North West London
Acute Provider Collaborative

NWL APC BOARD IN COMMON - READING ROOM

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20 January 2026

11:00 GMT Europe/London

AGENDA

4.1.3 LEARNING FROM DEATHS Q2 - INDIVIDUAL TRUST REPORTS

REFERENCES

Only PDFs are attached

- 4.1.3 A - THH Learning from Deaths Report Q2 25.26 v2.pdf
- 4.1.3 B - CWFT Learning from Deaths Report Q2 25.26 v2.pdf
- 4.1.3 C - ICHT Learning from Death Quarter Two 2025-26 v4.pdf
- 4.1.3 D - LNWH Learning from Deaths Report Q2 25.26 v2.pdf

NWL Acute Provider Collaborative Board in Common (Public)
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The Hillingdon Hospital NHS Foundation Trust Learning from Deaths Report Quarter 2

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Purpose of report (for decision, discussion or noting)

Purpose: Information or for noting only

This report presents the data from the Learning from Deaths programme for Quarter Two (Q2) of 2025/26 for information. It is a statutory requirement for Trusts to present this information to their boards. This is achieved through presentation of this report to the Hillingdon Hospital Quality & Safety Committee and the submission of overarching learning drawn from across the four NWL acute provider collaborative (APC) trusts to the APC Quality Committee and Board in common.

Report history

Outline committees or meetings where this item has been considered before being presented to this meeting.

Trust Quality and Safety Executive Committee	**Quality and Safety Committee**	**Mortality Surveillance Group**
10/11/2025	09/12/2025	19/11/2025
To be presented	To be presented	To be presented

Executive summary and key messages

- Since HSMR+ was introduced, Hillingdon have had HSMR consistently above 100, although still within expected statistical range. For this update there has been a slight fall in HSMR which is a positive development. The HSMR for year July 2024 to June 2025 is 102.9.

- Standardised Hospital Mortality Indicator (SHMI) continues to improve and for year to June 2025 is 93.05. SHMI has remained below the NHS benchmark of 100 for the last two years.

- During the 12-month period October 2024 to September 2025; 690 in-hospital adult deaths were recorded within the Trust's mortality review system, of these 100% have had medical examiner (Level 1) screening. Level 1 screening identified 10% of cases that would benefit from in-depth structured judgement review (SJR). Of these 78% have completed this in-depth structured judgement review.

- For the 12-month period October 2024 to September 2025 there has been one case of sub-optimal care identified (CESDI 2) where different care might have made a difference to the outcome and no cases (CESDI 3) where different care would reasonably be expected to have made a difference to the outcome.

- The new APC Inphase system has been procured with a view of launching the system in the Trust early 2026, which will see an improvement in how the data and learning is captured whilst triangulating information with coroner's inquest and learning from incidents and complaints. This will improve the monitoring of completion of SJRs whilst strengthening the learning and improving patient care and experience.

Impact assessment

Tick all that apply

☐ Equity
☒ Quality
☐ People (workforce, patients, families or careers)
☐ Operational performance
☐ Finance
☐ Communications and engagement
☐ Council of governors

Mortality case review following in-hospital death provides clinical teams with the opportunity to review expectations, outcomes and learning in an open manner. Effective use of mortality learning from internal and external sources provides enhanced opportunities to reduce in-hospital mortality and improve clinical outcomes and experience for patients and their families

Strategic priorities

Tick all that apply

- ☐ Achieve recovery of our elective care, emergency care, and diagnostic capacity (APC)
- ☐ Support the ICS's mission to address health inequalities (APC)
- ☐ Attract, retain, develop the best staff in the NHS (APC)
- ☒ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation (APC)
- ☐ Achieve a more rapid spread of innovation, research, and transformation (APC)
- ☐ Help create a high quality integrated care system with the population of north west London (ICHT)
- ☐ Develop a sustainable portfolio of outstanding services (ICHT)
- ☐ Build learning, improvement and innovation into everything we do (ICHT)

Main Report

1. Learning and Improvements

This report provides a Trust-level quarterly review of mortality learning for Q2 2025/26 with performance scorecard (see Appendix 1 and 2 reflecting all quarters of the financial year.

All in-hospital deaths are scrutinised by the Trust's Medical Examiner Service; this initial screening provides an independent review of care and is the basis for triggering cases meeting the criteria for Structured Judgement Review.

2. Relative Risk of Mortality

The Trust uses the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) to monitor the relative risk of mortality. Both tools are used to determine the relative risk of mortality for each patient and then compare the number of observed deaths to the number of expected deaths; this provides a relative risk of mortality ratio (where a number below 100 represents a lower than expected risk of mortality).

Population demographics, hospital service provision, intermediate / community service provision has a significant effect on the numbers of deaths that individual hospital sites should expect; the SHMI and HSMR are designed to reduce this impact and enable a comparison of mortality risk across the acute hospital sector. By monitoring relative risk of mortality the Trust is able to make comparisons between peer organisations and seek to identify improvement areas where there is variance.

2.1. Summary Hospital-Level Mortality (SHMI) Indicator

The SHMI is the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die based on the England average, given the characteristics of the patients treated. SHMI captures all deaths which occurred in hospital (excluding stillbirths) and those deaths that occur within 30 days of discharge into the community and is a wider measure of mortality than HSMR.

SHMI continues to improve with the current SHMI for year to June 2025 at 93.05 and has remained below the NHS benchmark of 100 for the last two years. There were 920 deaths observed against an expected 990 given case mix and adjusted for wider NHS performance. Hillingdon outperforms the NHS benchmark (100) but is not significantly low.

North West London Acute Collaborative SHMI indicators

Trust	Provider spells	Observed deaths	Expected deaths	SHMI	LCL 95%CI	UCL 95%CI
LNWH	105685	2690	3130	85.92	0.8565	1.1676
THH	48775	920	990	93.05	0.8494	1.1774
ICHT	118365	2180	3035	71.73	0.8564	1.1677
CWFT	89,540	1720	2275	75.50	0.8552	1.1693

SHMI by APC provider, July 2024 to June 2025, Source: NHS Digital, published 13th November 2025

2.2. Hospital Standardised Mortality Ratio (HSMR)

The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths. HSMR+ looks at 41 diagnostic groups which contribute to 80% of in-hospital deaths. Across the APC, the new methodology has impacted Hillingdon Hospital and since HSMR+ was introduced, Hillingdon have had HSMR consistently above 100, although still within expected statistical range.

For this update there has been a slight fall in HSMR which is a positive development. The HSMR for year July 2024 to June 2025 is 102.9, with 655 deaths observed against an expected 636.5 predicted in the model when adjusted for Hillingdon case mix given case mix.

North West London Acute Collaborative HSMR indicators

Trust	Provider spells	Observed deaths	Expected deaths	HSMR	Lower CI	Upper CI
LNWH	201763	2,003	2075.4	96.5	92.3	100.8
THH	83790	655	636.5	102.9	95.2	111.1
ICHT	244530	1600	2129.9	75.1	71.5	78.9
CWFT	160590	1220	1547.3	78.8	74.5	83.4

HSMR (41 diagnostic groups) by APC provider, July 2024 to June 2025, Source: Telstra

2.3. Trust response to HSMR and SHMI alerts

The Mortality Surveillance Group monitors expected and observed deaths across diagnostic groups and where statistically significant variation is identified the group undertakes coding and care review to identify any themes or potential improvement areas.

Due to the deterioration in HSMR following a change in methodology, a deep dive was conducted into the clinical care and coding for patients dying following pneumonia and fractured neck of femur as these groups were showing a rate of death greater than expected. This demonstrated no concerns with clinical care that would have caused an increase in mortality. Rather, it uncovered issues with data quality, coding and wrong descriptions of admissions as elective rather than non-elective which will have caused the observed deterioration in HSMR. A task & Finish Group is being established to address these issues.

There are no new alerting groups to report in this update.

3. Thematic Review

The Mortality Surveillance Group (MSG) challenges assurance regarding the opportunity and outcomes from the Trust's learning from deaths approach.

MSG provides leadership to this programme of work; it is supported by bi-monthly updates of relative risk of mortality, potential learning from medical examiners following level 1 scrutiny and divisional learning following Morbidity & Mortality Meetings and completed Structured Judgement Reviews which is then disseminated to all the directorates and throughout the divisions.

3.1. Medical Examiner's Service

The Medical Examiner Service in Hillingdon is responsible for scrutinising all deaths in the borough and identifying learning points, or deaths needing to be referred to the Coroner.

- The Hillingdon Hospital Medical Examiner Service has scrutinised 137 hospital deaths (136 adult deaths and 1 neonatal death) during Q2 2025/6. This represents 35.6% of our total 384 caseload, with 247 referrals (64.4%) from the London Borough of Hillingdon sources, specifically residential care [94 (45.5%)]. expected natural deaths at home [103 (45%)], and hospice [34 (9.5%)], with 6 [0.02%] other locations.
- The funding model predicts 45% Hospital and 55% Community deaths.
- The median time from death to transmission of documentation to the Register office is 1 day for hospital deaths, and 3 days for non-Hillingdon Hospital deaths. This is on a par with the best national figures.
- For Hillingdon Hospital patients, there were 29/137 (21.2%) interactions with the coroner, 26 (19%) were formally referred. were 3 (2.2%) ME-MCCD requests and 20 (14.6%) were retained for investigation. These are low coroner referral rates compared to historical national rates. For completeness, the corresponding non-THH figures are 42/247 (17%), 28/247 (11.3%), 7/247 (2.8%) and 8/247(3.2%).
- The weekend on-call medical examiner service for urgent registrations, with medical examiner availability corresponding to Register Office hours, seems to be working well, with some (but not all) challenges overcome. Just 4 deceased made use of this (see below).

Challenges:

- Timely attendance of Attending Practitioners to complete the required registration paperwork, as per their continuing duty of care to the deceased.
- There are still occasions where ward staff and doctors are giving the wrong information to the bereaved about our capacity to cater for urgent (e.g. faith-based) weekend registrations.
- Provision of accurate timely discharge summaries to GPs from Cerner.
- The Springboard dashboard function, which allows rapid access to the Cerner record of all hospital patients with a confirmed death, has been rolled out to all the staff that need this. This represents a great improvement in notification of death, but still seems to depend on free text entry of date of death and is therefore subject to error. When an error occurs, it tends to be propagated unless corrected, and this has caused delays in the process, and some distress to the bereaved.

Improvements:

- This has been the third full quarter in which medical examiner scrutiny has been statutory. The team maintains excellent working relationships with all stakeholders.
- The Springboard dashboard function, as above, has been rolled out to all staff that need it. This assures timely office notification if a confirmation of death is completed, notwithstanding the point made above.
- Planned communication with consultant staff about the importance of timely completion of documentation after death.

Recommendations:

- Further education to all Trust staff on the processes around statutory scrutiny and the importance of timely registration of patient deaths.
- Cerner adaptations to account for statutory Medical Examiner scrutiny, including discharge processes and internal consistency.

3.2. Structured Judgement Review

Mortality case review provides clinical teams with the opportunity to review expectations, outcomes and potential improvements with the aim of:

- Identifying sub-optimal or excellent care
- Identifying service delivery problems
- Developing approaches to improve safety and quality
- Sharing concerns and learning with colleagues

In-hospital adult deaths are screened by the Medical Examiner team using the Level 1 Review form. This supports the identification of cases that would benefit from Structured Judgement Review. Deaths are then discussed by the divisions for their oversight, through their specialty M&M meetings and through the unplanned care M&M forum. Planned care do hold specialty M&M meetings and there is an ask that all specialities in unplanned care hold these regular meetings as part of their governance process.

There have been no prevention of future deaths (PFD) notices issued in this quarter.

During the 12-month period October 2024 to September 2025; 690 in-hospital adult deaths were recorded within the Trust's mortality review system, of these 100% have had Level 1 medical examiner screening. The Level 1 screening identified 68 (10%) cases that would benefit from in-depth structured judgement review (SJR). Of these 78% have completed this in-depth structured judgement review.

Period	No. of Adult deaths	No. of cases screened	No. of cases flagged for SJR	No. of cases with completed SJR	%	%
					Cases screened	SJRs completed
Q3 24/25	201	201	15	15	**100%**	**100%**
Q4 24/25	209	209	23	22	**100%**	**96%**
Q1 24/25	144	144	11	6	**100%**	**55%**
Q2 25/26	136	136	19	10	**100%**	**53%**
Totals	**690**	**690**	**68**	**53**	**100%**	**76%**

Table 1: Adult mortality review status by financial quarter, October 2024 to September 2025

'Family/Carer' concerns was the most frequent trigger for structured judgement review in quarter two (8 cases) which is the same trigger as that found in quarter one (6 cases).

The percentage of in-patient deaths identified for structured judgement review in quarter two increased to 14%, it was 8% in quarter one.

Care Division	No. of Adult deaths	No. of cases screened	No. of cases flagged for SJR	No. of cases with completed SJR	%	%
					Cases screened	SJRs completed
Unplanned	554	554	47	38	**100%**	**81%**
Planned	136	136	21	15	**100%**	**71%**
Totals	**690**	**690**	**68**	**53**	**100%**	**78%**

Table 2: Adult mortality review status by division, October 2024 to September 2025

Completion of Structured Judgement Reviews are monitored by the divisions by way of a monthly SJR status report and regular monthly meeting for oversight of compliance.

A trial of a monthly divisional mortality group review meeting has been set up within planned care which monitors the progress of outstanding SJRs, reviews SJRs with a CESDI grade of 1 and 2 and discusses actions. This is working well and will be developed further with the implementation of Inphase and to be considered for Unplanned Care.

3.2.1 CESDI Grading of Care

Outcome, avoidability and / or suboptimal care provision is graded using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categories:

- Grade 0: No sub-optimal care or failings identified and the death was unavoidable
- Grade 1: A level of sub-optimal care identified during hospital admission, but different care would NOT have made a difference to the outcome and the death was unavoidable
- Grade 2: Sub-optimal care identified and different care MIGHT have made a difference to the outcome, i.e. the death was possibly avoidable
- Grade 3: Sub-optimal care identified and different care WOULD REASONABLY BE EXPECTED to have made a difference

All cases graded as CESDI 0 and CESDI 1 are sent to divisional leads for oversight and to ensure that there is discussion and presentation at appropriate specialty and morbidity and mortality meetings where learning can be shared.

