

Table 1: Structured Judgement Reviews in Q4 2025/26 by specialty

Acute Medicine	22
Breast and Reconstructive Breast Surgery	1
Cardiac Surgery	2
Cardiology	8
Clinical Haematology	8
Clinical Oncology	2
Colorectal Surgery	6
Cystic Fibrosis (Adults)	1
Elderly Medicine	15
Emergency General Surgery	5
Emergency Medicine (A&E)	9
Ear Nose and Throat (ENT)	1
Gastroenterology	3
General Medicine	5
Hepatology	9
Infection and Travel Medicine	2
Medical Oncology	3
Neurology	3
Neurosurgery	5
Orthopaedic Trauma	17
Pancreatic Surgery	1
Renal Services (Adult)	2
Respiratory Medicine	16
Stroke Services	20
Thoracic Surgery	3
Transplantation Surgery	4
Upper GI Surgery	1
Urology	2

Table 2: Structured Judgement Reviews in Q4 2025/26 by overall care score

Overall Care Score 1	0
Overall Care Score 2	5
Overall Care Score 3	24
Overall Care Score 4	81
Overall Care Score 5	66

Of the 5 SJRs completed with an overall care score of two, three patients were recorded as non-elective admissions, one was elective and one was not specified but was an admission via ED.

A full overview of each case is included in Table 3.

Section 2 - Table 3: Structured Judgement Reviews in Q4 2025/26 with an overall care score of 2 recorded

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 the review of deaths in Table 3

On review of themes associated with incidents reported for patients subject to an SJR, incident type generally follows patterns for most reported incidents trust wide (Pressure ulcer, medication, communication and falls). These incident types generally affect older, or chronically unwell patients who are less able to survive complications associated with these incident types.

There is also a notable theme around delays in care and delays in access to care. These cases are complicated and it can be hard to determine level of harm of a delay, however these incidents are documented and investigated due to the breakdown in established processes and workflows to prevent future harm.

Section 2 - Table 4: Structured Judgement Reviews in Q4 2025/26 with an overall care score of 3 recorded who also had a datix completed within Q4 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 the review of deaths in Table 4

There were 34 Structured Judgement Review records completed within Q4 2025/26 that received an overall care score of '3'. Of the patients assessed within those 24 reviews, nineteen patients also had incidents reported to datix within the same quarter.

Cross-reference of the Table 4 cases with the SJR records identified that, although incidents recorded on Datix often related to pressure ulcers, falls, medication, infection or communication, the SJR narratives identified broader learning around clinical review, escalation and system flow. Common themes included prolonged ED waits, outlier ward management, multiple ward moves, delayed routine medical or specialty review, documentation gaps, falls prevention, medication continuity, and timely recognition of deterioration. A number of reviews described care as broadly appropriate in the context of significant frailty, comorbidity or advanced disease, but identified opportunities to improve reliability of processes around monitoring, escalation, handover and care planning.

The cases with more significant learning included delayed surgical decision-making in a patient initially managed conservatively for diverticulitis, delayed or insufficient review for a patient managed as an outlier while medically fit for discharge, concerns around anticoagulation/medication absorption in the context of vomiting, hyperkalaemia management in renal impairment, and delayed antibiotics or under-recognition of sepsis severity. These themes align with the wider SJR problem-in-care data, particularly clinical monitoring, treatment and management planning, medication/fluids/electrolytes, and assessment or diagnosis.

Section 2 - Table 5: Problems in care leading to harm – as % of total SJRs

Type 1: Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)	7 (4% of SJRs)
Did the problem lead to harm? (Probably / Yes)	3 (1.7% of SJRs)
Type 2: Problem with medication / IV fluids / electrolytes / oxygen (other than anaesthetic)	10 (5.7% of SJRs)
Did the problem lead to harm? (Probably / Yes)	6 (3.4% of SJRs)
Type 3: Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)	9 (5.1% of SJRs)
Did the problem lead to harm? (Probably / Yes)	4 (2.3% of SJRs)
Type 4: Problem with infection management	3 (1.7% of SJRs)
Did the problem lead to harm? (Probably / Yes)	2 (1.1% of SJRs)
Type 5: Problem related to operation / invasive procedure (other than infection control)	2 (1.1% of SJRs)
Did the problem lead to harm? (Probably / Yes)	2 (1.1% of SJRs)
Type 6: Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)	9 (5.1% of SJRs)
Did the problem lead to harm? (Probably / Yes)	7 (4% of SJRs)
Type 7: Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR))	2 (1.1% of SJRs)
Did the problem lead to harm? (Probably / Yes)	0 (0% of SJRs)
Type 8: Problem of any other type not fitting the categories above	10 (5.7% of SJRs)
Did the problem lead to harm? (Probably / Yes)	3 (1.7% of SJRs)

Overall, the Q4 SJR findings demonstrate that most reviewed deaths involved good or excellent care, often in clinically complex patients with significant frailty, multimorbidity or advanced disease. Where learning was identified, it most commonly related to timely recognition and escalation of deterioration, clinical monitoring, documentation of decision-making, medication and fluid management, and coordination of care across specialties or care locations. System factors, including ED crowding, delayed admission, ward moves and outlier management, were recurrent contributors to reduced continuity of review and increased complexity in care delivery.

