The Leeds Teaching Hospitals NHS Trust

Annual Mortality and Learning from Deaths Report 2025/26

Trust Board
26 November 2026

Presented for:	Assurance
Presented by:	Elizabeth Garthwaite, Chief Medical Officer
Author:	Katie Middleton Tansley, Clinical Effectiveness and Compliance Manager Lucy Atkin, Head of Quality Governance
Previous Committees:	Reviewed by the Mortality Improvement Project Group and Clinical Effectiveness and Outcomes Group

Freedom of Information Act (FOIA) Exemption	☐**YES** (restricted from the FOIA) ☒**NO** (available to the public under the FOIA)

Link to Strategic Objective	Outcomes – being outstanding now and in the future.
Link to Provider Capability Assessment	Governance, risk and regulatory
Link to CQC Well-led Statement	Governance, Management and Sustainability
Regulatory Impact	Regulation 12: Safe care and treatment
	Regulation 17: Good governance

Key points	**Purpose**
1. This report provides annual assurance on the Trust's mortality processes and Learning from Deaths framework for 2025/26.	Assurance
2. NHS England Summary Hospital-level Mortality Indicator (SHMI) remained within the expected range during the year. Hospital Standardised Mortality Ratio (HSMR)/ Healthcare Evaluation Data (HED) outputs continued to require triangulation with coding review, clinical review and specialty-level intelligence, particularly following the transition from Dr Foster to HED.	Assurance
3. 726 adult Structured Judgement Reviews (SJRs) were recorded on the online SJR system during 2025/26. Most reviews described good or excellent care. Adult mortality screening compliance remained high, at approximately 95-97% across quarterly reporting.	Information
4. The themes identified in 2025/26 show significant continuity with those reported in 2024/25. Recurring areas include recognition and escalation of deterioration, timely senior review, sepsis management, medicines and fluid management, documentation, and the impact of patient flow pressures including prolonged Emergency Department stays and transfers between care settings. In 2025/26, the analysis also identified greater prominence of themes relating to communication with patients, families and carers, clarity of treatment ceilings	Information

and escalation decisions, and continuity of care for patients moving between specialties or locations. The recurrence of several themes across successive years reinforces the importance of linking mortality review findings to existing Trust improvement programmes and demonstrating the impact of actions taken.	
5. The 2025/26 internal audit of the Mortality Framework was classified as Needs Improvement, with two high-rated findings relating to SJR completion, documentation, action tracking, tool access and reviewer training. A Mortality Framework Improvement Plan has been developed and is being delivered and monitored.	Assurance
6. The mortality governance structure is being reviewed, with a potential move from the Mortality Improvement Group in its current form to a strengthened mortality project group model. This is intended to support delivery of the Mortality Framework Improvement Plan, improve specialty engagement and strengthen the route from mortality review into Learning from Deaths reporting and QSAG assurance.	Information

Risk Appetite Framework			
Level 1 Risk	**Level 2 Risks**	**(Risk Appetite Scale)**	**Impact**
Workforce Risk			
Operational Risk			
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
Financial Risk			
External Risk			

Mortality Annual Report 2025/26

Leeds Teaching Hospitals NHS Trust – at a glance

Monitoring mortality through national indicators, local review and learning from deaths to improve the safety and quality of patient care.

NHS Leeds Teaching Hospitals NHS Trust

Overall Trust mortality remained broadly within expected limits during 2025/26, with NHS England SHMI remaining within the expected range.

1 Key highlights

- High adult mortality screening compliance maintained
- **726** adult SJRs recorded during the year
- HED implemented as the Trust's mortality benchmarking and analytics system
- Internal audit of the Mortality Framework completed
- SHMI remained within the expected range

Medical Examiner and governance activity

- **19** family-raised significant concerns
- **20** concerns raised by Medical Examiners or staff
- **75** referrals to other governance processes

2 How do we learn from deaths?

- National indicators (SHMI / HSMR / HED)
- Local mortality screening
- Structured Judgement Reviews
- Medical Examiner scrutiny
- Specialist mortality review processes
- Patient safety review processes

→ **Learning and improvement** → Governance, assurance and action

These routes provide different perspectives and do not always follow a single linear pathway.

Mortality indicators are surveillance tools, not direct measures of quality of care.