All cases graded as CESDI 2 or CESDI 3 are discussed in the Incident Review Group for a decision on appropriate learning response.

During the 12-month period October 2024 to September 2025, 53 structured judgement reviews have been completed.

Period	CESDI 0	CESDI 1	CESDI 2	CESDI 3
Q3 24/25	8	6	1	0
Q4 24/25	20	2	0	0
Q1 24/25	5	1	0	0
Q2 25/26	7	2	1	0
Total	**40**	**11**	**2**	**0**

Table 3: Completed mortality cases by CESDI grade, October 2024 to September 2025

Cases received during Q2:

- One case was graded as a CESDI 2
- Four cases were graded as a CESDI 1.
- Eleven cases were graded as a CESDI 0.

Following review of the one case graded CESDI 2, key themes and issues identified were:

- Patient received a further dose of morphine in the Emergency Department. There was evidence in this case that there needs to be a review of the handover process between ambulance crews and the Emergency Department to ensure that staff check drug history and medications already administered by ambulance crews.

A Multi-disciplinary review is being carried out In respect of the care that this patient received, the outcome of which is still in progress.

Following review of the Four cases graded CESDI 1, key themes and issues identified were:

- Better documentation with regards to understanding the rationale behind aspects of the medical management, changes to medication and treatment options. This did not impact

the outcome nor would it have done in this situation but it is important that this is recognised and does not happen again.

- Delay in chemotherapy treatment because it was not recognised that the patient would need a PICC line in the lead up to their treatment.
- Patient was escalated to a tertiary centre, however the transfer did not take place. A Consultant-to-Consultant discussion could have clarified the situation, facilitated the transfer to the neurosurgical centre and significantly reduced the stress on the patient/relatives and the treating team. Similarly, a formal joint team consultation and a patient/relative meeting should have taken place, the latter only took place when the patient was in a critical condition and transfer to the Intensive Care Unit.
- Lack of documentation of the NELA score, this should be part of the discussion with the family and in the pre-operative anaesthetic assessment.

Actions are identified in line with the learning to support improving patient care.

Evidence of excellent care has been recognised during patients' phase of care in Ten of the reviews completed (n=10):

- Admission and Initial management (n=6)
- Ongoing care (n=6)
- Care during procedure (n=5)
- Perioperative care (n=0)
- End of Life care (n=8)

Themes of excellent care highlighted included:

- **Specialist Input and Multidisciplinary Collaboration:** Good MDT approach to the decision-making process which demonstrated a cohesive and excellent patient centred care approach. Good examples of senior led discussions and appropriate escalation.
- **Communication with Families and Next of Kin (NOK):** There was evidence of good communication with NOK. Evidence in a number of cases that families were kept informed with regular discussions about changing management to palliation.
- **Clinical Decision-Making and escalation of care:** There were timely investigations and referrals for further opinions which were then followed thoroughly. Good communication between surgical consultants and constant review which led to prompt decision to operate when patient was unwell.
- **Documentation quality:** There was evidence of excellent documentation which meant that it was clear what events occurred and how reversible causes were excluded. Nursing documentation was clear and thorough. Evidence, of joint teamwork among specialties and all teams involved in the decision-making process clearly documented.

3.2.2 Ethnicity

The ethnicity data shows a consistent picture in terms of the proportion of deaths by ethnicity during Q2 2025/26 as in previous quarterly reports. The percentage of deaths where ethnicity is not known has continuously decreased during the last three quarters and in this quarter there have been no deaths where ethnicity is not known. Further analysis by ethnicity is provided in appendix B.

This quarter ‘White British’ remains the most frequently identified ethnicity associated with in-hospital mortality, accounting for 58% of deaths occurring during Q2, this is lower than during Q1 which was 64%. It is noted that 42% of ‘White British’ people make up the resident population for the London Borough of Hillingdon. ‘Asian – or Asian British Indian’ was again recognised as the second largest ethnic group in this quarter associated with in-hospital deaths, accounting for 11% of deaths and which aligns with the demographic composition of our local population.

As in the previous quarter the ‘White British’ group made up the highest number of referrals, 53% in quarter two which aligns with previous quarters, although lower than Q1 which was 80%.

In this quarterly period 69% of completed SJRs received with a CESDI 0 were for ‘White British’ deaths and 13% of CESDI 0 cases were for the ‘Other – Any Other Ethnic Group’. The one CESDI 2 graded case was for an individual of ‘White British ethnicity’. Whilst three of the CESDI 1 graded cases were for individuals of ‘White British’ ethnicity and one CESDI 1 graded case was for an individual of ‘White – Any Other Ethnic Group’.

3.3. Perinatal Mortality Review Tool (PMRT)

The Perinatal Mortality Review Tool (PMRT) is a national mandatory monitoring and assurance dataset developed by MBRRACE-UK. It is used to collect very detailed information about the care mothers and babies have received throughout pregnancy, birth and afterwards. The purpose of the PMRT is to support hospital learning from deaths by providing a standardised and structured review process. The PMRT is designed to support the review of:

- All late fetal losses (22 weeks + 0 days to 23 weeks + 6 days).
- All antepartum and intrapartum stillbirths.
- All neonatal deaths from birth at 22 weeks + 0 days to 28 days after birth.

During quarter two:

- There were two stillbirths during this quarter. One early neonatal death and two terminations of pregnancy (TOP) were notified and do not require a PMRT.
- There was one termination of pregnancy (TOP) that was not notified to MBRRACE-UK within the required timeframe. A request for leniency has been submitted to MBRRACE and NHS Resolution, given that our PMRT standards have consistently remained at 100%, following significant improvements in response to the Stillbirth Review recommendations. The outcome of this request will remain unknown until the end of the Maternity Incentive Scheme reporting period.
- This particular case involved a medical TOP and did not require a multi-disciplinary team (MDT) review. Therefore, there was no harm or adverse outcome for the family, and the impact is solely related to data collection for MBRRACE.
- A thorough and robust review of the notification processes for TOPs has been undertaken, with immediate learning implemented and failsafe processes put in place.
- The crude stillbirth rate is 4.13 per 1000 births and a decrease from 5.51 last quarter. This continues to show a marked improvement from the previous year and indicates a positive

trajectory heading into the new year. While early signals are encouraging, continued surveillance and embedding of learning remain essential.

- Although there were no neonatal deaths in this quarter, the crude rate remains at 1.15 per 1000 births. This is reflected from the previous quarters where there was an increase in expected neonatal deaths.

Challenges:

- From the five reviews which were closed in this quarter, there appears to still be some challenges surrounding postnatal and bereavement care including tests and investigations either being missed or not sent correctly.
- Two of the cases reviewed discussed language needs not being fully met which has been a recurrent theme.

Improvements made:

- During September 2025 all labour ward co-ordinators were trained to become bereavement champions to help the staff caring for bereaved families and to reduce errors occurring.

Recommendations:

- An Audit will be carried out early in 2026 to evaluate the effectiveness of having bereavement champions on Labour ward has made.
- An email is now being sent by the Fetal Medicine Unit team to the governance team including the PMRT midwife to inform them of any future admissions of Terminations of Pregnancy due on the Labour ward to prevent any missed notifications.

3.4. Child Death Overview Panel (CDOP)

Hillingdon sits as 1 of 7 boroughs covered by the North West London Child Death Review team. The NW London Child Death Review service acts in accordance with the statutory guidance for the Child Death Review partners.

During quarter two there were four deaths in children/young people who were residents of the borough, two of whom had previously received care at Hillingdon Hospital.

1) 20+3 baby, extreme prematurity with post-mortem showing chorioamnionitis and funisitis. Awaiting PMRT.
2) Term baby with known congenital malformations antenatally, delivered at Hillingdon Hospital and transferred to Great Ormond Street Hospital for ongoing management. Postnatal scans confirmed significant central nervous system malformations and care was redirected.
3) 13yr previously treated for low grade spindle cell tumour of the anterior mediastinum and upper abdomen, travelled abroad and collapsed with sepsis

4) 27+3 MCDA twin, PPROM with pulmonary hypoplasia. Booked at Hillingdon Hospital but care transferred to Queen Charlotte's and Chelsea Hospital.

Challenges:

The most recent National Child Mortality Database report (July 2025) focussed on learning from child death reviews on palliative and end of life care provision. Several key recommendations were made:

- Recommendation 1: Review commissioning arrangements to ensure adequate and equitable 24 hr access to paediatric palliative care, in line with NICE;
    - Hillingdon has access to 7day Children's Community Nursing Team cover but the service is not commissioned for 24hr provision.
- Recommendation 2: Ensure all bereaved families are allocated a key worker, which is funded and embedded appropriately, in line with the Child death review statutory and operational guidance;
    - The Hillingdon Hospital NHS Trust is one of two trusts in NWL who do not have a named nurse for bereavement.
- Recommendation 3: Ensure all named medical specialists receive and complete appropriate training in parallel planning and documenting advance care plans;
    - Not currently part of curriculum.
- Recommendation 4: Integrated Care Boards working with care providers should ensure that the ReSPECT / resuscitation document is easily visible;
    - Continues to be a challenge across NWL with lack of consistent location/format.
- Recommendation 5: Ensure timely access to essential medications needed for the delivery of end-of-life care at home;
    - Limited experience in prescribing/dispensing end-of-life medications.

Improvements:

Above report and gaps have been presented at the NWL Child Death Review Strategic group and will be highlighted to commissioners by the NWL Integrated Care Board Director of Nursing.

Recommendations:

- Development of consistent approach to documenting ACPs/ReSPECT plans across NWL (Cerner).
- Shooting Stars to work with Child Death Review team to develop training sessions re: end-of-life parallel planning and prescribing of end-of-life medications.

3.5. Learning from Life and Death Reviews

A national Learning Disabilities Mortality Review (LeDeR) programme was established in May 2015 in response to the recommendations from the Confidential Inquiry into premature deaths of people with learning disabilities. From January 2022, LeDeR reports have included death of autistic people without a learning disability. In response to this change and following stakeholder engagement, the new name for the LeDeR programme is 'Learning from Life and Death Reviews – people with a learning disability and autistic people'.

The Trust reported three deaths to LeDeR in Q2.

Month of death	SJR review status	Specialty	CESDI grade
August	Closed	Intensive Care	CESDI 0
September	Open	Diabetes & Endocrinology	Pending
September	Open	Acute Medicine	Pending

Table 4: LeDeR cases reported from July 2025 – September 2025

The Learning from Life and Death Review programme seeks to coordinate, collate and share information about the deaths of people with learning disabilities and autistic people so that common themes, learning points and recommendations can be identified and taken forward at both local and national levels. The Trust is committed to ensuring deaths of patients with known / pre-diagnosed learning disabilities and / or autism are reported to the Learning from Life and Death Review programme and reviewed accordingly.

Since July 2023 Learning from Life and Death Review notifications are only for those aged 18 years and over. The NWL ICB have representatives attend Child Death Review Meetings. This ensures that the death is looked at from a health inequalities perspective. The Child Death Review Team monitor the themes from reviews and continue to share them with the NWL ICB Learning from Life and Death Review team.

In collaboration with North West London ICB and the network of Hospital's Learning Disability Nurses, work is underway to implement an electronic referral system within Cerner. A new Learning Disability Toolkit form will soon go live, enabling staff to refer patients electronically.

4. Areas of focus

4.1. Cerner EPR

There continues to be a consistent improvement in the data captured by the Digital Services team which was caused by Cerner workflows around deaths not being followed and the last update reported one discrepancy identified.

Monitoring will continue, to ensure the mortality data accurately reflects the correct figures. A weekly mortality data quality report, which includes each of the issues identified, highlighted

patients and areas is continuing to be sent to the Divisional Directors and Chief Nurse Information Officer for dissemination to the affected areas.

4.2. Monitoring of compliance, learning and actions

As outlined in previous reports the Trust does not have a digital platform for mortality. The new APC Inphase system has now been procured with a view of launching the system in the Trust early 2026. The mortality module will enable level 1 reviews and SJRs to be recorded and monitored electronically which will support with monitoring compliance, triangulation of data and learning from incidents, audits and complaints and mortality for us all. This will also support with improving the completion of SJRs, monitoring and evidencing the learning that is identified as part of the Structured Judgement Review.

Progress updates on this are provided at the Trust Mortality Surveillance Group meeting.

4.3. Morbidity & Mortality

There is evidence that specialty Morbidity & Mortality (M&M) meetings are being held regularly for several specialties, including General Surgery, Trauma & Orthopaedics, Intensive Care, Emergency Care, Care of the Elderly and more recently Respiratory are in the process of establishing this with a dedicated Cerner list having been created for them. Compliance for other specialties to commence M&M meetings in unplanned care needs to be a point of discussion and update will be given in the next report following the Trust Mortality Surveillance Group meeting in November.

Compliance across the Trust continues to improve in capturing outcomes and learning at the M&M meetings and there is focused work with them to ensure that the improvements needed are accurately reflected with smart actions identified.

Outcomes and learning from the M&M meetings will be included in the divisional exception reports presented to the Mortality Surveillance Group for overview and assurance.

4.4. Mortality Leads

As previously reported there remains vacant posts for a mortality lead in Medicine and Surgery.

5. Conclusion

The outcome of the Trust’s mortality surveillance programme continues to be a rich source of learning that is supporting the organisation’s safety improvement objectives.

The Trust’s mortality review programme provides a standardised approach to case reviews designed to improve understanding and learning about problems and processes in healthcare associated with mortality, and also to share best practice.

The Trust is committed to better understanding the distribution of mortality according to the breakdown of our patient demographics (Appendix 2) and ensure that we tackle any health inequalities that we identify in doing so.