3. Learning from specialist areas

3.1 Children's Hospital

Leeds Children's Hospital has a dedicated child death review process for all deaths of children under 18 years. The Children's Hospital does not use the adult PPM+ mortality screening tool or Structured Judgement Review methodology, as SJR has not been validated for children. Instead, child deaths are reviewed through the established Child Death Review Meeting process, with cases identified by the treating team, relevant professionals invited, outcome forms completed, learning agreed, and feedback provided to families via the key worker. All child deaths in Leeds are reviewed by the Child Death Overview Panel, with neonatal deaths reviewed through the neonatal CDOP subgroup with maternity. Sudden unexpected deaths in infancy and childhood are investigated by a SUDIC paediatrician. Learning points are disseminated within Leeds Children's Hospital and relevant national reporting is completed, including MBRRACE for neonatal deaths under 28 days and specialty reporting where applicable.

3.2 Emergency Department

Learning from Emergency Department deaths contributes to the Trust's Learning from Deaths programme by identifying themes relating to diagnosis, escalation, and timely treatment that may have wider organisational relevance.

The Emergency Department reviews all deaths for consideration of a Structured Judgement Review (SJR). Many patients are managed under shared-care arrangements or present with conditions arising in the community rather than as a consequence of care provided within the Emergency Department.

3.3 Adult Critical Care

Critical Care is not routinely designated as the lead service for Structured Judgement Reviews (SJRs), as patients are often managed under shared-care arrangements involving multiple specialties.

A bi-monthly Mortality and Morbidity Meeting supports review of cases and identification of learning. During the reporting period, learning arising from SJRs related to communication processes, inter-specialty information sharing, and diagnostic review.

SJUH ICU for wards J53 and J81 recorded 51 deaths, with 24 having triggers on the Mortality Review Screening Tool. Seven SJRs were completed, plus an additional two reviewed that were carried out by another specialty.

Themes identified :

- Care generally good and collegiate between specialties; appropriate recognition of dying patients and palliation measures.
- Importance of reviewing critically unwell patients immediately prior to transfer between hospital sites to ensure there has been no change in clinical state that warrants further intervention (or delaying/cancelling transfer).
- Governance regarding advanced critical care practitioners undertaking interhospital transfer of patients between sites- this has now been paused unless no other viable options, in order to allow time for training.

- Importance of communication between home teams and critical care team and documentation of actions that have been undertaken in order to avoid misunderstanding/ensure appropriate follow-up actions.

LGI Critical Care (L02, L03, L04, L05, L06, L07) recorded 51 deaths, with 25 having triggered on the MST. 8 SJRs were performed (3 per month).

Summary of SJR's

- Two SJRs showed good care with no further investigation required. SJRs closed and uploaded
- Two SJRs were done in combination with Vascular Surgery team. No ICU issues highlighted. One of these was presented at the Vascular M+M.
- One case involved a missed cervical spine injury transferred from a local hospital (HRI). The missed diagnosis occurred prior to the patient arriving at LTHT and the care at LTHT was good. Nevertheless, the issue was highlighted on the SJR and was shared with the CD for Neurosurgery to be shared with Huddersfield if not already done.
- Two cases were discussed with Cardiology colleagues via M+M lead
 - One of these related to a femoral artery injury. The case was discussed as part of Cardiology M+M process and was felt to be a recognised complication with no other issues identified.
 - The other case involved a patient who suffered a liver rupture as part of CPR, probably from a mechanical CPR device. This case has now been presented at three M+M meetings (Cardiology, ICU, Anaesthesia) in order to raise awareness about the diagnosis and to help improve handover processes between Catheter labs, ICU and Anaesthesia.
- The final case was reviewed and found to have no deficits in care. However, the clinical staff involved requested updates regarding the cause of death as the patient's deterioration had occurred so quickly. Liaison with the Bradford Coroner's office has occurred twice (March 2026 and June 2026). The final report is still outstanding as it is a Forensic PM and histology is awaited. However, no issues with LTHT care were identified.

Summary of M+M

- M+M occurred in February 2026 at LGI site (bimonthly). The M+M was a combined speciality meeting between Critical Care, Neurosurgery and Trauma, with the Clinical Directors for both Neurosurgery and Trauma present at the meeting. The topic was ICP versus Early Trauma surgery and had presentations from both specialities, as well as case presentations from ICU.
- The meeting was very well attended as has led to further cross-speciality discussion. A "Key Points" document for patients with both Trauma and raised ICP is currently in development, with ICU and Trauma components complete and the Neurosurgery input awaited.