3 Main learning themes

- Deterioration and escalation
- Documentation and handover
- Monitoring, medicines and fluids
- Patient flow, transfers and complex care coordination
- Communication with patients, families and carers

4 Where we need to improve

- Internal audit rated the Mortality Framework 'Needs Improvement'
- Greater consistency in SJR completion and documentation
- Stronger action tracking and follow-up of learning
- Clearer reviewer training and support arrangements

5 Improvement and assurance in 2025/26

- Mortality Framework Improvement Plan developed
- Use of the online SJR system increased
- Monitoring and oversight arrangements strengthened
- Links between mortality review, coding, governance and Learning from Deaths strengthened

6 Future direction for 2026/27

- Review the mortality governance structure
- Strengthen the mortality project group model
- Introduce a rolling cycle of engagement with specialty M&M meetings
- Feed learning more consistently into Learning from Deaths reporting and QSAG
- Increase visibility of HED mortality alerts and trends

1. Summary

Leeds Teaching Hospitals NHS Trust (the Trust) monitors mortality outcomes through a combination of national indicators, local mortality screening, Structured Judgement Reviews, Medical Examiner scrutiny, specialist mortality review processes and patient safety intelligence. Together, these routes provide assurance, identify learning themes and support improvement in the quality and safety of patient care.

Mortality review contributes to the NHS outcomes domains of preventing people from dying prematurely and treating and caring for people in a safe environment, protecting them from avoidable harm. Mortality indicators such as SHMI and HSMR are not direct measures of quality of care, but they are important surveillance tools. They help identify where further investigation, triangulation or clinical review may be required.

The Trust uses a staged and proportionate approach to reviewing mortality signals. High-level indicators are considered alongside coding, case-mix, clinical context, specialty data, national audit outputs, SJR findings, Medical Examiner escalations and relevant patient safety review processes. This helps determine whether further action is needed, such as focused coding review, case note review, thematic review, specialty discussion or a formal patient safety learning response.

The remainder of this report is structured in three parts. The first section summarises mortality indicators and review activity for 2025/26. The second section describes the learning, assurance and improvement themes identified through those routes. The final section considers the governance implications, limitations and proposed future direction for mortality oversight in 2026/27.

This report should also be read alongside the Trust's Quality Account 2025/26, which describes mortality review within the wider Patient Safety and Quality Strategy approach to insight, involvement and improvement. This includes strengthened mortality reviews, implementation of HED, and improved alignment between mortality review, patient safety learning and quality governance.

1.1 SHMI, HSMR and HED

The Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) compare observed number of deaths against risk-adjusted expected number of deaths. SHMI includes deaths in hospital and within 30 days of discharge across all diagnosis groups, while HSMR focuses on in-hospital deaths in selected diagnosis groups.

During 2025/26, the Trust ended its contract with Telstra Health UK for the Dr Foster system and implemented Healthcare Evaluation Data (HED). HED is an NHS-developed national benchmarking and performance analytics platform created by University Hospitals Birmingham. It provides monthly mortality indicators, clinical quality dashboards, access to multiple national datasets, automated mortality alerts, peer benchmarking and specialty-level insights to support CSU discussion and governance. HED provides web-based analytical and benchmarking dashboards across mortality, clinical quality and safety, coding, operational efficiency and other performance domains.

During 2025/26, colleagues across Quality Governance, Mortality and Analytical teams undertook training and onboarding, with further work required to define local mortality reporting methods, thresholds and escalation triggers.

The Trust's SHMI remained relatively stable during the year. Although it was initially categorised as higher than expected, it subsequently moved within the 'as expected' band. This change reflected widening of the statistical control limits used by NHS England to determine SHMI banding, rather than a marked reduction in the Trust's SHMI value. SHMI control limits are recalculated using national data and allow for variation between trusts, and therefore may change between reporting periods. The Q4 report noted that the latest NHS England SHMI for February 2025 to January 2026 was 1.1123 and within the expected range. Nationally 11 trusts were 'higher than expected', 99 'as expected' and 8 'lower than expected'.