6. Glossary

a. **Medical Examiners** are responsible for reviewing every inpatient death before the medical certificate cause of death (MCCD) is issued, or before referral to the coroner in the event that the cause of death is not known or the criteria for referral has been met. The Medical Examiner will request a Structured Judgement Review if required or if necessary refer a case for further review and possible investigation through our incident reporting process via the quality and safety team. The ME will also discuss the proposed cause of death including any concerns about the care delivered with bereaved relatives.
b. **Structured Judgement Review (SJR)** is a clinical judgement based review method with a standard format. SJR reviewers provide a score on the quality of care provided through all applicable phases of care and will also identify any learning. The SJR will be completed within seven days of referral.
c. **Structured judgement reviewers** are responsible for conducting objective case note reviews of identified cases. They will seek, when required, specialist input and advice from clinical colleagues, including members of the multi-disciplinary teams to ensure high quality, comprehensive review is undertaken, using the full range of medical records available to them.
d. **Specialty M&M** reviews are objective and multidisciplinary reviews conducted by specialties for cases where there is an opportunity for reflection and learning. All cases where ME review has identified issues of concern must be reviewed at specialty based multi-disciplinary Mortality & Morbidity (M&M) reviews.
e. **Child Death Overview Panel (CDOP)** is an independent review aimed at preventing further child deaths. All child deaths are reported to and reviewed through Child Death Overview Panel (CDOP) process.
f. **Perinatal Mortality Review Tool (PMRT)** is a review of all stillbirths and neonatal deaths. Neonatal deaths are also reviewed through the Child Death Overview Panel (CDOP) process. Maternal deaths (during pregnancy and up to 12 month post-delivery unless suicide) are reviewed by Healthcare Safety Investigation Branch and action plans to address issues identified are developed and implemented through the maternity governance processes.

Learning Disabilities Mortality Review (LeDeR) is a review of all deaths of patients with a learning disability. The Trust reports these deaths to the Local integrated care boards (ICBs) who are responsible for carrying out LeDeR reviews. SJRs for patients with learning disabilities are undertaken within the Trust and will be reported through the Trust governance processes.

Author: Paula Perry, Clinical Governance Facilitator
Date: 31/10/2025

List of appendices

Appendix 1 – Performance Scorecard

Appendix 2 – Ethnicity

Appendix 3 – Flow Chart referral to LeDeR

Appendix 1 – Performance Scorecard

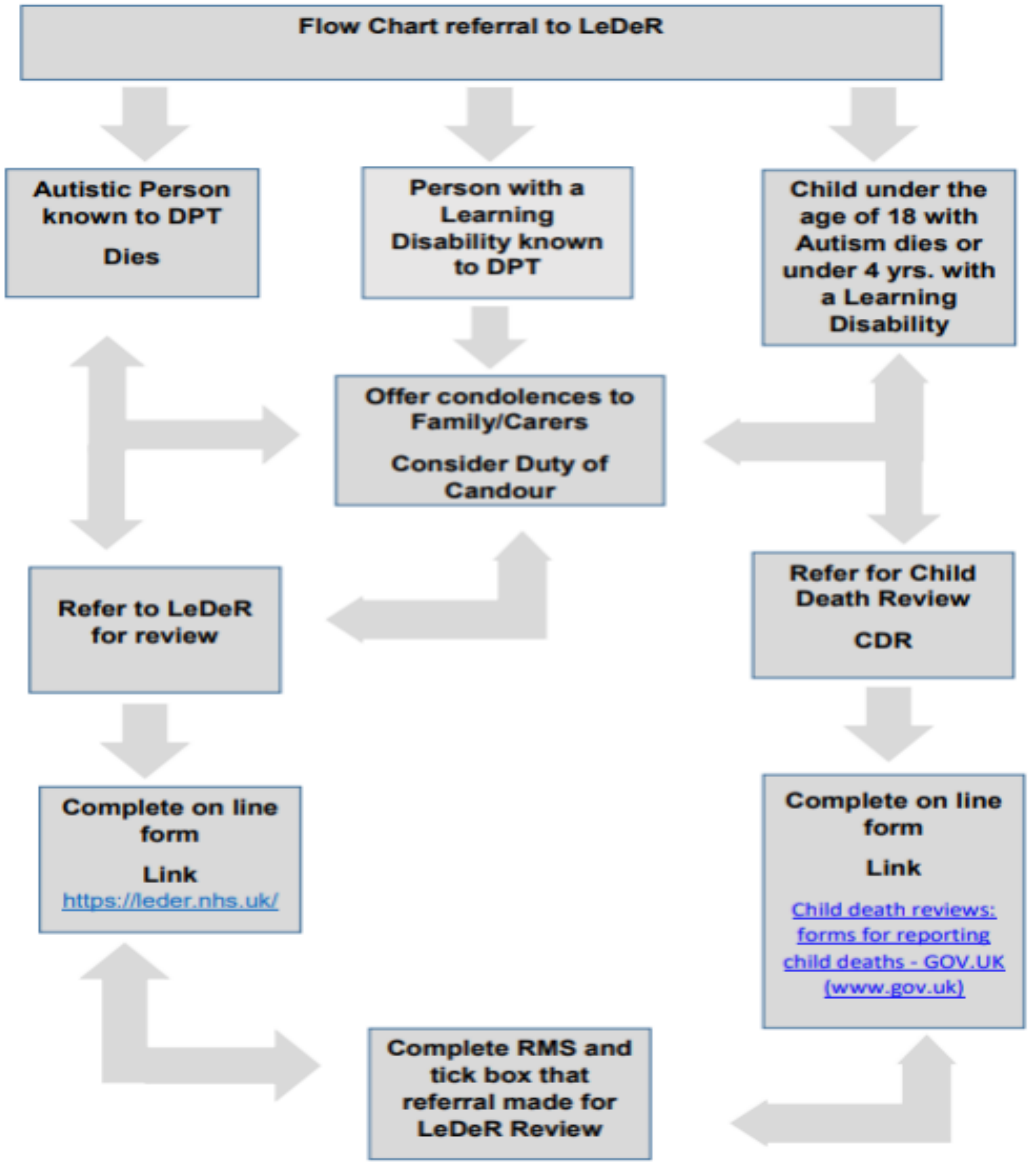
	Q3	Q4	Q1	Q2	Comments	National LfD minimum requirement?
Summary data						
Total no. deaths (adult and children, including neonatal and excluding stillbirths)	204	210	147	137	Inpatient deaths only	
Total no. adult deaths	201	209	144	136	Inpatients over 18 years age	Y
No. adult deaths per 1,000 non-elective bed days	TBC	TBC	TBC	TBC		
Total no. child deaths	3	0	0	0	Inpatients over 28 days and less than 18 year only	
Total no. neonatal deaths	0	1	3	1	Inpatients livebirths under 28 days of age	
Total no. stillbirths	5	2	5	2	Inpatient not live births	
Review summary						
Deaths reviewed by Medical Examiner	204	210	147	137		
% Deaths reviewed by Medical Examiner	100%	100%	100%	100%	% of total deaths	% of row 1
Deaths referred for Level 2 review	15	23	11	19		
% Deaths referred for Level 2 review	7%	11%	8%	14%	% of total adult deaths	% of row 2
Level 2 reviews completed	15	22	6	10		
% Level 2 reviews completed	100%	96%	55%	53%	% of total referrals this quarter	Y
Total Deaths Reviewed Through the LeDeR Methodology	2	3	1	3		
Level 2 referral reason breakdown						
Requests made by a Medical Examiner	(6) 40%	(6) 23%	(1) 10%	(4) 21%	% of total referrals	
Concerns raised by family / carers	(5) 33%	(17) 65%	(6) 60%	(8) 42%	% of total referrals	

Patients with learning disabilities	(2) 13%	(3) 12%	(1) 10%	(3) 16%	% of total referrals	
Patients with severe mental health issues	(3) 20%	(4) 15%	(2) 20%	(5) 26%	% of total referrals	
Unexpected deaths	(1) 7%	(0) 0%	(2) 20%	(2) 11%	% of total referral	
Elective admission deaths	(0) 0%	(0) 0%	(0) 0%	(0) 0%	% of total referrals	
Requests made by speciality mortality leads / through local Mortality and Morbidity review processes	(0) 0%	(0) 0%	(0) 0%	(1) 5%	% of total referrals	
Service or diagnosis alarms as agreed by APC mortality surveillance group	(0) 0%	(0) 0%	(0) 0%	(0) 0%	% of total referrals	
Random selection of deaths for SJR review	(0) 0%	(0) 0%	(0) 0%	(0) 0%		
Level 2 review outcomes						
CESDI 0 - No suboptimal care	8	20	5	7	% of cases reviewed	Total Figure
CESDI 1 - Some sub optimal care which did not affect the outcome	6	2	1	2	% of cases reviewed	Total Figure
CESDI 2 - Suboptimal care – different care might have made a difference to outcome (possible avoidable death)	1	0	0	1	% of cases reviewed	
CESDI 3 - Suboptimal care - would reasonably be expected to have made a difference to the outcome (probably avoidable death)	0	0	0	0	% of cases reviewed	Y

Appendix 2 – Ethnicity

		2024/25		2025/26		2024/25		2025/26	
	Total	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Asian - Any Other Asian Background	35	13	10	6	6	6.47%	4.74%	4.14%	4.41%
Asian or Asian British - Bangladeshi	4	1	1	1	1	0.50%	0.47%	0.69%	0.73%
0.74Asian or Asian British - Indian	80	19	24	16	21	9.45%	11.37%	11.03%	15.44%
Asian or Asian British - Pakistani	12	4	4	3	1	1.99%	1.90%	2.07%	0.73%
Black - Any Other Black Background	2	0	2	0	0	0.00%	0.95%	0.00%	0.00%
Black or Black British - African	14	1	2	6	5	0.50%	0.95%	4.14%	3.68%
Black or Black British - Caribbean	9	3	3	0	3	1.49%	1.42%	0.00%	2.21%
Mixed - Any Other Mixed Background	2	1	1	0	0	0.50%	0.47%	0.00%	0.00%
Mixed - White and Asian	1	1	0	0	0	0.50%	0.00%	0.00%	0.00%
Mixed - White and Black African	2	2	0	0	0	0.99%	0.00%	0.00%	0.00%
Mixed - White and Black Caribbean	1	1	0	0	0	0.50%	0.00%	0.00%	0.00%
Other - Any Other Ethnic Group	25	11	6	5	3	5.47%	2.84%	3.45%	2.21%
Other - Chinese	3	0	0	1	2	0.00%	0.00%	0.69%	1.47%
Other - Not Known	28	19	6	3	0	9.45%	2.84%	2.07%	0.00%
Other - Not Stated	0	0	0	0	0	0.00%	0.00%	0.00%	0.00%
White - Any Other White Background	43	3	20	9	11	1.49%	10.43%	6.20%	8.09%
White - British	419	121	126	92	79	60.20%	59.72%	64.14%	58.09%
White - Irish	11	1	4	2	4	0.50%	1.90%	1.38%	2.94%
Total	691	201	209	144	136	100.00%	100.00%	100.00%	100.00%

APPENDIX 3 – Flow Chart referral to LeDeR



NWL Acute Provider Collaborative Board in Common (Public)
20/01/2026
Item number: 4.1.3
This report is: Public

Chelsea and Westminster Hospital NHS Foundation Trust Learning from Deaths report Quarter 2 2025/26

Author: Stacey Humphries
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Accountable director: Sanjay Krishnamoorthy
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Job title: Chief Medical Officer

Purpose of report (for decision, discussion or noting)

Purpose: Assurance

Report history

Outline committees or meetings where this item has been considered before being presented to this meeting.

CWNHSFT Trust Mortality Surveillance Group 07/11/2025 Approved	CWNHSFT Executive Management Board 19/11/2025 What was the outcome?	CWNHSFT Quality Committee 25/11/2025 What was the outcome?

Executive summary and key messages

The Trust is one of the best performing acute (non-specialist) providers in England in terms of relative risk of mortality with a Trust wide SHMI of 0.76 (where a number below 1 is better than expected mortality) for the period covering July 2024 - June 2025 (Source: HES). This positive assurance is reflected across the Trust as both sites continue to operate significantly below the expected relative risk of mortality.

During October 2024 to September 2025; 1,314 in-hospital adult or child deaths were recorded within the Trust's mortality review system (Datix), of these 92% have been screened and 40% have had a full mortality case review.

There were no cases of sub-optimal care that would reasonably be expected to have made a difference to the patient's outcome. There were 5 cases of sub-optimal care graded CESDI 2 (suboptimal care identified and different care MIGHT have made a difference to the outcome) identified and escalated for a decision on appropriate learning response.

Where the potential for improvement is identified, learning is shared at Divisional mortality review groups and presented to the Trust-wide Mortality Surveillance Group for assurance of actions taken; this ensures appropriate scrutiny of actions, and that learning outcomes are shared and cascaded.

Impact assessment

Tick all that apply

- ☐ Equity
- ☒ Quality
- ☐ People (workforce, patients, families or careers)
- ☐ Operational performance
- ☐ Finance
- ☐ Communications and engagement
- ☐ Council of governors

Strategic priorities

Tick all that apply

- ☐ Achieve recovery of our elective care, emergency care, and diagnostic capacity (APC)
- ☐ Support the ICS's mission to address health inequalities (APC)
- ☐ Attract, retain, and develop the best staff in the NHS (APC)
- ☒ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation (APC)
- ☐ Achieve a more rapid spread of innovation, research, and transformation (APC)
- ☐ Help create a high quality integrated care system with the population of North West London (ICHT)
- ☐ Develop a sustainable portfolio of outstanding services (ICHT)
- ☐ Build learning, improvement and innovation into everything we do (ICHT)

Main report

1. Learning and Improvements

The Trust's Mortality Surveillance programme offers assurance to our patients, stakeholders, and the Board that high standards of care are being provided and that any gaps in service delivery are being effectively identified, escalated, and addressed. This report provides a Trust-level quarterly review of mortality learning for Q2 2025/26 with performance scorecard (see Appendix 1 and 2) reflecting all quarters of the financial year.

1.1. Relative Risk of mortality

The Trust uses the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) to monitor the relative risk of mortality. Both tools are used to determine the relative risk of mortality for each patient and then compare the number of observed deaths to the number of expected deaths; this provides a relative risk of mortality ratio (where a number below 100 represents a lower than expected risk of mortality).

Population demographics, hospital service provision, intermediate / community service provision has a significant effect on the numbers of deaths that individual hospital sites should expect; the SHMI and HSMR are designed to reduce this impact and enable a comparison of mortality risk across the acute hospital sector. By monitoring relative risk of mortality the Trust is able to make comparisons between peer organisations and seek to identify improvement areas where there is variance.

1.2. Summary Hospital-level Mortality (SHMI) Indicator: Trust wide

The SHMI is the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die based on the England average, given the characteristics of the patients treated. It includes deaths which occurred in hospital and deaths which occurred outside of hospital within 30 days (inclusive) of discharge. Deaths related to COVID-19 are excluded from the SHMI.