3.4 Major Trauma Centre

All major trauma deaths are subject to case record review.

16 deaths were identified. The importance of considering premorbid state was highlighted, in addition to the importance of recognising the dying patient.

3.5 Maternity and Perinatal

Perinatal

Following the launch of the national tool in 2018, Maternity services can demonstrate the application of the MBRRACE perinatal mortality review tool on cases of perinatal mortality (stillbirth, late pregnancy loss and neonatal death). Demonstration of full compliance with use of the PMRT is also one of the safety criteria for NHS Resolution Maternity incentive scheme (MIS).

During Q4 2025/26, the PMRT review group met seven times and reviewed 25 perinatal mortality cases, including three babies born and died at another Trust where antenatal care had been provided by LTHT. Prematurity remained a key theme: 5 babies were born at under 28 weeks' gestation and 11 cases were under 34 weeks. There were 7 term cases, 4 of which involved severe congenital cardiac or other severe congenital abnormalities. The main classifications of death included severe congenital/cardiac abnormalities, which accounted for 11 of the 17 babies who died at LTHT, and placental-related causes, which accounted for 7 of the 16 stillbirths at LTHT.

All 25 cases were graded using the PMRT grading framework. Most identified care issues were graded as B, meaning they were not considered to have affected the outcome. However, one case was graded C for care prior to death, where missed opportunities were identified in recognising threatened extreme preterm labour/chorioamnionitis and in providing perinatal optimisation. One case was graded D for care after death, relating to a serious communication failure between Trust Bereavement Services and the allocated funeral directors, which resulted in parents being unable to attend their baby's funeral despite this being their wish. Apologies were offered, and an investigation and process review are underway.

Key learning themes included the need to improve recognition and escalation in threatened preterm labour, chorioamnionitis and evolving maternal sepsis; ensure women's concerns are listened to and considered holistically; strengthen processes for Kleihauer testing following pregnancy loss; and improve compliance with clinical documentation such as partogram completion and bladder care in labour. Further learning related to ensuring appropriate site/pathway for care, including ambulance transfer pathways for babies requiring active resuscitation, availability and suitability of bereavement facilities, and consistent application of guidance for late bookers and repeat scans. Actions are being monitored through the PMRT action tracker, with themes escalated to relevant teams, Matrons, the LMNS, Maternity Safety Support Programme and partner organisations where required.

Parent feedback was received from 15 families and was central to the reviews. Families described examples of excellent, compassionate care from maternity, neonatal and bereavement teams, with several parents expressing gratitude for emotional and practical support. However, feedback also highlighted areas for improvement, including communication when breaking bad news, clarity of information, continuity and experience of community care, early burial arrangements, and ensuring families are cared for away from mothers and babies where possible following loss. The feedback has informed actions around bereavement pathway review, staff communication training, consideration of further SANDS or bespoke bereavement training, and wider sharing of learning across maternity

and neonatal services. The LTHT annual rolling stillbirth rate for March 2025 to February 2026 was reported as 4.16 per 1,000 births.

Maternity

A high-risk postnatal woman died at home approximately four months after delivery, following a pregnancy and postnatal course complicated by multiple risk factors and a subsequent pulmonary embolism.

This case highlights a series of missed opportunities across the antenatal and postnatal pathway in a patient with multiple, significant risk factors. Persistent and increasing proteinuria throughout pregnancy was not fully explored, representing a missed opportunity to consider nephrotic syndrome and seek early specialist input. This may have contributed to an underestimation of thrombotic risk and influenced decisions around thromboprophylaxis. In addition, there were gaps in core processes including timely referral to the placental localisation clinic and incomplete documentation of antenatal VTE risk assessment, LMWH education, and patient adherence. Collectively, these factors suggest that risk was not consistently recognised, synthesised, or escalated within a coordinated multidisciplinary plan.

Postnatally, learning centres on the management of a very high-risk patient following major surgery. Although routine postnatal assessments were documented as appropriate, the overall VTE risk may not have been sufficiently mitigated. Earlier symptoms suggestive of thrombosis were not fully investigated in the context of known limitations of imaging, and opportunities for repeat imaging or escalation were not taken. When the patient re-presented with a pulmonary embolism, care was fragmented across specialties with poor communication and inaccurate information (including incorrect postnatal timing), contributing to potentially inappropriate clinical advice. There was insufficient clarity around responsibility for postnatal patients outside maternity settings, and consultant-level oversight was not consistently evident.

Overall, the case demonstrates how cumulative gaps in risk recognition, communication, and cross-specialty coordination can contribute to adverse outcomes. Key learning includes the need for clearer guidance and escalation pathways for significant proteinuria, robust and well-documented VTE risk assessment and patient education, improved systems for managing postnatal patients across services, and stronger multidisciplinary working with early senior involvement.

There was a review held for an additional maternal death at regional level, with documentation completed outside of the central quality team.