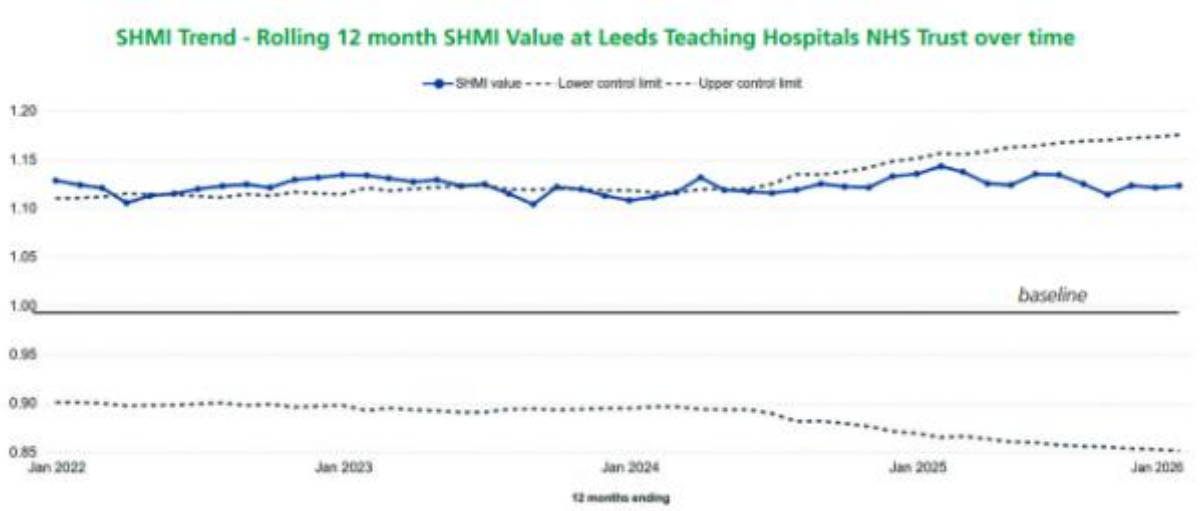
HES based SHMI provided by HED indicated a higher-than-expected position for March 2025 to February 2026, which differed from the NHS England SHMI. This discrepancy requires ongoing monitoring through the mortality project arrangements, with attention to differences in data source, methodology and timing.

Trust SHMI and HSMR

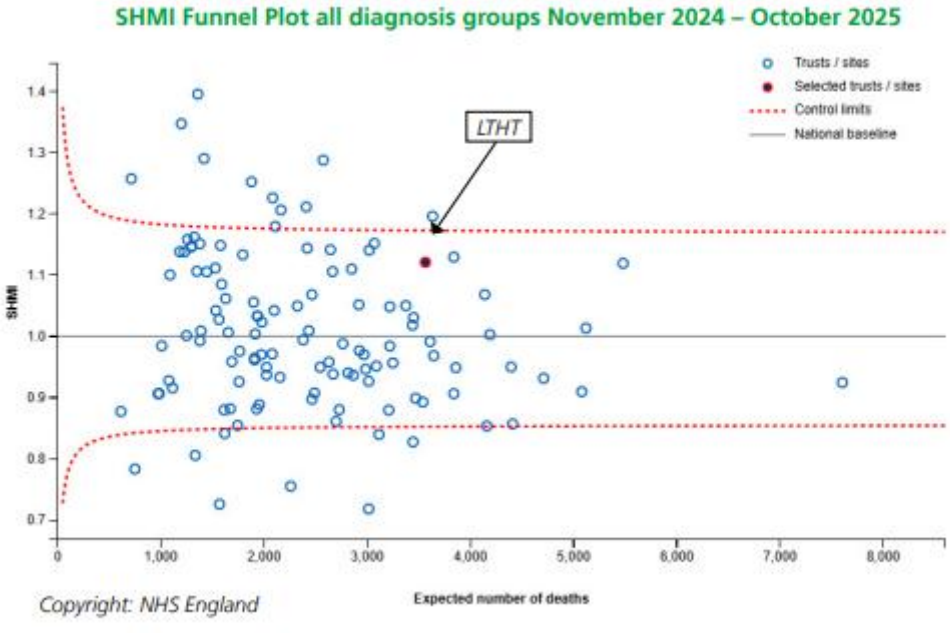
Trust level mortality, Nov-24 to Oct-25	Spells	Value	Observed Deaths	Expected Deaths	95% Confidence Interval
SHMI	102,320	1.121	4,000	3,565	0.8526-1.1729
HSMR	62,030	113.81	2254	1980.54	109.16-118.61