The SHMI gives an indication of whether the observed number of deaths on Trust sites within 30 days of discharge from hospital is 'higher than expected', 'as expected' or 'lower than expected' when compared to the national baseline.

In August 2024, Chelsea & Westminster NHS Foundation Trust stopped recording Short Day Emergency Care (SDEC) contacts as emergency admissions and moved this activity into the Emergency Care Data Set (ECDS), as required by NHS England. This change removed a large number of low-risk patients from the inpatient dataset used for SHMI, resulting in a slightly higher risk profile and a corresponding rise in SHMI noted since September 2024. National comparisons remain inconsistent because some trusts have implemented this change while others have not, although the deadline has passed. It will therefore take time for the national position to stabilise.

Funnel plots for the period July 2024 to June 2025 still show the Trust as having a significantly lower mortality rate than expected:

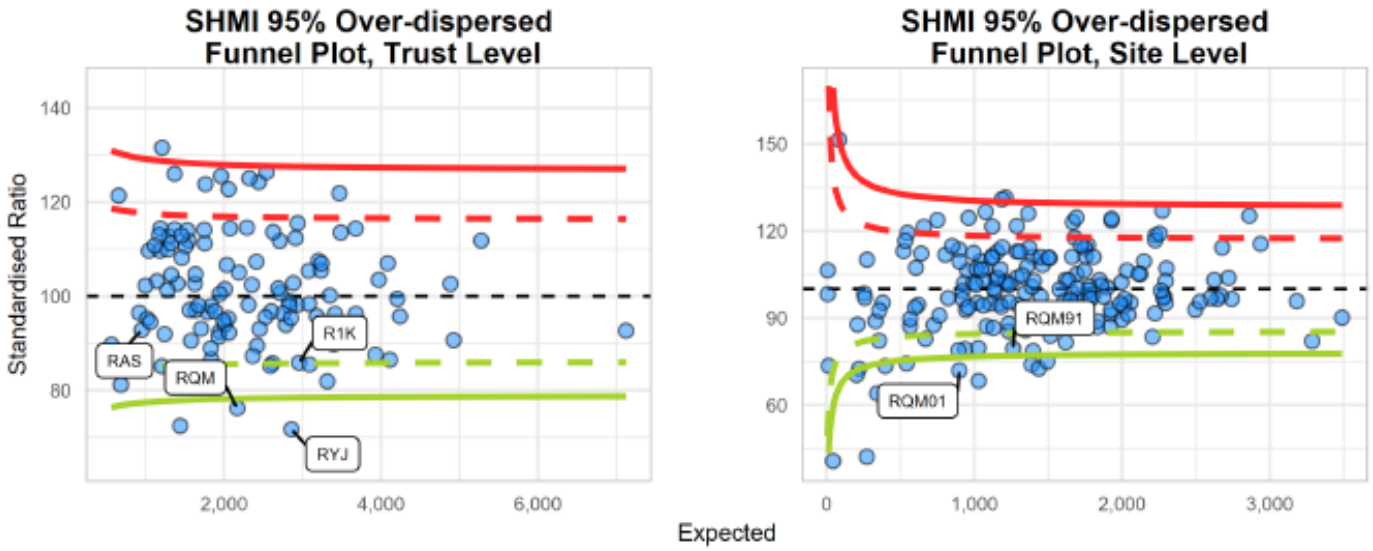


Figure 1: SHMI comparison of England acute hospital sites based on outcomes between July 2024 and June 2025

The Trust-wide SHMI for the period July 2024 – June 2025 is 75.50 (where a number below 100 represents lower than expected risk of mortality).

North West London Acute Collaborative SHMI indicators

Trust	Provider spells	Observed deaths	Expected deaths	SHMI	LCL 95%CI	UCL 95%CI
LNWH	105685	2690	3130	85.92	85.65	116.76
THH	48775	920	990	93.05	84.94	117.74
ICHT	118365	2180	3035	71.73	85.64	11 6.77
CWFT	89,540	1720	2275	75.50	85.52	116.93

Table 1. SHMI by APC provider, July 2024 to June 2025, Source: NHS Digital, published 13th November 2025

The table below show the details for Hospital Evaluation Data (HED) HES SHMI and its variants for Chelsea & Westminster (at site level), for the 12 month period July 2024 - June 2025.

Site	SHMI	LCL 95%CI	UCL 95%CI	Expected number of deaths	Observed number of deaths	Total discharges	% adms. with palliative care coding	Mean comorbidity score per spell	In-Hospital SHMI	Out-of-Hospital SHMI
WMUH	79.4	74.6	84.5	1262.8	1003	44787	1.70%	4.6	82	73.7
CWH	71.9	66.4	77.6	898.8	646	38714	1.60%	3.6	71	73.8

Table 2. SHMI breakdown by site

A recent increase in SHMI for both sites seems to be more related to a reduction in expected deaths, rather than an increase in observed deaths. As discussed above, this may be influenced by the removal of SDEC activity from the inpatient dataset.

The positive assurance provided by the SHMI is reflected across the Trust as both sites continue to operate significantly below the expected relative risk of mortality.

1.2.1. SHMI diagnosis groups which are statistically significantly high

There are 144 SHMI diagnosis groups used within the SHMI definition, some of which are single CCS groups and others are aggregates of CCS groups. Diagnostic groups are aggregated to calculate the Trust's overall relative risk of mortality. The Mortality Surveillance Group monitors expected and observed deaths across diagnostic groups; where statistically significant variation is identified the group undertakes coding and care review to identify any themes or potential improvement areas.

At the time of reporting there are no SHMI Diagnosis groups that have a statistically significant SHMI.

1.3. Hospital Standardised Mortality Ratio (HSMR)

The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for all diagnostic (CCS) groups in a specified patient group. The expected deaths are calculated from logistic regression models with a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

The Trust-wide HSMR for the period July 2024 – June 2025 is 78.8 (where a number below 100 represents lower than expected risk of mortality).

North West London Acute Collaborative HSMR indicators

Trust	Provider spells	Observed deaths	Expected deaths	HSMR	Lower CI	Upper CI
LNWH	201763	2,003	2075.4	96.5	92.3	100.8
THH	83790	655	636.5	102.9	95.2	111.1
ICHT	244530	1600	2129.9	75.1	71.5	78.9
CWFT	160590	1220	1547.3	78.8	74.5	83.4

Table 3: HSMR (41 diagnostic groups) by APC provider, July 2024 to June 2025, Source: Telstra

The table below show the details for Chelsea & Westminster site level HSMR for the 12 month period July 2024 - June 2025.

Trust / Site	Discharges	Observed deaths	Expected deaths	HSMR	HSMR Lower CI	HSMR Upper CI
RQM01 - CHELSEA & WESTMINSTER HOSPITAL	15,628	344	504.1	68.2	61.2	75.8
RQM91 - WEST MIDDLESEX UNIVERSITY HOSPITAL	22,148	595	710.5	83.7	77.1	90.8

Table 4 – HSMR outcomes by site over period June 2024 – July 2025

1.4. Crude mortality

The crude rate is calculated by dividing the observed number of in hospital deaths by the total number of patients within the hospital. The outcome is multiplied by 1000 to give the number of mortalities per thousand patients.

Crude rates are easy to produce and provide a useful means of monitoring outcomes over time.

The disadvantage of crude rates is that they cannot be used to compare the mortality experience between different sites because of possible differences in the population demographic, hospital services and surrounding health economies. However, an advantage of such statistical bias is that it can illuminate the differences between the two hospital sites.

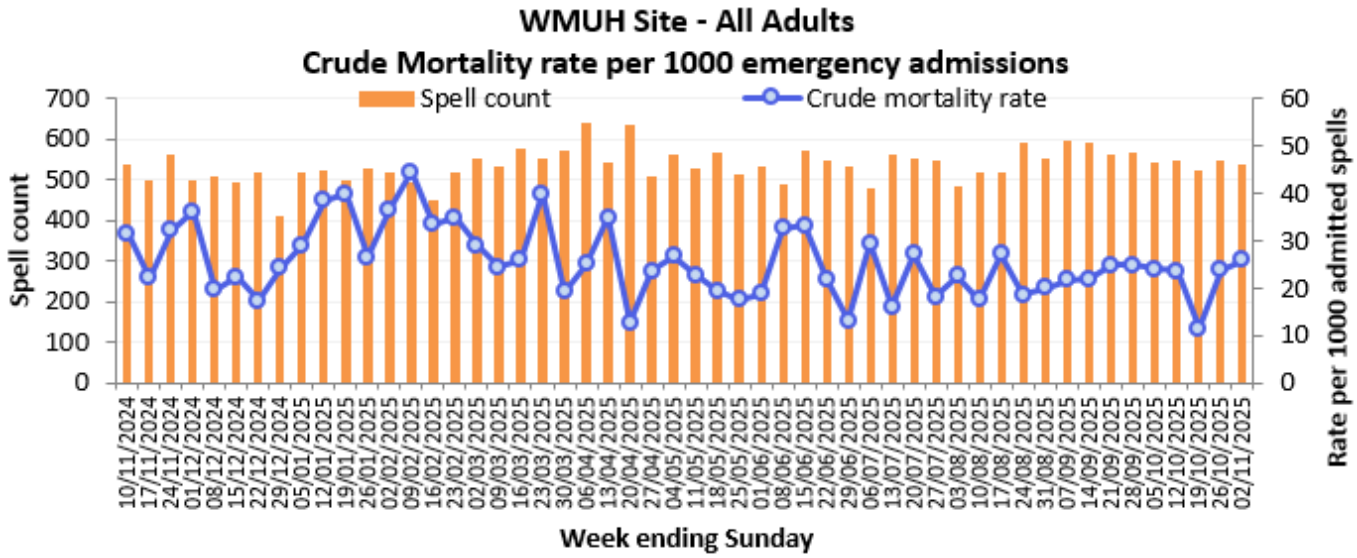


Figure 2 – Weekly adult emergency spell counts and crude mortality rate per 1000 patients, West Middlesex University Hospital

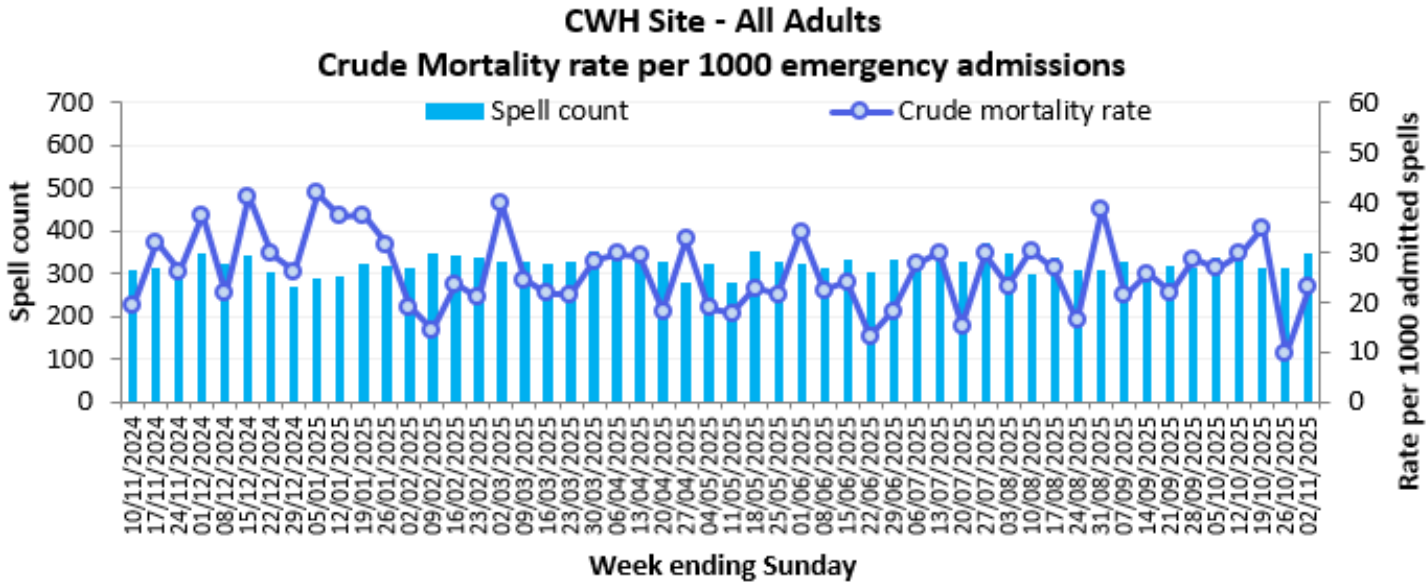


Figure 3 – Weekly adult emergency spell counts and crude mortality rate per 1000 patients, Chelsea and Westminster Hospital

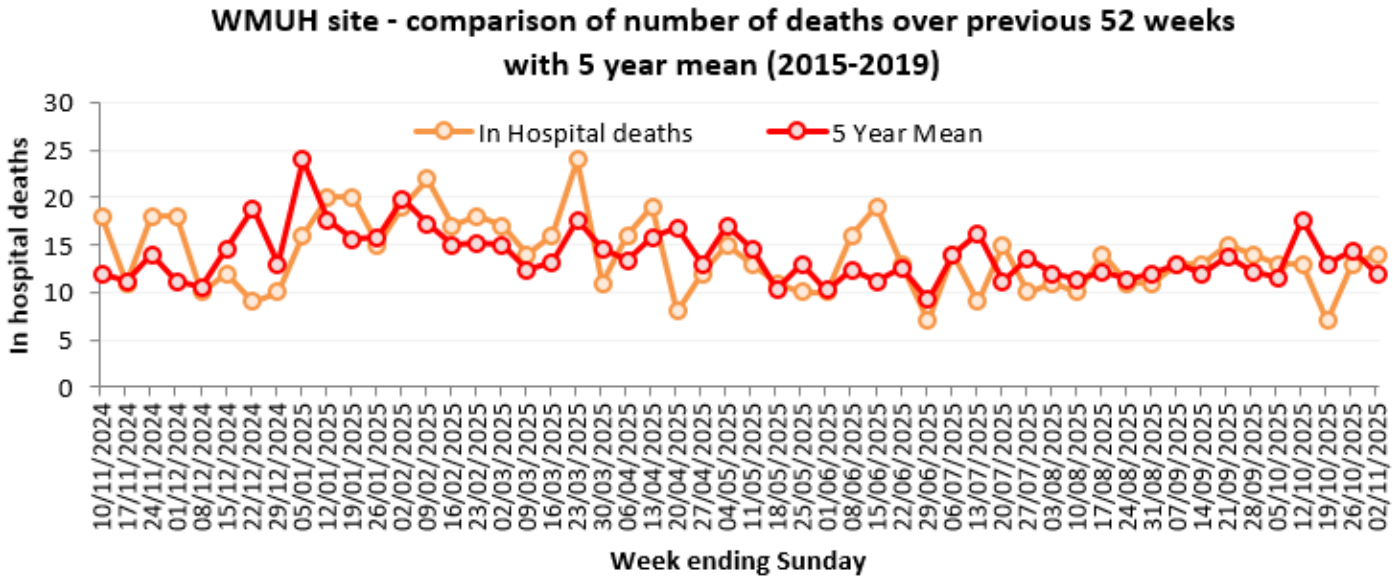


Figure 4 – Crude mortality in last 52 weeks compared with 5 year mean, West Middlesex University Hospital