A woman with pre-existing COPD and complex pregnancy-related renal disease developed progressive nephrotic syndrome, renal impairment and severe cardiomyopathy during pregnancy, requiring transfer between multiple hospitals, preterm delivery at 26 weeks, and ongoing specialist care postpartum. Despite intensive treatment, she developed multi-organ failure and multiple embolic strokes, dying 7 weeks and 4 days after birth.

This case was discussed through a regional multidisciplinary maternal mortality review because care was provided across five hospitals and multiple specialist teams. The discussion identified an approximately eight-week delay in specialist renal assessment despite progressive proteinuria and deteriorating renal function, with limited access to obstetric renal expertise and uncertainty regarding referral pathways. The group felt there

were missed opportunities for earlier maternal medicine involvement, multidisciplinary review and coordinated management of worsening renal disease, which was considered a contributing factor to the subsequent cardiac deterioration. Concerns were also raised that significant clinical findings, including an abnormal echocardiogram showing severe cardiac dysfunction, did not trigger sufficient escalation at the earliest opportunity.

A recurring theme throughout the review was the fragmentation of care across multiple organisations, resulting in a lack of clear clinical ownership and coordination. The group concluded that involvement of several providers, unclear referral pathways between maternal medicine, nephrology and obstetric services, and inconsistent communication reduced opportunities for holistic oversight of a rapidly deteriorating patient. Further learning related to the need for ongoing obstetric involvement when pregnant or recently postnatal women are admitted outside maternity services, and the importance of robust discharge processes, as failure to communicate the postnatal discharge to community services resulted in missed opportunities for follow-up and support. The review recommended strengthening maternal medicine referral criteria, establishing clearer leadership and handover arrangements for complex cases, improving access to specialist multidisciplinary care, and ensuring effective communication and postnatal follow-up for women receiving care outside maternity settings.

4. Mortality Indicators

In Q3 2025-26 LTHT begun the implementation of the 'HED' (Healthcare Evaluation Data) System which had recently been procured as a replacement to Dr Foster.

Leeds Teaching Hospitals NHS Trust has access to [Healthcare Evaluation Data \(HED\)](#). A web-based analytical performance and benchmarking system.

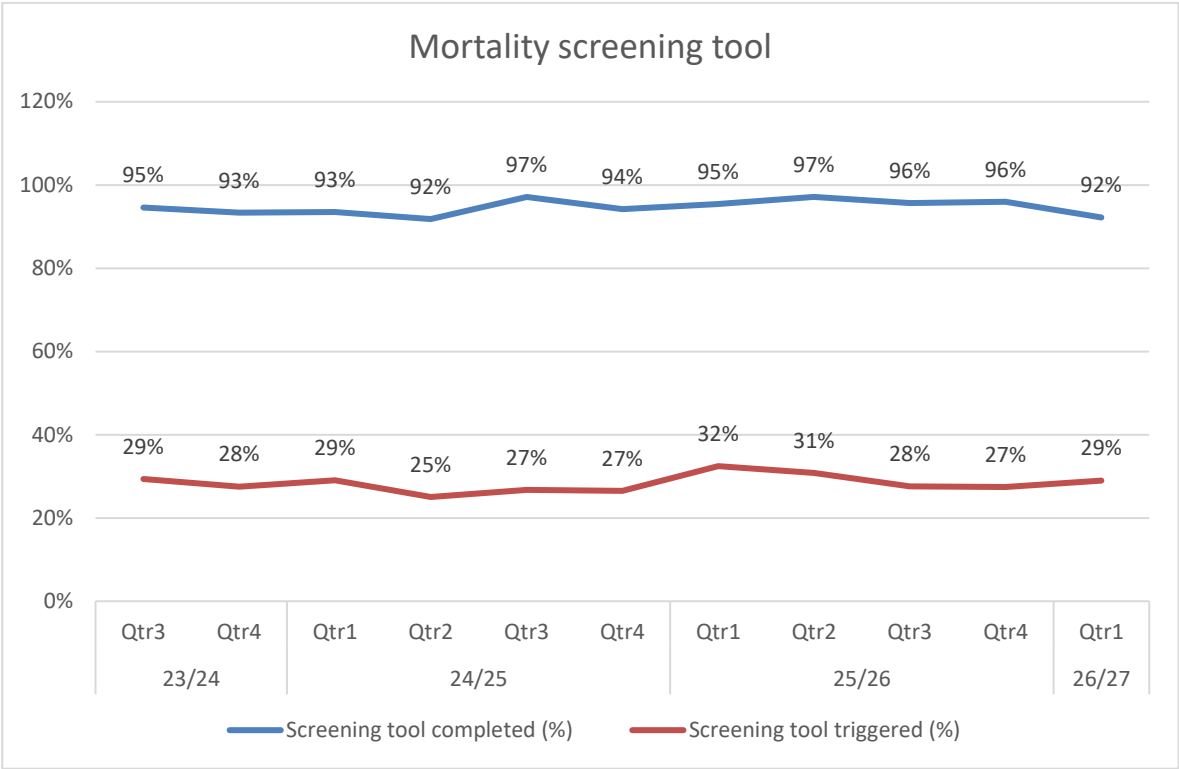
The HED suite of dashboards and modules allows healthcare organisations to utilise analytics which harness HES (Hospital Episode Statistics), national inpatient and outpatient and ONS (Office of National Statistics) Mortality data sets as well as many more to support the range of indicators across key performance areas, including Mortality, Clinical Quality & Safety, Operational Efficiency, A&E, Coding, Market Share and Consultant Revalidation.