SHMI Indicator by rolling 12 month reporting period

Month of Publication	Reporting Period	Trust Rate	National Range
Apr-25	Dec-23-Nov-24	113.26	72-127
May-25	Jan-24-Dec-24	113.51	72-135
Jun-25	Feb-24-Jan-25	114.28	70-128
Jul-25	Mar-24-Feb-25	113.71	71-134
Aug-25	Apr-24-Mar-25	112.5	70-133
Sep-25	May-24-Apr-25	112.36	72-131
Oct-25	Jun-24-May-25	113.48	71-127
Nov-25	Jul-24-Jun-25	113.42	72-126
Dec-25	Aug-24-Jul-25	112.47	71-128
Jan-26	Sep-24-Aug-25	111.37	72-140
Feb-26	Oct-24-Sep-25	112.3	72-134
Mar-26	Nov-24-Oct-25	112.1	71-136



The Trust's SHMI did not necessarily improve when it moved from "higher than expected" to "as expected". The statistical control limits used to determine SHMI banding can change between publications because they are recalculated using the underlying national data and allow for over-dispersion between trusts. In this period, the widening of the control limits meant that the Trust's relatively stable SHMI subsequently fell within the "as expected" band.



Clinical coding continued to be a key component of mortality interpretation during 2025/26. The Quality Account reports continued collaboration between Clinical Coding and the Mortality Improvement Group, including identification of coding errors and implementation of improvements. The mandatory Data Security and Protection Toolkit (DSPT) audit demonstrated achievement of required standards, with primary diagnosis accuracy at 91.3%, secondary diagnosis at 86.1%, primary procedure at 95.8% and secondary procedure at 90.7%. These data quality controls are important because mortality indicators are sensitive to coding accuracy, case mix, admission method and documentation quality.

2. Governance and Reporting Structure

During 2025/26, the Mortality Improvement Group (MIG) remained the Trust-level strategic group for mortality oversight, authorised by the Clinical Effectiveness and Outcomes Group to lead, support and report on activities related to mortality. The group reviewed mortality data, mortality review processes, coding information, Medical Examiner escalations, specialty presentations and Learning from Deaths reporting.

The Terms of Reference state that MIG should meet bi-monthly. During 2025/26, five meetings were evidenced within the papers provided: 20 May 2025, 17 June 2025, 21 October 2025, 25 November 2025 and 10 February 2026. This did not represent an even bi-monthly cadence, with a prolonged gap between June and October 2025.This should be acknowledged as a limitation in year. However, the Mortality Improvement Project Group continued to take place in between planned MIG meetings.

Where meetings were held, minutes demonstrate continued oversight of mortality indicators, clinical coding KPIs, SJR allocation and completion, specialty mortality presentations, Learning from Deaths reports and the Mortality Framework Improvement Plan.

3. Learning from Deaths Framework and Review Process

The Trust's Learning from Deaths process uses mortality screening, Structured Judgement Review, Medical Examiner escalation, incident review routes and specialist mortality review processes to identify good practice, areas for improvement and required actions. Not all deaths are reviewed using adult SJR methodology. Alternative review processes are used for children, maternity and perinatal deaths, major trauma and other agreed specialist pathways.

3.1 Mortality Screening

Mortality screening compliance remained high during 2025/26. Quarterly reporting indicated adult mortality screening tool completion of approximately 95% in Q1, 97% in Q2, 96% in Q3 and 96% in Q4. The most common trigger continued to be referral to the Coroner; in most cases this did not relate to concerns about clinical care.

Quarter	Adult MST completion	Completed MSTs triggering further review
Q1	95%	33%
Q2	97%	31%
Q3	96%	27%
Q4	96%	28%

3.2 Medical Examiner Service

The Medical Examiner Service continued to provide independent scrutiny of deaths and an important route for identifying concerns, family questions and cases requiring further clinical governance review. Since the Medical Examiner system became statutory in England and Wales, the Leeds Medical Examiner office has scrutinised 100% of all non-coronial deaths across primary and secondary care, including adult, neonatal and paediatric deaths. Where concerns are identified, the Medical Examiner may recommend review through the most

appropriate governance process, including Structured Judgement Review, safeguarding, M&M discussion or patient safety review.