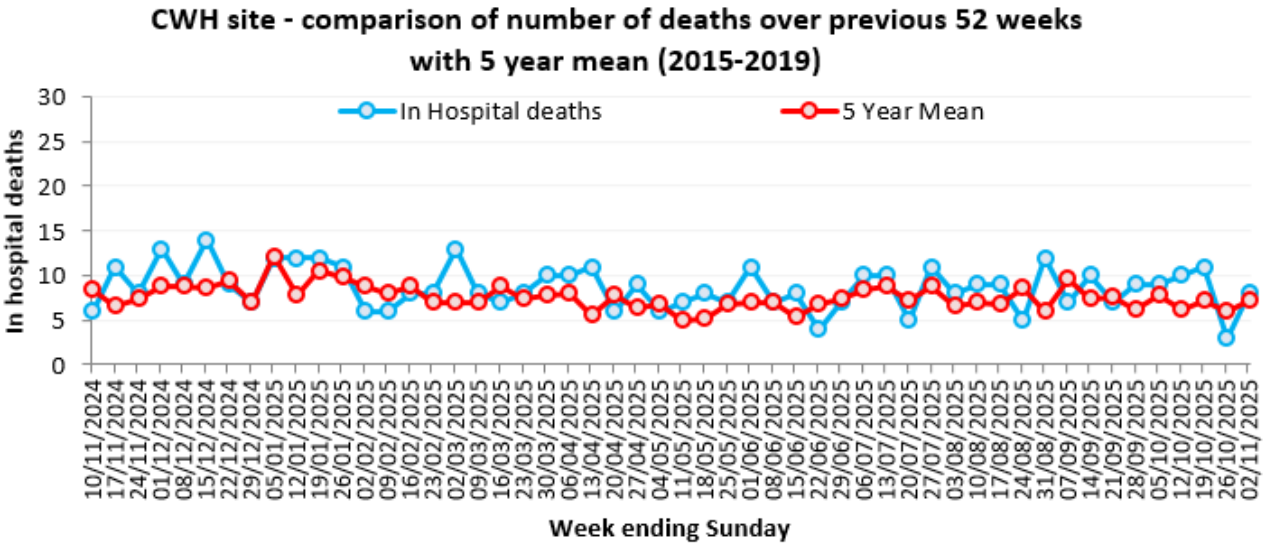
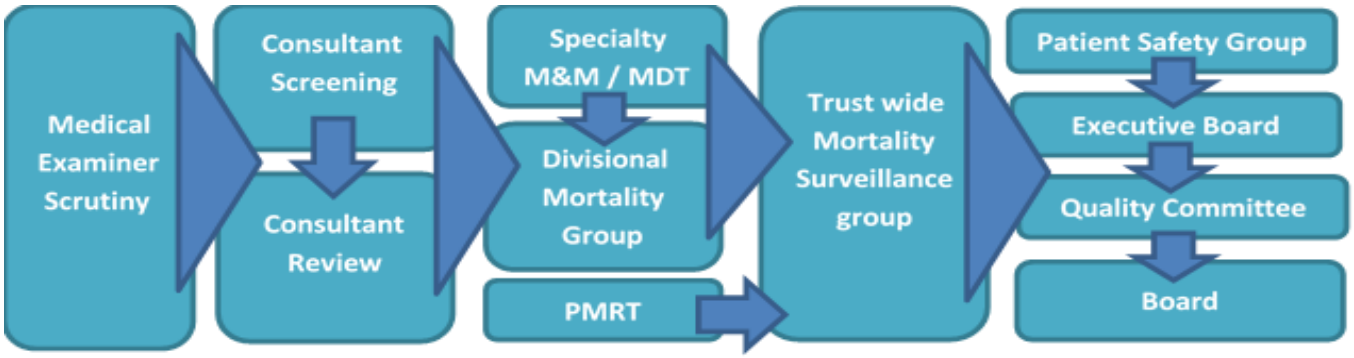


Figure 5 – Crude mortality in last 52 weeks compared with 5 year mean, Chelsea and Westminster Hospital

Crude mortality is monitored by the Mortality Surveillance Group on a monthly basis; no further review has been triggered as a result of this monitoring during the reporting period.

2. Thematic Review

The Mortality Surveillance Group (MSG) challenges assurance regarding the opportunity and outcomes from the Trust's learning from deaths approach.



MSG provides leadership to this programme of work; it is supported by monthly updates on relative risk of mortality, potential learning from medical examiners, learning from inquests, and divisional learning from mortality screening / review. MSG is a sub-group of the Patient Safety Group and is aligned to the remit of the Quality Committee.

3. Medical Examiner's office

An independent medical examiner's service was introduced to the Trust in April 2020 to provide enhanced scrutiny to deaths and to offer a point of contact for bereaved families wishing to raise concerns.

The purpose of this service is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- Ensure the appropriate direction of deaths to the coroner
- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- Improve the quality of death certification
- Improve the quality of mortality data

During Q2 2025/26 the medical examiner's (ME) service scrutinised 100% of in-hospital adult and child deaths and identified 63 cases of potential learning for the Trust and 17 cases of potential learning for other organisations. Potential learning identified during medical examiner scrutiny is shared with the patient's named consultant, divisional mortality review group and the Trust-wide Mortality Surveillance Group. Full consultant led mortality review is required whenever the ME's identify the potential for learning.

Thematic learning from medical examiner scrutiny is reported to the Mortality Surveillance Group, Executive Management Board, and Quality Committee (via annual ME report).

3.1. Medical Examiner's Office – Positive feedback

The positive feedback collected by the ME service highlights a deeply embedded culture of compassionate, respectful, and person-centred care across Chelsea and Westminster Hospital NHS Foundation Trust. Families consistently praised staff for their kindness, empathy, and attentiveness, especially during end-of-life care. Communication was described as clear and supportive, with staff taking time to explain, reassure, and involve relatives. Efficiency in processes such as rapid response and timely documentation was noted, alongside collaborative teamwork across departments. Individual staff and teams were frequently recognised for going above and beyond, with special appreciation for palliative care, ICU, and bereavement support. Cultural sensitivity, dignity, and holistic support were recurring themes, reflecting the hospital's commitment to excellence in care.

The following themes were highlighted for deaths occurring between October 2024 and September 2025:

- **Compassionate Care** – Staff consistently described as kind, caring, and supportive.
- **Clear Communication** – Families appreciated honest, empathetic updates.
- **Teamwork** – Strong collaboration across departments.
- **Efficiency** – Fast responses and timely documentation.
- **Cultural Sensitivity** – Respect for religious and family needs.
- **Staff Recognition** – Many individuals and teams praised by name.
- **Holistic Support** – Emotional and spiritual care from chaplains and volunteers.
- **Dignity and Respect** – Thoughtful gestures and respectful treatment.

4. Adult and child mortality review

Mortality case review provides clinical teams with the opportunity to review expectations, outcomes and potential improvements with the aim of:

- Identifying sub-optimal or excellent care
- Identifying service delivery problems
- Developing approaches to improve safety and quality
- Sharing concerns and learning with colleagues

In-hospital adult and child deaths are screened by consultant teams using the screening tool within Datix, this supports the identification of cases that would benefit from full mortality review.

Learning from review is shared at specialty mortality review groups (M&Ms / MDTs); where issues in care, trends or notable learning is identified action is steered through Divisional Mortality Review Groups and the trust-wide Mortality Surveillance Group (MSG).

Trust mortality review targets:

- 100% of in-hospital adult and child deaths to be screened
- At least 30% of all adult deaths aligned to the Emergency and Integrated Care (EIC) Division to undergo full mortality review
- At least 80% of all adult and child deaths aligned to Planned Care Division (PCD), Women's Neonates, HIV/GUM, Dermatology (Specialist Care Division - SCD), and West London Children's Health (WLCH) to undergo mortality review
- 100% of cases aligned to a Coroner inquest to undergo full mortality review

- 100% of cases where potential learning identified by Medical Examiner to undergo full mortality review

During October 2024 to September 2025; 1,314 in-hospital adult or child deaths were recorded within the Trust's mortality review system (Datix), of these 92% have been screened and 40% have had full mortality case review.

	No. of deaths	No. of cases screened only and closed	No. of cases with full mortality review	No. of cases pending screening	% Screened	% with Full Review	% Pending
Q3 24/25	340	172	163	5	**99%**	**48%**	**1%**
Q4 24/25	378	201	163	14	**96%**	**43%**	**4%**
Q1 25/26	297	165	118	14	**95%**	**40%**	**5%**
Q2 25/26	299	150	82	67	**78%**	**27%**	**22%**
Totals	**1314**	**688**	**526**	**100**	**92%**	**40%**	**8%**

Table 5: Adult and child mortality review status by financial quarter, October 2024 – September 2025

Process compliance is monitored by the Divisional Mortality Review Groups, Mortality Surveillance Group, and overseen by the Patient Safety Group, Executive Management Board, and Quality Committee.

Division	No. of deaths	No. of cases screened and closed	No. of cases with full mortality review	No. of cases pending screening	% Screened	% with Full Review	% Pending
Emergency and Integrated Care	1064	681	323	60	**94%**	**30%**	**6%**
Planned Care	237	2	196	39	**84%**	**83%**	**16%**
West London Children's Healthcare	7	0	7	1	**100%**	**100%**	**14%**
Specialist Care	6	5	0	0	**83%**	**0%**	**0%**
Totals	**1314**	**688**	**526**	**100**	**92%**	**40%**	**8%**

Table 6: Adult and child mortality review status by Division, October 2024 – September 2025

Gaps in process compliance at Specialty and Divisional level are monitored by the Mortality Surveillance Group. Divisional plans to achieve the required compliance are reported to the Mortality Surveillance Group and Executive Management Board.

	No. of deaths	No. of cases screened and closed	No. of cases with full mortality review	No. of cases pending screening	% Screened	% with full review	% Pending
Acute Frailty Service	5	2	2	1	**80%**	**40%**	**20%**
Acute Medicine	329	245	82	2	**99%**	**25%**	**1%**
Anaesthetics	1	0	0	1	**0%**	**0%**	**100%**
Bariatric	1	0	0	1	**0%**	**0%**	**100%**
Burns	8	0	8	0	**100%**	**100%**	**0%**

	No. of deaths	No. of cases screened and closed	No. of cases with full mortality review	No. of cases pending screening	% Screened	% with full review	% Pending
Cancer Services	1	0	0	1	**0%**	**0%**	**100%**
Cardiology	34	13	21	0	**100%**	**62%**	**0%**
Care Of Elderly	285	217	59	9	**97%**	**21%**	**3%**
Colorectal	10	0	2	8	**20%**	**20%**	**80%**
Diabetes/Endocrine	66	42	11	13	**80%**	**17%**	**20%**
Ear, Nose, Throat	0	0	0	0	**0**	**0**	**0**
Early Pregnancy	0	0	0	0	**0**	**0**	**0**
Emergency Department	93	3	75	15	**84%**	**81%**	**16%**
Gastroenterology	68	32	33	3	**96%**	**49%**	**4%**
General Surgery	29	1	11	17	**41%**	**38%**	**59%**
Gynaecology	1	0	0	1	**0%**	**0%**	**100%**
Haematology	6	1	1	4	**33%**	**17%**	**67%**
HDU	8	0	8	0	**100%**	**100%**	**0%**
Hepatology	6	4	2	0	**100%**	**33%**	**0%**
HIV	5	5	0	0	**100%**	**0%**	**0%**
ICU	129	0	128	1	**99%**	**99%**	**1%**
Maternity / Obstetrics	0	0	0	0	**0**	**0**	**0**
Maternity Community	0	0	0	0	**0**	**0**	**0**
Medical Oncology	22	14	4	4	**82%**	**18%**	**18%**
Neurology	1	1	0	0	**100%**	**0%**	**0%**
NICU / SCBU	0	0	0	0	**0**	**0**	**0**
Paediatric Emergency	0	0	0	0	**0**	**0**	**0**
Paediatric Medical	7	0	7	0	**100%**	**100%**	**0%**
Palliative Care	0	0	0	0	**0**	**0**	**0**
Plastics/Hands	1	0	1	0	**100%**	**100%**	**0%**
Respiratory	104	72	26	6	**94%**	**25%**	**6%**
Rheumatology	0	0	0	0	**0**	**0**	**0**
Stroke	44	35	7	2	**95%**	**16%**	**5%**
Trauma / Orthopaedics	30	1	26	3	**90%**	**87%**	**10%**
Urology	20	0	12	8	**60%**	**60%**	**40%**
Total	**1314**	**688**	**526**	**100**	**92%**	**40%**	**8%**

Table 7: Adult and child mortality review status by Specialty, October 2024 – September 2025

The Trust operates a learning from deaths process that places significant value on case discussion and learning undertaken within specialty and divisional multi-disciplinary teams. These meetings are scheduled throughout the year (monthly) and supported by a wide range of clinical staff and the clinical governance department. This approach to quality ensures learning is agreed and widely cascaded.

Process compliance metrics should be reported to the Quality Committee and Board in arrears as some cases are still progressing and should therefore not be used to draw conclusions regarding process compliance.