For Mortality HED provides:

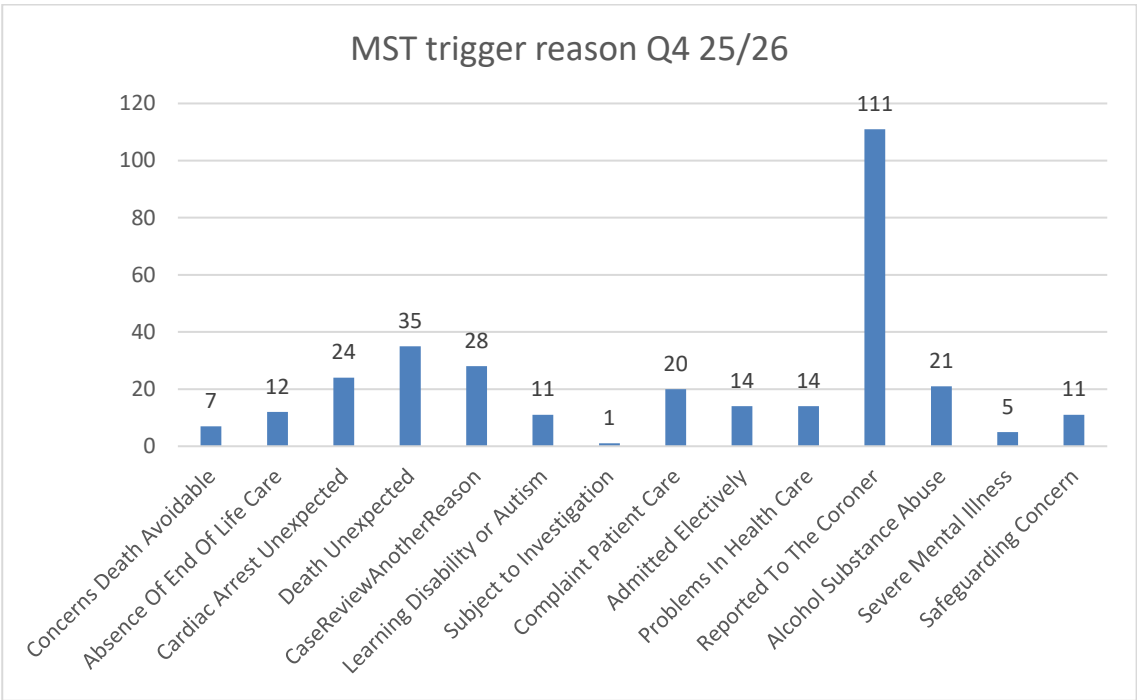
- Dashboard view of Mortality indicators with the ability to set up a customised view
- Mortality background including CCS groups, co-morbidities and other methodology
- HSMR module
- SHMI module(s)
- CUSUM module
- VLAD module
- SSMR & crude mortality
- Paediatric mortality
- Interpreting mortality data in funnel plots & using control limits
- Differences between mortality modules & approaches

4.1 Mortality Screening tool

4.1 - Figure 1: Mortality screening tool completion (Trust wide)



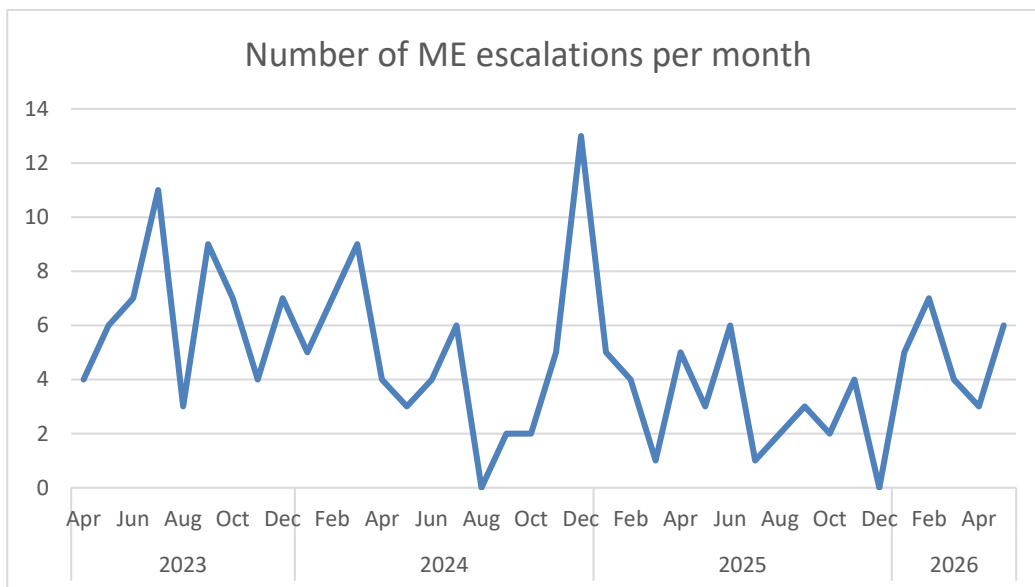
4.1 - Figure 2 Mortality screening tool trigger reason