During 2025/26, Medical Examiner scrutiny identified 19 deaths where significant concerns were raised by bereaved families or carers, 20 where significant concerns were raised by the Medical Examiner or staff, one death relating to learning disability or severe mental illness, two deaths in areas where people are not expected to die, and seven deaths where learning would inform existing or planned improvement work. A further 75 deaths were referred to other clinical governance processes, and 15 patient safety incidents were notified as a result of Medical Examiner scrutiny.

Of the above deaths, 30 cases were escalated by the Medical Examiner service to the Quality Governance team during 2025/26: five in Q1, three in Q2, six in Q3 and sixteen in Q4.

Themes included patients with disability needs, falls, frequency of observations, possible missed opportunities for earlier intervention, safeguarding concerns in the community, failed discharge or transfer processes, discharge planning, delays in assessment, diagnosis or treatment, and concerns relating to recognition of deterioration. Where appropriate, escalations resulted in SJR completion or progression through local governance and patient safety routes.

3.3 Structured Judgement Reviews

Across 2025/26, 726 adult SJRs were recorded on the online SJR system. The majority of reviews reflected good or excellent care. Across the year, 582 reviews were scored as good or excellent, representing approximately 80% of completed SJRs. No reviews were identified in the quarterly reports as scoring 1 (very poor care).

Quarter	SJR Total	Excellent (5)	Good (4)	Adequate (3)	Poor (2)	Very Poor (1)
Q1	191	59 (30.9%)	90 (47.1%)	34 (17.8%)	6 (3.1%)	0 (0%)
Q2	184	79 (42.9%)	74 (40.2%)	20 (10.9%)	11 (6.0%)	0 (0%)
Q3	175	62 (35.4%)	71 (40.6%)	33 (18.9%)	9 (5.1%)	0 (0%)
Q4	176	66 (37.5%)	81 (46.0%)	24 (13.6%)	5 (2.8%)	0 (0%)
Annual Total	**726**	**266 (36.6%)**	**316 (43.5%)**	**111 (15.3%)**	**31 (4.3%)**	**0 (0%)**

Outcome	Number
No problems identified	582
Problems identified	142
Not recorded on SJR	2

Of the 726 SJRs completed during 2025/26, 142 (19.6%) recorded one or more problems in care and 582 (80.2%) recorded no problems. The response was not recorded in two reviews (0.3%).

3.4 Deaths Escalated through patient safety processes

Deaths with potential patient safety concerns were escalated through the Trust's potential patient safety incident processes and considered at the Weekly Quality Meeting to agree the most appropriate learning response. In Q1, two deaths were escalated through this route. In Q2, four deaths were escalated. In Q3 and Q4 the quarterly reports describe specific cases managed through Patient Safety Incident Investigation, Patient Safety Rapid Review, After Action Review, Patient Safety Learning Review or specialty governance routes rather than presenting a directly comparable annual trend table.

4 Learning, Improvement and Assurance Themes

The 2025/26 quarterly reports show consistent learning themes across SJRs, Medical Examiner escalations, patient safety learning responses and specialist mortality review processes. Many reviews identified good or excellent care delivered to frail, complex or critically unwell patients, often with appropriate recognition of dying, compassionate end-of-life care and family involvement. Where learning was identified, it most often related to reliability of core clinical and system processes.

4.1 Cross-cutting themes for improvement

- Timely recognition and escalation of deterioration, including use of NEWS, observation frequency and appropriate escalation to senior clinicians or Critical Care outreach.
- Clinical monitoring and timely re-review, particularly where patients had prolonged ED stays, were outliers, or were awaiting discharge/transfer.
- Access to timely senior or specialist review, including specialist input for complex surgical, medical, neurological and maternity cases.
- Documentation and handover, including clarity of clinical reasoning, escalation decisions, family communication, treatment ceilings and inter-specialty actions.
- Medication, fluid and electrolyte management, including anticoagulation, antibiotics, hyperkalaemia, fluids during renal impairment and medication continuity across care locations.
- Sepsis and infection management, including timely antibiotics, under-recognition of severity and escalation of suspected sepsis.
- Patient flow and system pressures, including prolonged waits in ED, delayed admission, multiple ward moves, outlier ward management, delayed transfers and reduced continuity of review.
- Communication with patients, families and carers, including accessible communication, use of interpreters, reasonable adjustments and clarity when discussing prognosis or treatment decisions.