5. Perinatal mortality review

The Perinatal Mortality Review Tool (PMRT) is a national mandatory monitoring and assurance dataset developed by MBRRACE-UK. It is used to collect very detailed information about the care mothers and babies have received throughout pregnancy, birth and afterwards. The purpose of the PMRT is to support hospital learn from deaths by providing a standardised and structured review process.

The PMRT is designed to support review of:

- All late fetal losses (22 weeks + 0 days to 23 weeks + 6 days);
- All antepartum and intrapartum stillbirths;
- All neonatal deaths from birth at 22 weeks + 0 days to 28 days after birth;

Learning from these cases is captured within the PMRT. The national target is to complete PMRT review within 6 months. The reporting time scales for PMRT do not align within the timescales of this report therefore the below data is 2 quarters behind. During the 3 month period ending March 2025; 18 cases were identified as requiring PMRT review (including post-neonatal deaths not reported via MBRRACE-UK).

	No. reported	Not supported for review	Review in progress	Review completed	Grading of care: no. with issues in care likely to have made a difference to outcome
Stillbirths and late fetal losses	13	3	0	10	**0**
Neonatal and post-natal deaths	11	3	2	6	**0**

Table 8: PMRT review status by case category, 1 January 25– 31 March 25

Learning from PMRT review is reported to the Mortality Surveillance Group; where sub-optimal care that could have impacted outcome is identified cases are escalated as potential serious incidents. The organisation publishes a Learning from Serious Incidents report on a quarterly basis and outcomes / learning is received by the Patient Safety Group and Executive Management Board on a monthly basis.

6. Learning from Life and Death Reviews

A national Learning Disabilities Mortality Review (LeDeR) programme was established in May 2015 in response to the recommendations from the Confidential Inquiry into premature deaths of people with learning disabilities. From January 2022, LeDeR reports have included deaths of autistic people without a learning disability. In response to this change and following stakeholder engagement, the new name for the LeDeR programme is 'Learning from Life and Death Reviews – people with a learning disability and autistic people'.

The Trust reported 5 deaths in Q2:

Ref	Month of Death	Approval status	Specialty	CESDI grade
MM15657	Sep	Awaiting Specialty Review	Acute Medicine	CESDI 0
MM15418	Aug	Awaiting Specialty Review	ICU	CESDI 0
MM15325	Jul	Closed	Acute Medicine	CESDI 0
MM15288	Jul	Awaiting Specialty Review	Urology	Awaiting PSII
MM15156	Jul	Closed	Acute Medicine	CESDI 0

Table 9: Learning from Life and Death Review cases during July – September 2025

The Learning from Life and Death Review programme seeks to coordinate, collate and share information about the deaths of people with learning disabilities and autistic people so that common themes, learning points and recommendations can be identified and taken forward at both local and national levels. The Trust is committed to ensuring deaths of patients with known / pre-diagnosed learning disabilities and /or autism are reported to the Learning from Life and Death Review programme and reviewed accordingly.

Since July 2023 Learning from Life and Death Review notifications are only for those aged 18 years and over. The NWL ICB have representatives attend Child Death Review Meetings. This ensures that the death is looked at from a health inequalities perspective. The Child Death Review Team monitor the themes from reviews and continue to share them with the NWL ICB Learning from Life and Death Review team.

7. Areas of focus

The Trust's mortality review programme provides a standardised approach to case review designed to improve understanding and learning about problems and processes in healthcare associated with mortality, and also to share best practice.

Where problems in care are identified these are graded using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categories:

- Grade 0: No suboptimal care or failings identified and the death was unavoidable
- Grade 1: A level of suboptimal care identified during hospital admission, but different care would NOT have made a difference to the outcome and the death was unavoidable
- Grade 2: Suboptimal care identified and different care MIGHT have made a difference to the outcome, i.e. the death was possibly avoidable
- Grade 3: Suboptimal care identified and different care WOULD REASONABLY BE EXPECTED to have made a difference to the outcome i.e. the death was probably avoidable

During the past 12 months, 464 full mortality reviews have been closed following discussion at specialty, divisional or Trust wide mortality review groups.

Period	CESDI 0	CESDI 1	CESDI 2	CESDI 3
Q3 24/25	132	24	2	0
Q4 24/25	124	24	3	0
Q1 25/26	94	12	0	0
Q2 25/26	39	10	0	0
Total	389	70	5	0

Table 10: Closed mortality cases by CESDI grade October 2024 – September 2025

Five cases were identified via the mortality review process as a CESDI 2 (different care MIGHT have made a difference to the outcome, i.e. the death was possibly avoidable). Each of these cases were escalated to the executive for a decision on appropriate learning response.

All cases of suboptimal care are presented to the Mortality Surveillance Group to ensure shared learning across the Trust. There were four cases identified at West Middlesex hospital and one case identified at Chelsea and Westminster hospital. This is within expectations in a patient cohort with increased frailty and comorbidities.

Mortality Ref	CESDI grade	Incident Ref	Site	Area	Datix sub-category	Incident investigation status
MM13640	CESDI 2	INC146405	CWH	General Surgery	Inadequate or inappropriate care/treatment	Patient Safety Incident Investigation (PSII) Completed
MM13656	CESDI 2	INC145028	WMH	Trauma / Orthopaedics	Patient Fall	Patient Safety Incident Investigation (PSII) Completed
MM14029	CESDI 2	INC148457	CWH	Emergency Department	Failure / Delay to act on results	After Action Review (AAR) Completed
MM14374	CESDI 2	INC150601	CWH	ICU	Airway Management Issues	After Action Review (AAR) Completed
MM14373	CESDI 2	INC152557	WMH	Acute Medicine	Delay or failure to monitor	Patient Safety Incident Investigation (PSII) Underway

Table 11: CESDI grade 2 cases linked to an incident learning response, October 2024 – September 2025

Population demographics, hospital service provision, intermediate/community service provision all have an effect on the numbers of incidents occurring on each site. Mortality reviews graded CESDI 2 and 3 will have an associated patient safety incident reported.

The Trust is committed to delivering a just, open and transparent approach to investigations that reduces the risk and consequence of recurrence. Key themes from incident investigations linked to mortality review are submitted to the Patient Safety Group and the Executive Management Group for shared learning and consideration of whether further Quality Improvement Projects, deep-dives, or targeted action is required.

The organisation publishes a learning from Safety learning responses on a monthly basis and outcomes/learning is received by the Patient Safety Group, local Quality Committee and Executive Management Board on a monthly basis (with case outlines and associated actions).

There were 70 cases graded as a CESDI 1 (e.g. level of suboptimal care identified during hospital admission, but different care or management would NOT have made a difference to the outcome and the death was unavoidable). Learning from CESDI 1 cases provides the Trust and our teams with excellent learning from which to develop our improvement approaches.

The following specialist teams have successfully identified CESDI 1 learning opportunities from across the patient journey (not necessary occurring whilst the patient was under the care of that speciality). The identification of CESDI grade 1 cases should not be used to draw conclusions regarding quality and safety within the identifying specialty.

Specialty	CW	WM	Total
Acute Medicine	12	8	20
ICU	11	6	17
Care Of Elderly	6	6	12
Gastroenterology	1	7	8
Trauma / Orthopaedics	1	3	4
Respiratory	1	2	3
Diabetes/Endocrine	2	0	2

Specialty	CW	WM	Total
Urology	0	1	1
Plastics/Hands	1	0	1
Emergency Department	0	1	1
Cardiology	0	1	1
Total	**35**	**35**	**70**

Table 12: CESDI grade 1 cases by Specialty, October 2024 – September 2025

The Divisional Mortality Review Groups (DMRGs) provide rigorous scrutiny of mortality cases to identify key learning themes and escalate any concerns.

The main themes emerging from DMRG reviews include the need for accurate and timely communication and handover, thorough documentation of clinical decisions and escalation plans, prompt escalation and senior review for deteriorating patients, clear allocation of responsibility and coordination between specialties, adherence to clinical guidelines, robust patient safety processes, early and ongoing end-of-life discussions with families, and systematic use of incident reviews to drive improvements in practice and systems.

Appendix 4 elaborates on these themes further.

8. Prevention of future deaths (PFD) 25/26

The Trust has not been issued with a Prevention of Future Deaths (PFD) notice during Q2 2025/26.

9. Conclusion

The outcome of the Trust's mortality surveillance programme continues to provide a rich source of learning that is supporting the organisation's safety improvement objectives.

The Trust continues to be recognised as having one of the lowest relative risk of mortality (SHMI) across the NHS in England. The Trust is committed to better understanding the distribution of mortality according to the breakdown of our patient demographics (Appendix 2) and ensure we tackle any health inequalities that we identify in doing so.

As part of the rollout of the Patient Safety Incident Response Framework (PSIRF) the mortality review template is being used as a learning response tool and the follow-up of safety action plans will be done via the Divisional Mortality Review Groups as well as the Mortality Surveillance Group going forward. Any cases that are escalated as CESDI 2 and 3 are also brought to the weekly Initial Incident Review Group for a proportionate decision on learning response and approval by the executive team.

10. Glossary

10.1. **Medical Examiners** are responsible for reviewing every inpatient death before the medical certificate cause of death (MCCD) is issued, or before referral to the coroner in the event that the cause of death is not known or the criteria for referral has been met.. The ME will also discuss the proposed cause of death including any concerns about the care delivered with bereaved relatives.

10.2. **Specialty M&M** reviews are objective and multidisciplinary reviews conducted by specialties for cases where there is an opportunity for reflection and learning. All cases where ME review has identified issues of concern must be reviewed at specialty based multi-disciplinary Mortality & Morbidity (M&M) reviews.

10.3. **Child Death Overview Panel (CDOP)** is an independent review aimed at preventing further child deaths. All child deaths are reported to and reviewed through Child Death Overview Panel (CDOP) process.

10.4. P**erinatal Mortality Review Tool (PMRT)** is a review of all stillbirths and neonatal deaths. Neonatal deaths are also reviewed through the Child Death Overview Panel (CDOP) process. Maternal deaths (during pregnancy and up to 12 month post-delivery unless suicide) are reviewed by Healthcare Safety Investigation Branch and action plans to address issues identified are developed and implemented through the maternity governance processes.

10.5. **Learning from Life and Death Reviews** is a review of all deaths of patients with a learning disability/Austism. The Trust reports these deaths to the Local integrated care boards (ICBs) who are responsible for carrying out the reviews. Mortality reviews for patients with learning disabilities are undertaken within the Trust and will be reported through the Trust governance processes.

Appendix 1 - Performance Scorecard

	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26	Comments	National LfD min. requirement?
Summary data						
Total no. deaths (adult and children)	340	378	297	299	Inpatients deaths only	
Total no. adult deaths	338	375	296	298	Inpatients over 18 years age	Y
Total no. child deaths	2	3	1	1	Inpatients over 28 days and less than 18 year only	
Total no. neonatal deaths	15	12	14	12	Inpatients livebirths under 28 days of age	
Total no. stillbirths	15	13	15	9	Inpatient not live births	
Deaths reviewed by Medical Examiner	99%	100%	100.0%	100%	% of total deaths (row 3)	
Deaths referred for Level 2 review	50%	45%	42%	34%	% of total deaths (row 3)	
Level 2 reviews completed	95%	90%	86%	48%	% of total referrals this quarter	Y
Requests made by a Medical Examiner (Potential learning identified)	46%	45%	42%	61%	% of total referrals	
Potential learning identified (Screening)	36%	35%	42%	46%	% of total referrals	
Concerns raised by family / carers (Screening)	14%	11%	10%	10%	% of total referrals	
Patients with learning disabilities (Screening)	3%	4%	6%	5%	% of total referrals	
Patients with severe mental health issues (Screening)	0%	1%	1%	0%	% of total referrals	
Unexpected deaths (Screening)	14%	18%	10%	14%	% of total referrals	
Requests made by speciality mortality leads through local Mortality and Morbidity review processes	26%	25%	30%	11%	% of total referrals	
Other reason (Linked SI, Inquest, Nosocomial Covid, DMRG request)	5%	5%	3%	6%	% of total referrals	
CESDI 0 - No suboptimal care	84%	81%	88%	80%	% of cases reviewed (&closed)	
CESDI 1 - Some sub optimal care which did not affect the outcome	15%	16%	12%	20%	% of cases reviewed (&closed)	
CESDI 2 - Suboptimal care – different care might have made a difference to outcome (possible avoidable death)	1%	2%	0%	0%	% of cases reviewed (&closed)	
CESDI 3 - Suboptimal care - would reasonably be expected to have made a difference to the outcome (probably avoidable death)	0%	0%	0%	0%	% of cases reviewed (&closed)	Y

Table 11. Trust mortality review data as at 06/11/2025

Appendix 2 – Ethnicity breakdown (for Total no. deaths adult and children)

	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26	Total
White - British	149	164	142	127	582
Other - Not Stated	46	53	34	55	188
Asian or Asian British - Indian	30	35	23	22	110
White - Any Other White Background	26	26	28	19	99
Asian - Any Other Asian Background	14	23	27	26	90
To be recorded	20	30	14	14	78
Other - Any Other Ethnic Group	20	13	6	11	50
White - Irish	5	11	5	6	27
Asian or Asian British - Pakistani	10	4	7	3	24
Black - Any Other Black Background	2	10	3	6	21
Black or Black British - African	5	4		4	13
Black or Black British - Caribbean	5	3	3	2	13
Mixed - Any Other Mixed Background	2		3	2	7
Other - Chinese	3	1	1		5
Mixed - White and Asian	1			2	3
Mixed - White and Black African	1	1			2
Mixed - White and Black Caribbean			1		1
Asian or Asian British - Bangladeshi	1				1
Grand Total	340	378	297	299	1314

Appendix 3 – Themes highlighted from Positive feedback collected by the ME service

The following themes were highlighted for deaths occurring between October 2024 and September 2025:

- **Compassionate and Person-Centred Care**
  - Families and patients consistently describe staff as “kind”, “caring”, “compassionate”, and “amazing”.
  - There is clear evidence of sensitive, responsive support, especially at the end of life, allowing patients to die with dignity.
  - Staff are praised for caring not only for patients but also for their families, ensuring everyone feels supported.
- **Excellent Communication**
  - Many comments highlight “excellent communication” between staff and families, including clear explanations and regular updates.
  - Staff are recognised for being attentive, empathetic, and for taking time to answer questions and provide reassurance.
- **Teamwork and Collaboration**
  - Several examples mention effective teamwork, with different departments (medical, palliative care, ICU, surgical, nursing, and support staff) working together to provide seamless care.
  - There are specific mentions of collaborative efforts in complex cases and emergency situations.
- **Going Above and Beyond**
  - Staff are frequently described as going “above and beyond”, being “phenomenal”, and “doing everything they could” for patients and families.
  - Acts such as arranging urgent documentation for funerals, accommodating large families, and making special efforts to ensure family presence at critical moments are noted.
- **Timeliness and Efficiency**
  - Positive feedback includes praise for the speed and efficiency of services, such as rapid ambulance response, quick issue of medical certificates, and prompt referrals to palliative care.
- **Recognition of Individuals and Teams**
  - Many staff members are named and personally thanked for their outstanding care, including doctors, nurses, palliative care teams, and support staff.
  - Teams such as ICU, AMU, Ron Johnson, Chelsea Wing, and palliative care are repeatedly highlighted for their excellence.
- **Dignity and Respect**
  - Care is described as “respectful”, with staff ensuring privacy, tidying rooms, and maintaining dignity for patients and families.
  - Special mention is made of staff being accommodating to cultural and religious needs, such as urgent burials.
- **Holistic Support**
  - Feedback notes the involvement of chaplains, butterfly volunteers, and bereavement teams, providing emotional and spiritual support alongside medical care.