In Q4 2025/26 96% of adult deaths had a mortality screening tool completed. Of the completed screening tools, 27% triggered. The commonest reason for triggering was a referral to the coroner – in the majority of cases the referral did not relate to concerns about clinical care.

Section 4.1 - Table 10 Number of Deaths Eligible for Screening

CSU	Number of Deaths Eligible for Screening	Number Screened	Number Triggered
Abdominal Medicine and Surgery	74	73	29
Cardio-Respiratory	142	135	38
Centre for Neurosciences	71	70	21
Chapel Allerton Hospital	2	1	1
Childrens	1	0	0
Head & Neck	1	1	0
Institute of Oncology	87	77	12
Specialty & Integrated Medicine	251	250	41
Trauma and Related Services	45	40	35
Urgent Care	40	38	10

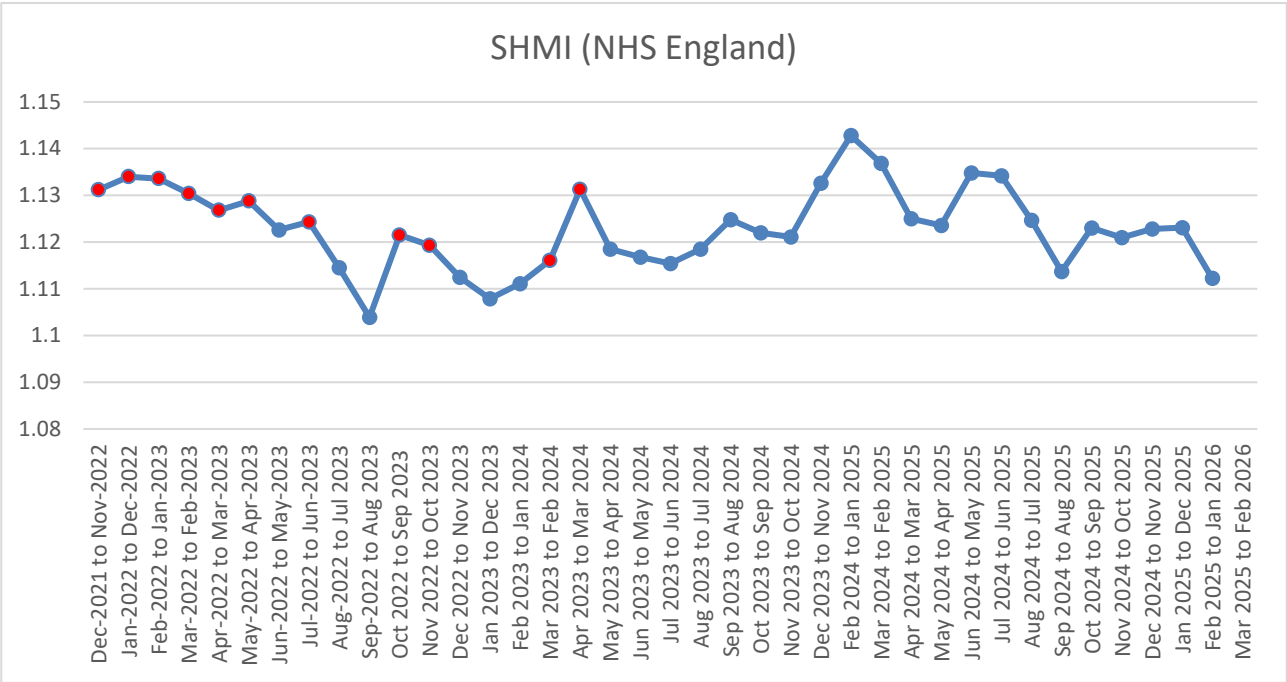
5 Medical examiner**5.1 - Figure 3 Number of ME escalations per month**

In Q4 25/26, there were 16 deaths escalated by the medical examiner service for review. One escalation related to safeguarding concerns in the community. Four related to failed discharge or transfer or issues in discharge planning. Four escalations related delays in assessment, diagnosis, treatment or recognising a deteriorating patient. In one escalation there was no concerns regarding care but the case was routinely escalated due to patient's learning disability.