The themes identified through mortality review are consistent with wider Trust quality and patient safety improvement priorities described in the Quality Account. In particular, learning relating to deterioration, sepsis, escalation, medicines, healthcare associated infection, VTE prevention, patient flow and communication with families aligns with active Trust improvement programmes and collaboratives. This provides an opportunity in 2026/27 to strengthen the link between mortality review outputs and existing improvement routes, so that themes identified through SJRs, Medical Examiner scrutiny and specialist review processes are translated into measurable improvement work rather than remaining as narrative learning.

4.2 Good practice themes

- Strong multidisciplinary working and collaborative decision-making between specialties.
- Early senior review and prompt involvement of specialist teams in many cases.
- Compassionate end-of-life care, including recognition of dying, palliative care involvement and sensitive bereavement support.
- Good communication with families and carers, including clear discussions around ceilings of care and treatment decisions.
- Robust specialist review processes in areas such as Critical Care, Children's Services, Major Trauma, Maternity and Perinatal Services.

While 142 reviews identified opportunities for learning or care-process improvement, no reviews completed during 2025/26 were scored as very poor care (score 1), and over 80% of reviews judged care to be good or excellent.

5 Specialist mortality review processes

The Trust recognises that not all deaths are best reviewed through a single standardised process. Alongside mortality screening and Structured Judgement Review, specialist review arrangements are in place for patient groups and services including neonatal and perinatal care, child death review, critical care, learning disability mortality review, major trauma and specialty-level mortality meetings. These routes allow deaths to be considered by the clinicians and multidisciplinary teams with the most appropriate expertise, while supporting Trust-wide learning when their outputs are captured consistently.

During 2025/26, the Trust received examples of detailed specialist mortality review practice, including structured neonatal review, critical care review and tracking processes, and the Child Death Review Meeting process. These examples demonstrated that there is significant learning and assurance generated through local and specialist routes. However, the annual report should be read as a summary of the Trust’s overall mortality framework rather than a complete account of each individual specialist process. The level of detail available through quarterly reporting has varied, and this has highlighted the need for a more systematic approach to capturing the outputs of specialist mortality review processes. Strengthening this link will support clearer Trust-wide reporting of themes, actions, impact and escalation through Learning from Deaths reporting and onward to QSAG.

The Quality Account also demonstrates that mortality-related learning is generated through a wider range of specialist and national audit routes. These include Hospital Associated Thrombosis specialist reviews, NCEPOD participation, PICANet, National Neonatal Audit Programme, National Perinatal Mortality Review Tool, National Major Trauma Registry, National Cardiac Audit Programme, National Emergency Laparotomy Audit and other national clinical audit datasets. These routes provide important specialty-specific intelligence and benchmarking, but their outputs are not yet consistently drawn together into a single Trust-wide mortality learning view. This should be considered as part of the proposed 2026/27 specialty M&M engagement programme.

6 Mortality Improvement Group work programme and specialty review

The MIG work programme was used to bring specialty and cohort mortality information together with national mortality indicators, clinical coding intelligence and local review findings. During 2025/26, the group received updates on neonatal mortality, neurosurgery and intracranial/TARN data, congenital cardiology/cardiac circulatory anomalies, PICANet, LeDeR, gastroenterology, critical care, child death review processes, coding KPIs, SJR allocation and completion, and the implementation of HED.

Several specialty discussions provided useful assurance and learning. Neurosurgery data was reported as stable and within national range, with a good SJR structure and all deaths discussed in monthly governance. Congenital cardiology review identified the need for careful monitoring of small numbers and proposed flagging/validation of paediatric cardiac deaths. Gastroenterology reported stable and improving mortality trends, with SJR findings not identifying systemic concerns but highlighting rapid antibiotics in sepsis and occasional delays in investigation.