Appendix 4 – Themes highlighted at the Divisional Mortality Review Groups

Following case discussions at the DMRGs, the following themes and issues were flagged to the Mortality Surveillance Group between October 2024 and June 2025:

- **Communication and Handover**
  - Importance of accurate and timely handover, especially during transfers and at discharge.
  - Need for clear, consistent communication with families, especially where prognosis is uncertain or complex.
  - Ensuring all relevant information (e.g. oxygen requirements, escalation plans) is documented and shared.
- **Documentation and Record Keeping**
  - Correct and thorough documentation of clinical decisions, handovers, and treatment escalation plans (TEPs).
  - Avoiding errors such as copying and pasting incorrect information.
  - Ensuring all actions and rationale are clearly recorded, especially for complex or high-risk cases.
- **Escalation and Timeliness of Care**
  - Prompt escalation of deteriorating patients and prioritisation of emergency procedures based on clinical need.
  - Timely senior review and multidisciplinary team (MDT) involvement, particularly in complex or rapidly changing cases.
  - Early referral to palliative care when appropriate.
- **Specialty Coordination and Ownership**
  - Clear allocation of responsibility for patients, especially those with complex needs or who are medical outliers.
  - Improved coordination between specialties (e.g. medicine, surgery, palliative care, radiology) to avoid delays and confusion.
- **Adherence to Guidelines and Protocols**
  - Following clinical guidelines for medication use (e.g. opioids in renal impairment), escalation, and end-of-life care.
  - Regular review and updating of guidelines and order sets to reflect best practice and learning from incidents.
- **Patient Safety and Risk Management**
  - Ensuring robust processes for monitoring, such as telemetry and observation frequency.
  - Addressing environmental and system factors (e.g. broken facilities, bed pressures) that impact care quality.
  - Safeguarding checks and proactive symptom control for vulnerable patients.
- **End-of-Life Care and Family Involvement**
  - Early and ongoing discussions about prognosis, escalation, and end-of-life care with patients and families.
  - Respecting patient and family wishes, and ensuring privacy and dignity at the end of life.
- **Learning from Incidents and Feedback**
  - Reflecting on cases to identify learning points and share them with relevant teams.
  - Using incident reviews and mortality meetings to drive improvements in practice and systems.

NWL Acute Provider Collaborative Board in Common (Public)
20/01/2026
Item number: 4.1.3
This report is: Public

ICHT Learning from Deaths quarterly report – Quarter Two 2025/2026

Author: Heena Asher & Shona Maxwell
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Accountable director: Professors Julian Redhead & Raymond Anakwe
Job title: Medical Directors

Purpose of report

Purpose: Assurance

This report presents the data from the ICHT Learning from Deaths programme for Quarter Two (Q2) of 2025/26 for information. It is a statutory requirement to present this information to the Trust public board. This was achieved through presentation to our standing committee, with an overarching summary paper drawing out key themes and learning from the individual reports from the four NWL acute provider collaborative (APC) trusts presented to the APC quality committee and then Board in common. A glossary is provided at the end of the report.

Report history

ICHT Learning from deaths forum
Various
The group discussed and agreed the content of this report, including themes for learning and improvement.

ICHT Executive management board quality group and Executive Management Board (EMBQ and EMB)
20/10/2025 & 28/10/2025
The committee noted the findings from our learning from deaths programme and approved the report for onward submission.
The importance of M&M meetings was discussed, and an action added for divisions to ensure improvement plans will meet target compliance.

ICHT Quality Committee & Standing Committee
06/11/2025 & 06/01/2025
The report was noted and approved for onward submission.

Executive summary and key messages

1.1. Mortality rates remain statistically significantly low.

1.2. All deaths this quarter underwent Medical Examiner review, with cases raising care quality concerns referred for Structured Judgement Review (SJR). Completed SJRs have identified examples of excellent team working and good communication with families. No new themes for improvement were identified with ongoing work to improve treatment for patients with signs of deterioration as part of our safety improvement programme.

1.3. There were six SJRs which identified some sub-optimal care which might or would reasonably have been expected to have made a difference to the patient's outcome. These are all investigated through the patient safety incident investigation framework (PSIRF) to confirm the learning response and any actions. The importance of the morbidity & mortality (M&M) meetings was highlighted to support learning; divisions have been asked to review their improvement plans at specialty level and submit a trajectory to reach a compliance target of 90% in this financial year.

1.4. There has been a reduction over the last two quarters in cases involving suboptimal treatment of deteriorating patients and we have seen a reduction by over 50% in moderate harm and above incidents in this category over the last year, positive indicators of the impact of our improvement work.

1.5. This level of scrutiny is important to ensure all issues are considered and questions from the bereaved are highlighted and answered. The low number of issues found that affected the outcome and our low mortality rates are positive reflections of the care delivered.

1.6. Since new statutory requirements relating to death certification came into effect in September 2024 we continue to have an increase in referrals to the Medical Examiner service from community providers. We continue to improve our internal processes to make the service more effective for bereaved families and engage with community partners to ensure we embed the new ways of working required across the system.

Impact assessment

☒ Quality

Improving how we learn from deaths which occur in our care will support identification of improvements to quality and patient outcomes.

Strategic priorities

☒ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation (APC)

☒ Develop a sustainable portfolio of outstanding services (ICHT)

☒ Build learning, improvement and innovation into everything we do (ICHT)

Key risks arising from report

The committee is asked to note the findings from our Learning from Deaths programme, with no new issues requiring escalation. A key focus is embedding specialty M&M meetings. Divisions have been asked to review their plans to address the current gaps to target.

Main Report

2. Learning and Improvements

2.1. Learning from Deaths (LFD) is a standard monthly agenda item on all Divisional Quality and Safety meetings where investigations and learning are shared which is then disseminated to all the directorates and throughout the divisions.

2.2. Sixty-four structured judgment reviews (SJRs) were completed in this quarter, 61 for deaths which occurred in Q2, and 3 for deaths from Q1. Fifty-one found no suboptimal care (80%), with thirty-eight (60%) specifically identifying that patients received good or excellent care including communication with the next of kin. Eighteen (29%) identified good documentation, teamwork and senior decision making. Critical Care and cardiology services were specifically highlighted positively.

2.3. Three cases (5%) highlighted issues with communication with next of kin, and four cases (6%) the need for improved documentation.

2.4. This quarter, 6 SJRs identified that sub-optimal care might or would reasonably have been expected to have made a difference to the patient's outcome (CESDI 2 or 3). This was similar to last quarter and a slight increase from Q4 24/25 (4). No overall common themes have been identified and patient safety investigations are underway, the outcome of which will be reported in future reports.

2.5. There has been a reduction over the last two quarters in cases involving suboptimal treatment of deteriorating patients and we have seen a reduction by over 50% in moderate harm and above incidents in this category over the last year, positive indicators of the impact of our improvement work.

3. Key themes

3.1. Mortality rates

3.1.1 Our mortality rates remain statistically significantly low. The rolling 12-month HSMR, based on data to June 2025, has reduced to 75.1 (compared to 77.6 in the previous quarter) and is fourth lowest when compared nationally. Our SHMI is the lowest at 71.73, based on data to June 2025.

3.1.2 North West London Acute Collaborative HSMR indicators

Trust	Provider spells	Observed deaths	Expected deaths	HSMR	Lower CI	Upper CI
LNWH	201763	2,003	2075.4	96.5	92.3	100.8
THH	83790	655	636.5	102.9	95.2	111.1
ICHT	244530	1600	2129.9	75.1	71.5	78.9
CWFT	160590	1220	1547.3	78.8	74.5	83.4

HSMR (41 diagnostic groups) by APC provider, July 2024 to June 2025, Source: Telstra

3.1.3 North West London Acute Collaborative SHMI indicators

Trust	Provider spells	Observed deaths	Expected deaths	SHMI	LCL 95%CI	UCL 95%CI
LNWH	105685	2690	3130	85.92	85.65	116.76
THH	48775	920	990	93.05	84.94	117.74
ICHT	118365	2180	3035	71.73	85.64	11 6.77
CWFT	89,540	1720	2275	75.50	85.52	116.93

SHMI by APC provider, July 2024 to June 2025, Source: NHS Digital, published 13th November 2025

3.1.4 Following methodological changes that removed 'other perinatal conditions' as a diagnosis group, the maternity rate has remained at 0 (previously well over 100). WLCH initially saw an increase likely linked to these changes, there has been a reduction over

the last two quarters as the methodology becomes established. The updated HSMR model is predominantly adult-focused, limiting its relevance in maternity services and paediatrics. Crude death numbers have remained stable for WLCH throughout this period. The model remains highly sensitive to small changes in observed mortality due to very low expected deaths and does not account for variables such as the level of intensive care provided.

3.1.5 Last quarter at site level, there was an increase noted in HSMR at SMH and CXH. Both sites have now returned to a low relative risk and HH is reported as within expected range. All are below the NHS benchmark of 100.

3.1.6 QCCH is not reported at site level as the numbers of deaths are very low which causes too much variation for the data to be used effectively. Deaths are still reviewed through standard learning from deaths processes.

3.2. Diagnostic group reviews

3.3.1 No new diagnostic alerts were received in Q2. There are no alerts from previous quarters which remain under review.

3.3. Directorate reviews

3.3.2 Crude deaths reduced in Q2, with 424 reported compared to 440 in Q1, following elevated figures in Q3 (512) and Q4 (518) 2024/25. These increases were reviewed through the LFD forum and are linked to seasonal variation.

3.3.3 There was an increase in deaths in the urgent and emergency care directorate noted in Q1 report, which remains under investigation. The report will be reviewed in Q3 and findings will be summarised in the next report.

3.4. Medical Examiner reviews

3.4.1. The Medical Examiner (ME) service continues to provide independent scrutiny of non-coronial inpatient deaths. Of the 424 deaths this quarter, 316 were reviewed, and 108 referred directly to the coroner. Forty-three will be taken forward for inquest. The numbers are similar to the previous quarter.

3.4.2. The largest percentage of coronial referrals were death resulting from violence, trauma, or injury (34%), reflecting the major trauma centre at SMH, the same as last quarter.

3.4.3. The second most common reason was death associated with medical procedures or treatments (30%, like the previous quarter). Some of these cases involved complications following elective admissions and those who had undergone procedures or treatments at other hospitals prior to transfer. All such cases are reviewed to determine whether incidents requiring further investigation have occurred. While no issues currently require escalation, this continues to be reviewed.

3.4.4. Weekly review continues of all new cases to ensure investigations and file preparation can begin as early as possible where required. The increase in referrals and inquest listing over the last 3 years continues to cause resource implications, delays in response submission and adjournment requests.

3.4.5. Following the recent team restructure, resource allocation adjustments are now being implemented. These operational improvements remain subject to ongoing evaluation as new measures are introduced.

3.4.6. The ME service continue to scrutinise all non-coronial deaths in community boroughs of Hammersmith & Fulham and Westminster. This quarter, we reviewed 251 non-acute deaths, similar to last quarter. Primary care and independent providers are now fully aligned and engaged with the process.

3.4.7. In Q2, we issued 67.6% of urgent MCCDs within 24 hours and 66.7% of non-urgent MCCDs within three days, a slight decline from Q1 (74% and 71% respectively).

3.4.8. Efforts to enhance timeliness included implementing a new rota, monitoring and escalating delays to directorate leadership. The focus remains on managing the increasing community referrals while ensuring timely reporting and we are working with the providers to share outcomes for the non-acute deaths, with regular meetings in place.

3.5. Structured Judgement reviews (SJR)

3.5.1. The percentage of inpatient deaths referred for a SJR has increased from last quarter (16% compared to 13% in Q1) with 'requests made by medical examiner' the most common reason (22%) and unexpected deaths reducing from 37% to 23% this quarter.

3.5.2. There has been an increase in 'elective admission' cases referred for SJR over the last two quarters (15% in Q1 and 21% in Q2). This is being reviewed by the LFD forum, and findings will be summarised in the next report.

3.5.3. 80% of SJRs (n=51) found no suboptimal care (CESDI 0) compared to 76% in Q1 and 75% in Q4. Reviews identified evidence of excellent care, good communication and documentation in many cases.

3.5.4. A further 11% of reviews (n=7) found some suboptimal care that did not affect the patient outcome (CESDI 1) compared to 13% in Q1 and 19% in Q4. All cases are reviewed to decide whether a further incident investigation is required and the final harm levels.

3.5.5. Eight percent (n=5) of deaths found that suboptimal care may have made a difference to the outcome (CESDI 2) similar to previous quarters. No common themes were identified.

3.5.6. One case identified sub-optimal care which would reasonably be expected to have made a difference to the outcome (CESDI 3), similar to the last 2 quarters.

3.5.7. All cases with a CESDI 2 or 3 outcome automatically trigger an immediate incident review (IIR). Once all investigations have been completed, the case is discussed at the Death Review Panel (DRP), to triangulate and agree a final outcome, learning and improvements needed.