5 of these deaths have had an SJR completed. Two SJRs had an overall care score of 3 (adequate care), two score 4 (good care) and one 5 (very good care).

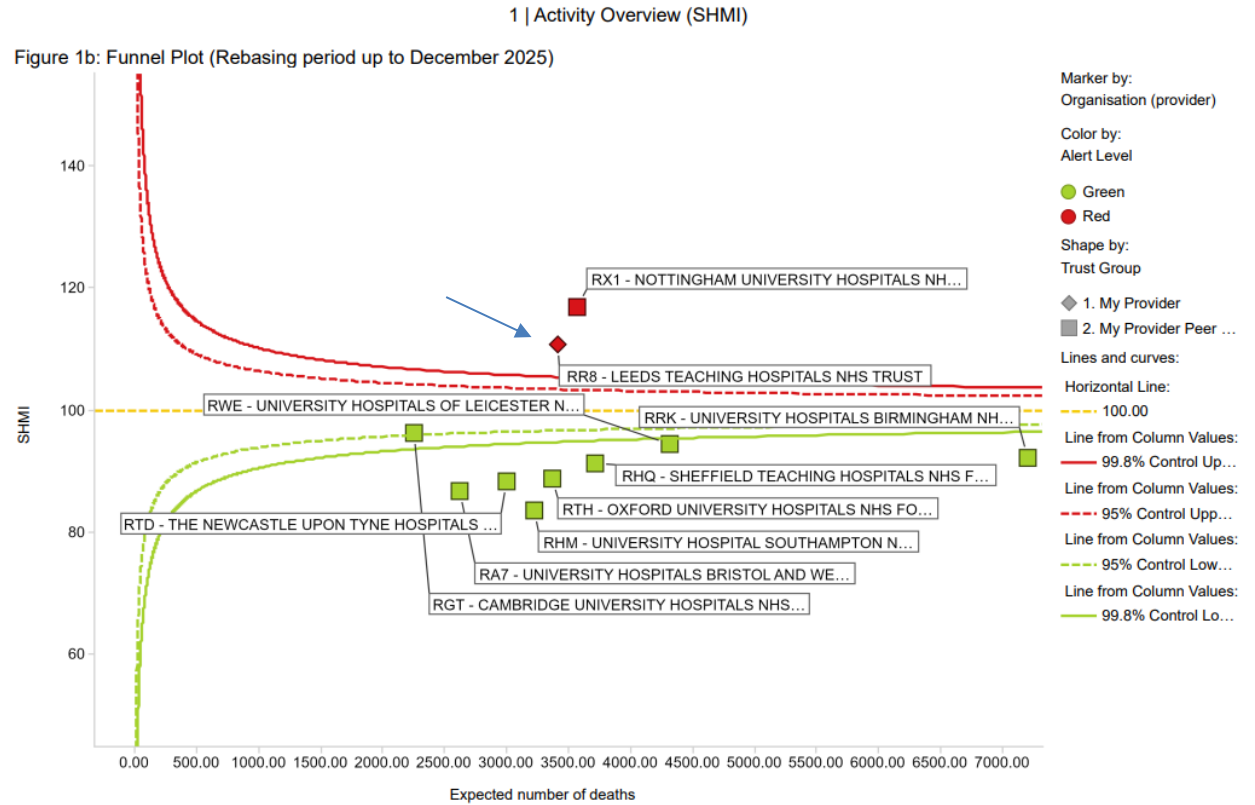
6 Mortality indicators

6.1 - Figure 4 SHMI (NHS England)



The SHMI value for February 2025 to January 2026 is 1.1123 (as expected).

6.2 - Figure 5 SHMI peer comparison (HES data)



The HES based SHMI provided by HED for LTHT for March 2025 to February 2026 is above the expected range. This will continue to be monitored by the Mortality Improvement Project Group to see if this is reflected in the SHMI figure provided by NHS England. The latest NHS England SHMI figure for February 2025 to January 2026 is within the expected range while the corresponding figure provided by HED with HES data shows SHMI value that is higher than expected. This discrepancy may reflect differences in the model and the data used.

7. Looking forward / improvement

During 2025/26, the Trust's Mortality Framework was subject to an internal audit review, with a particular focus on Structured Judgement Review processes. The final report was issued in February 2026 and gave an overall classification of "Needs Improvement", with two high-rated findings relating to SJR completion, documentation, action tracking, tool access and reviewer training.

The review recognised that the Trust has strengthened and formalised its Mortality Framework over recent years, with oversight through the Mortality Improvement Group and reporting through the quarterly Learning from Deaths report to the Quality Assurance Committee and Trust Board. However, it also identified variability in use of the SJR tool, local storage of reviews, evidence of discussion through specialty governance routes, and the way learning and actions are documented and monitored.