7 Internal audit and Mortality Framework Improvement Plan

During 2025/26, the Trust's Mortality Framework was subject to internal audit review, with a focus on Structured Judgement Reviews. The final report was issued in February 2026 and classified the framework as Needs Improvement. Two high-rated findings were identified: one relating to SJR completion, documentation, governance discussion and action tracking, and one relating to SJR tool access and reviewer training.

The Quality Account notes that the audit highlighted variability in SJR tool usage and access to training, alongside the need to strengthen discussion and follow-up of learning and improvement actions. It also recognised examples of good practice, including specialty-level action tracking, embedded mortality governance structures and established arrangements for screening deaths.

The audit recognised that the Trust had strengthened and formalised its Mortality Framework over recent years, with oversight through MIG and reporting through quarterly Learning from Deaths reports. However, it identified variability in use of the SJR tool, local storage of reviews, evidence of discussion through specialty M&M and governance meetings, action planning, action tracking and reviewer training.

In response, a Mortality Framework Improvement Plan was initiated in March 2026. The plan aims to ensure the Trust can demonstrate sustained learning from deaths, improved quality of care and effective Board assurance through a consistent, transparent and robust mortality review system.

The Q4 Learning from Deaths report stated that substantial progress had been made, including a Trust-wide SJR user survey with 39 responses, implementation of a revised monitoring and allocation process, introduction of a new tracker, formal mandating of the SJR tool, system watermarking, revised selection/allocation criteria, and clarification of training requirements. Fourteen actions were reported as completed at that point, with remaining work focused on embedding, guidance, training resources, quality assurance audit and escalation/action tracking.

8 Key Achievements in 2025/2026

Across 2025/26, the Trust maintained high adult mortality screening compliance, strengthened use of the online SJR system, and implemented HED as the replacement mortality and benchmarking system following the end of the Dr Foster contract. 726 adult SJRs were recorded during the year, improving visibility of review activity and providing a stronger basis for future mortality analysis, benchmarking and specialty-level interrogation.

Quarterly Learning from Deaths reporting continued to provide structured assurance across adult, paediatric, Emergency Department, Critical Care, Major Trauma, maternity and perinatal mortality review processes. Recurring themes related to deterioration and escalation, documentation, monitoring, medicines, patient flow and complex care coordination, while the internal audit led to a detailed improvement plan to strengthen consistency, quality, action tracking and evidence of learning.

The Trust also recognised examples of strong specialty mortality review practice, including Critical Care SJR tracking and M&M arrangements, Neurosurgery SJR governance, and established statutory or specialist review processes for children and perinatal deaths. These examples demonstrate that there is valuable learning and assurance being generated within specialist areas, while also highlighting the need to capture this more consistently through Trust-wide Learning from Deaths reporting.

9 Key Limitations in 2025/2026

The key limitation for 2025/26 is the Trust's ability to evidence mortality review activity consistently across all routes. Screening compliance remained high and use of the online SJR system increased, but the Trust is not yet able to demonstrate that all applicable SJRs are completed, recorded, discussed, actioned and tracked through a consistent process. Variation also remains in how specialties record learning, agree actions and evidence impact.

The internal audit of the Mortality Framework highlighted that the Trust's ability to evidence learning from deaths is limited where actions are not consistently documented, where SJR discussion is not clearly recorded in specialty M&M or governance meetings, and where reviewer training and access controls are not yet fully embedded. This does not mean that learning is not taking place, but it does mean that the Trust cannot always demonstrate this in a clear, consistent and auditable way.

Learning from specialist mortality review processes is not yet brought together consistently at Trust level. Strong review arrangements exist in neonatal care, children's services, critical care, major trauma and other specialty M&M processes, but their outputs are not captured in a standardised way through Learning from Deaths reporting. This can make Trust-wide assurance appear fragmented where detailed specialty information is available for some services or quarters but not others.

The transition from Dr Foster to HED has also created a period of data and reporting change. HED provides an opportunity to improve mortality benchmarking, routine outputs and specialty-level analysis, but the Trust is still developing familiarity with the system, including access, interpretation, triangulation with coding information and use of outputs for clinical review. As a result, some mortality indicators should continue to be interpreted with caution and alongside local clinical intelligence, coding review, specialty discussion and SJR findings.

Overall, the key limitation for 2025/26 is not the absence of mortality review activity, but the need to strengthen how that activity is standardised, evidenced and connected across the Trust. The 2026/27 improvement work will therefore focus on clearer governance, consistent SJR processes, better action tracking, strengthened support for reviewers, and a more systematic route for capturing learning from specialty mortality processes into Trust-wide reporting and QSAG assurance.

10 Future direction for 2026/2027

The year highlighted limitations in the current governance model, including meeting cadence, specialty engagement, SJR capture, action tracking and consistent evidence of improvement. These issues will shape the future direction for mortality oversight in 2026/27.

The proposed model would support a more focused, action-orientated approach to implementation of the Mortality Framework Improvement Plan, with clearer oversight of mortality review processes and stronger evidence that learning is translated into improvement.

A key area of development for 2026/27 will be the introduction of a planned cycle of engagement with specialty mortality and morbidity meetings. This will help the Trust understand how specialties review deaths, identify learning, record actions, monitor completion and share improvement, without duplicating local mortality processes.

Learning from these specialty reviews should feed into the Trust's Learning from Deaths reporting cycle, helping reporting move beyond activity measures and towards clearer evidence of themes, actions, impact and improvement. This will support more meaningful escalation and assurance through the Patient Safety and Quality Sub-Committee and wider quality governance structure.

The future mortality governance model should align with the wider Quality Account priorities for 2026/27, particularly the continued embedding of PSIRF, strengthening of improvement collaboratives, use of national indicators and standards to benchmark outcomes, and improved methods for sharing learning. The proposed move towards a strengthened mortality project group model and planned cycle of specialty M&M engagement should therefore be framed as part of the Trust’s wider approach to insight, involvement and improvement, rather than as a standalone mortality workstream.

11 Quality and Performance Implications

This report provides assurance that the Trust continued to review deaths through established Learning from Deaths processes during 2025/26, with high adult mortality screening compliance and most recorded SJRs reflecting good or excellent care. The main quality and performance implication is the need to strengthen consistent evidence of SJR

completion, governance discussion, action planning, action tracking, reviewer support and implementation of learning.

12 Financial Implications

There are no direct financial proposals within this report. Implementation of HED has replaced the previous Dr Foster subscription. Some future improvements to mortality review systems, data functionality, training and governance support may require resource consideration if they cannot be delivered within existing arrangements.

13 Risk

The Trust continues to operate a mortality review and reporting framework, however the internal audit findings identify risks relating to consistency, evidence and assurance. If SJR completion, action tracking and evidence of learning are not strengthened, there is a risk that learning from deaths is not consistently captured, acted upon or demonstrated to the Board, regulators, patients and families.

The Mortality Framework Improvement Plan is the primary mitigation for these risks and is supported by revised governance arrangements, HED development, specialty engagement and stronger links with QSAG reporting.

14 Communication and Involvement

This report has been developed from quarterly Learning from Deaths reports, MIG minutes, the Mortality Framework Improvement Plan, the internal audit report and specialty review information provided during 2025/26. Engagement has taken place through quarterly reporting, SJR improvement work and specific specialty discussions with Specialty Mortality Leads, CSU Triumvirate teams and relevant governance leads.

15 Impact on Equality & Health Inequalities

Learning from Deaths reporting in 2025/26 included themes relevant to health equity, including communication with patients and families where English is not a first language, disability needs, learning disability and autism considerations, reasonable adjustments, frailty, cognitive impairment, complex care coordination and postnatal/maternity pathways across multiple services. The findings reinforce the importance of individualised care planning, family/carer involvement, interpreter use where required, and clear documentation of discussions and decisions.

16 Publication Under Freedom of Information Act

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

17 Recommendation

The Board is asked to receive the annual assurance on the Trust's Learning from Deaths framework for 2025/26 and note the proposed future direction for mortality governance,

including a strengthened mortality project group model and planned engagement with specialty mortality and morbidity meetings.

18 Supporting Information

Documents used to prepare this draft include the 2024/25 annual mortality and Learning from Deaths report; Q1-Q4 2025/26 Learning from Deaths reports; MIG minutes from 2025/26; Mortality Improvement Group Terms of Reference; Mortality Framework internal audit report; and Mortality Framework Improvement Plan.