In response, a Mortality Framework Improvement Plan has been developed to strengthen consistency, quality and assurance across the review process. Key actions include mandating use of the SJR tool as the single source of review, improving monitoring and reconciliation of SJR allocation and completion, introducing quarterly quality assurance audits of completed SJRs, developing a standardised approach to outcome statements and action planning, and strengthening training and support for reviewers.

This improvement work will support future Learning from Deaths reporting by providing greater assurance on the quality of reviews, the completion and monitoring of actions, and the extent to which learning from deaths is shared, acted upon and embedded across clinical services.

The Mortality Framework Improvement Plan has made substantial progress, with a number of key actions now completed and embedded.

- User engagement work has been undertaken through a Trust-wide survey of SJR tool users, generating 39 responses that have informed improvements to the SJR process and tool.
- A revised monitoring and allocation process has been implemented, including the introduction of a new tracker to strengthen oversight of SJR allocation, completion and reporting.
- The Trust has formally mandated the use of the SJR Tool as the single authorised system for reviews, with system enhancements such as watermarking of reports implemented to support compliance.
- Significant progress has also been made in reviewing and standardising the selection and allocation of deaths for review, with revised criteria, processes and communications completed.

- Training requirements have been clarified, with an approach agreed that focuses on practical support, video-based learning and toolkits rather than formal mandatory training, reflecting feedback from reviewers.

Overall, 14 actions have been completed to date, establishing stronger governance, clearer processes and improved assurance arrangements. Remaining actions are largely focused on embedding these changes, enhancing system functionality, developing guidance and training resources, implementing quality assurance audits, and strengthening the escalation and action-tracking processes to ensure learning from deaths is consistently identified, acted upon and evidenced.

8. Quality and Performance Implications

This report provides assurance that the Trust continues to review deaths through established Learning from Deaths processes, including mortality screening, Structured Judgement Reviews, Medical Examiner escalations and specialist mortality review routes. The majority of Structured Judgement Reviews completed in Quarter 4 reflected good or excellent care, and adult mortality screening compliance remained high at 96%.

The report also identifies quality improvement themes with direct relevance to patient safety and care quality. These include recognition and escalation of deterioration, clinical monitoring, documentation and handover, diagnostic delay, communication between teams, adherence to specialist guidance, and care coordination for complex patients. These themes indicate areas where further improvement may reduce the risk of missed opportunities in care, improve clinical decision-making and support more consistent end-of-life care.

There are performance implications relating to the consistency and reliability of the mortality review process. The internal audit of the Mortality Framework identified variation in use of the Structured Judgement Review tool, evidence of discussion through local governance meetings, action planning, action tracking and reviewer training. This may affect the Trust's ability to demonstrate that learning from deaths is consistently identified, acted upon and embedded across services.

An improvement plan is in place to strengthen the quality and consistency of the process, including mandating use of the SJR tool, improving reconciliation of SJR allocation and completion, introducing quality assurance audits, strengthening reviewer training, and developing a standardised approach to outcome statements and action planning. This is expected to improve the quality of review outputs, strengthen governance assurance, and support clearer evidence of learning and improvement from deaths.

The Q4 findings indicate that the greatest opportunities for improvement relate less to isolated clinical decision-making and more to reliability of core processes across pathways. These include ensuring deteriorating patients are recognised and escalated promptly, maintaining senior oversight for outliers and patients awaiting discharge, improving documentation of clinical reasoning and communication with families, and ensuring consistent application of medication, fluid, falls and sepsis processes in complex or frail patients.

9. Financial Implications

There are no direct financial implications from this report.

10. Risk

The Quality Assurance Committee provides oversight of the Trust's mortality review and reporting framework. There was no material change to the risk appetite statement related to the level 2 risk categories set out on the front page of this report and the Trust continues to operate within the risk appetite for the level 1 risk category (clinical risk and regulatory risk) set by the Board.

11 Communication and Involvement

Specialty Mortality Leads and CSU Triumvirate teams have been sent the infographic for Q3 2025/26 and the detail of this report will be shared with them also. Areas that do not use SJR have been engaged with separately in order to identify learning.

12 Improving Health Equity

Several reviews involved patients with complex needs, frailty, cognitive impairment, communication needs or learning disability/autism considerations. The learning reinforces the importance of individualised care planning, family/carer involvement, reasonable adjustments, interpreter use where required, and clear documentation of discussions and decisions. These actions support equitable care by ensuring that patients with additional needs receive timely, coordinated and person-centred management.

13 Publication Under Freedom of Information Act

This paper has been made available under the Freedom of Information Act 2000.

14 Recommendation

Public Board is asked to receive the report and take assurance from the Learning from Deaths activity undertaken during Quarter 4 2025/26, including mortality screening, Structured Judgement Reviews, Medical Examiner escalations and specialist mortality review processes. Board are also asked to note the key learning themes identified and the improvement actions being taken through the Mortality Framework Improvement Plan to strengthen the quality, consistency and assurance of the review process.