3.5.8. This quarter, four SJRs for deaths from previous quarters were reviewed by the DRP. The table below shows the outcomes.

MM number	Quarter of death	CESDI score	Learning response type	Quarter of review at DRP	Poor care confirmed – Y/N	Death due to poor care – Y/N	Final harm level
MM29218	Q3 24/25	2	AAR	Q2 25/26	Y	Y	Death
MM29961	Q4 24/25	2	IIR	Q2 25/26	Y	N	Low harm
MM30974	Q1 25/26	3	IIR	Q2 25/26	N	N	No harm
MM30644	Q1 25/26	2	IIR	Q2 25/26	Y	Y	Death

3.5.9. For one of the four cases, there was no poor care identified. Poor care was confirmed in three cases, for one of these it was agreed that this did not contribute to the patient's death and was confirmed as low harm.

3.5.10. Two patient deaths were attributed to poor care, both classified as extreme harm. Actions taken include: (1) reviewing the rapid tranquillisation guideline to mandate senior decision-maker approval before parenteral sedation in patients lacking capacity; (2) creating a dedicated section in ICCA (ICU electronic record system) for all key considerations for patients with learning disabilities; and (3) embedding the ICU extubation checklist.

4. Other mortality review processes

4.1. **PMRT**

4.1.1. There were 20 perinatal deaths reported to MBRRACE-UK of which 17 (two late fetal losses, eleven stillbirths and four neonatal deaths) were eligible for full review using the Perinatal Mortality Review Tool (PMRT) framework.

4.1.2. One neonatal death met the criteria for referral to Maternity and Neonatal Safety Investigations (MNSI) for an independent external review in addition to PMRT.

4.1.3. Of the 17 eligible cases, five were discussed across three multidisciplinary panel meetings, none of which have received a grading of C or D.

4.1.4. During Q2, 15 cases from previous quarters were reviewed across six multidisciplinary panel meetings. One case was graded as C, indicating concerns regarding the care provided to the mother prior to the baby's death. The review highlighted missed opportunities to refer the patient to the prematurity team earlier in the pregnancy. An earlier referral could have enabled a planned cervical cerclage, which carries a lower risk of intrauterine death compared to the emergency procedure that was ultimately performed. This is being investigated as a patient safety incident investigation (PSII).

4.2. **LeDeR**

4.2.1. Six SJRs have been completed in this quarter for patients with a learning disability. All six found no sub-optimal care.

4.2.2. The Safeguarding team have completed LeDeR referrals for all cases in line with guidance.

4.3. **CDOP**

4.3.1. There were 7 deaths reported in Q2 for WLCH. CDOP referrals have been made, and detailed investigations will now take place. These reviews can take several months.

5. Areas of focus

5.1. Ethnicity

5.1.1. To improve data quality and reduce the proportion of deaths with unknown ethnicity, Q3 2024/25 saw the integration of data from the NWL Whole System Integrated Care (WSIC) platform. This enhanced dataset reduced unknown ethnicity cases from 17% (Cerner-only) to 9%, with further improvements seen since (see Appendix B).

5.1.2. The next steps are to include data relating to hospital services used by deceased patients to reveal any differences in healthcare access or use of services. We will also bring in additional demographic details, including age, gender, deprivation and primary language to expand the data set used and widen this analysis work. Further areas of focus will be discussed at the LFD forum and summarised in next quarter’s report.

5.2. Specialty Mortality and Morbidity meetings

5.2.1. The LFD forum continues to monitor compliance with the Trust Specialty M&M guidance that was agreed and implemented in January 2024.

5.2.2. There is evidence in Datix that Specialty M&M meetings are being held regularly for several specialties, including Cardiology, Renal and Stroke and Neurosciences directorates. There have been continued improvements in Urgent & Emergency Medicine and Critical care. Work continues to ensure outcomes are transferred and captured on Datix to accurately reflect the improvements.

5.2.3. Compliance across the Trust is continuing to improve but remains a key focus for improvement. Divisional action plans are being monitored through the performance and accountability review meetings; divisions have been asked to review their plans to address the current gaps to meet 90% compliance by year end.

6. Conclusion

6.1 Mortality rates across the Trust remain statistically significantly low. When considered with our harm profile and the outcomes of our SJRs we can provide assurance to the committee that we are providing safe care for most of our patients. Where care issues are found we have a robust process for referral for more in-depth review, the outcome of which is reported through the incident report and the quality assurance report to EMB and Quality Committee.

7. Glossary

7.1. **Medical Examiners (ME)** are responsible for reviewing every inpatient death before the MCCD is issued, or before referral to the coroner in the event that the cause of death is not known or the criteria for referral has been met. The Medical Examiner will request a Structured Judgement Review if required or if necessary refer a case for further review and possible investigation through our incident reporting process via the quality and safety team. The ME will also discuss the proposed cause of death including any concerns about the care delivered with bereaved relatives.

7.2. **Structured judgment reviews/Level 2 reviews** are additional clinical judgement reviews carried out on cases that meet standard criteria and which provide a score on the quality of care received by the patient during their admission.

7.3. **Specialty M&M** reviews are objective and multidisciplinary reviews conducted by specialties for cases where there is an opportunity for reflection and learning. All cases where ME review has identified issues of concern must be reviewed at specialty based multi-disciplinary Mortality & Morbidity (M&M) reviews.

7.4. **Child Death Overview Panel (CDOP)** is an independent review process managed by Local integrated care boards (ICBs) aimed at preventing further child deaths. All child deaths are reported to and reviewed through Child Death Overview Panel (CDOP) process.

7.5. **Perinatal Mortality Review Tool (PMRT)** is a review of all stillbirths and neonatal deaths. Neonatal deaths are also reviewed through the Child Death Overview Panel (CDOP) process. Maternal deaths (during pregnancy and up to 12 month post-delivery unless suicide) are reviewed by Healthcare Safety Investigation Branch and action plans to address issues identified are developed and implemented through the maternity governance processes.

7.6. **Learning Disabilities Mortality Review (LeDeR)** is a review of all deaths of patients with a learning disability. The Trust reports these deaths to NHSE who are responsible for carrying out LeDeR reviews. Level 2 reviews for patients with learning disabilities are undertaken within the Trust and will be reported through the Trust governance processes.

Other Acronyms

Imperial College Healthcare NHS Trust – ICHT
North West London Acute Provider Collaborative – APC

Sites

Charing Cross Hospital – CXH
Hammersmith Hospital – HH
Queen Charlotte's & Chelsea Hospital – QCCH

St Mary's Hospital – SMH
Western Eye Hospital – WEH

External organisations
Maternity and Newborn Safety Investigation programme – MNSI
Mothers and babies: reducing risk through audits and confidential enquiries – MBRRACE-UK

Committees and meetings
Executive Management Board – EMB
Executive Management Board Quality Group – EMBQ
Morbidity and Mortality meetings – M&M
Multidisciplinary Team meeting – MDT

Incident management and investigation terms
Patient Safety Incident Response Framework – PSIRF
Patient Safety Incident Response Plan – PSIRP
After Action Review – AAR
Initial Incident Review – IIR
Multidisciplinary Team Review – MDT review
Patient Safety Incident Investigation – PSII

Mortality/Inquests
Perinatal Mortality Review Tool – PMRT
Prevention of Future Deaths – PFD
Hospital Standardised Mortality Ratio – HSMR
Summary Hospital-level Mortality Indicator – SHMI
Medical Certificate of Cause of Death – MCCD

Appendix A – Performance scorecard

Financial Year	2024-2025		2025-2026	
Financial Quarter	Q3	Q4	Q1	Q2
No. Deaths	512	518	440	424
No. Adult Deaths	484	496	418	399
Adult Deaths per 1000 Elective Bed Days	0.04	0.05	0.04	0.04
No. Child Deaths	8	4	6	10
No. Neonatal Deaths	7	15	8	7
No. Stillbirths	13	3	8	8
ME Reviewed Deaths (excl Stillbirths) in Qtr	497	508	428	406
% ME Reviewed Deaths - Deaths (excl Stillbirths) in Qtr	100%	99%	99%	98%
SJRs Requested for Deaths in Qtr	48	67	54	65
% SJRs Requested for Deaths in Qtr of total adult deaths in Qtr	10%	14%	13%	16%
No. SJRs Completed in period	47	57	67	61
SJRs Completed for Deaths in Qtr	48	67	54	64
% SJRs Completed for Deaths in Qtr	100%	100%	100%	98%
No. LeDeR Completed	0	0	0	6
Requests made by a Medical Examiner - SJRs Requested for Deaths in	9	17	6	14
% Requests made by a Medical Examiner - SJRs Requested for Deaths	19%	25%	11%	22%
Concerns raised by family / carers - SJRs Requested for Deaths in Qtr	12	17	13	12
% Concerns raised by family / carers - SJRs Requested for Deaths in	25%	25%	24%	18%
Patients with learning disabilities - SJRs Requested for Deaths in Qtr	7	7	1	7
% Patients with learning disabilities - SJRs Requested for Deaths in Qtr	15%	10%	2%	11%
Patients with severe mental health issues - SJRs Requested for Deaths	2	6	4	4
% Patients with severe mental health issues - SJRs Requested for	4%	9%	7%	6%
Unexpected deaths - SJRs Requested for Deaths in Qtr	17	15	20	15
% Unexpected deaths - SJRs Requested for Deaths in Qtr	35%	22%	37%	23%
Elective admission deaths - SJRs Requested for Deaths in Qtr	4	5	8	13
% Elective admission deaths - SJRs Requested for Deaths in Qtr	8%	7%	15%	20%
Requests made by speciality mortality leads / through local Mortality and Morbidity review processes - SJRs Requested for Deaths in Qtr	2	3	5	5
% Requests made by speciality mortality leads / through local Mortality and Morbidity review processes - SJRs Requested for	4%	4%	9%	8%
Service or diagnosis alarms as agreed by APC mortality surveillance group - SJRs Requested for Deaths in Qtr	0	0	0	0
% Service or diagnosis alarms as agreed by APC mortality surveillance group - SJRs Requested for Deaths in Qtr	0%	0%	0%	0%
CESDI 0 - No suboptimal care - Completed SJRs for Deaths in Qtr	39	50	41	51
% CESDI 0 - No suboptimal care - Completed SJRs for Deaths in Qtr	81%	75%	76%	80%
CESDI 1 - Some sub optimal care which did not affect the outcome - Completed SJRs for Deaths in Qtr	4	13	7	7
% CESDI 1 - Some sub optimal care which did not affect the outcome - Completed SJRs for Deaths in Qtr	8%	19%	13%	11%
CESDI 2 - Suboptimal care – different care might have made a difference to outcome (possible avoidable death) - Completed SJRs	3	3	5	5
% CESDI 2 - Suboptimal care – different care might have made a difference to outcome (possible avoidable death) - Completed SJRs	6%	4%	9%	8%
CESDI 3 - Suboptimal care - would reasonably be expected to have made a difference to the outcome (probably avoidable death) -	2	1	1	1
% CESDI 3 - Suboptimal care - would reasonably be expected to have made a difference to the outcome (probably avoidable death) -	4%	1%	2%	2%

Appendix B – Ethnicity data

Financial Year	Cerner Data		Combined data set (WSIC and Cerner)	
Ethnicity_Cerner	No. Deaths	% Deaths	No. Deaths	% Deaths
Totals	917	100.0%	917	100.0%
-	17	1.9%	15	1.6%
Asian - Any Other Asian Background	52	5.7%	60	6.5%
Asian or Asian British - Bangladeshi	3	0.3%	4	0.4%
Asian or Asian British - Indian	55	6.0%	62	6.8%
Asian or Asian British - Pakistani	12	1.3%	13	1.4%
Black - Any Other Black Background	17	1.9%	29	3.2%
Black or Black British - African	30	3.3%	32	3.5%
Black or Black British - Caribbean	52	5.7%	49	5.3%
Mixed - Any Other Mixed Background	3	0.3%	7	0.8%
Mixed - White and Asian	-	-	2	0.2%
Mixed - White and Black African	5	0.5%	6	0.7%
Mixed - White and Black Caribbean	2	0.2%	7	0.8%
Other - Any Other Ethnic Group	151	16.5%	110	12.0%
Other - Chinese	4	0.4%	3	0.3%
Other - Not Known	13	1.4%	11	1.2%
Other - Not Stated	115	12.5%	52	5.7%
White - Any Other White Background	93	10.1%	152	16.6%
White - British	265	28.9%	266	29.0%
White - Irish	28	3.1%	41	4.5%

NWL Acute Provider Collaborative Board in Common (Public)
20/01/2026
Item number: 4.1.3
This report is: Public

London North West University NHS Trust

Learning from Deaths Report Quarter 2 2025/26

Author: Laila Gregory
Job title: Head of Clinical Effectiveness

Accountable director: Jon Baker
Job title: Chief Medical Officer

Purpose of report (for decision, discussion or noting)

Purpose: Assurance

This report presents the data from the Learning from Deaths programme for 2025/26 quarter 2 (Q2). It is a statutory requirement for Trusts to present this information to their boards; this is achieved through the presentation of this report to the LNWH Quality & Safety Committee and the submission of overarching learning drawn from across the acute provider collaborative (APC) to the APC Quality Committee and Board in common.

Report history

Outline committees or meetings where this item has been considered before being presented to this meeting.

Trust Executive Group	**LNWH Quality & Safety Committee**
12/10/2025	27/11/2025

Executive summary and key messages

The HSMR for the 12-month period July 2024 to June 2025 is 92.3 which remains lower than the national benchmark of 100. SHMI (July 2024 to June 2025) remains statistically low across the rolling 12-month at 85.92.

During the 12-month period to end of September 2025; 100% in-hospital adult and child deaths were recorded within the Trust's mortality review system (Datix), of these 100% have been screened and 377 have undergone level 2 in-depth review.

During Q2 20254/26; 13 cases had areas of sub-optimal care, treatment or service delivery identified at time of reporting. The Trust places significant value on case discussion and learning undertaken within specialty and divisional multi-disciplinary teams; for this reason, teams are given 4 months to complete level 2 mortality review, therefore 11% of cases occurring in Q2 remain open and within review timeframe.

Where potential for improvement is identified learning is shared at Divisional Boards / groups and presented to the Trust-wide Learning from Patient Deaths Group; this ensures outcomes are shared and learning is cascaded.

Impact assessment

Tick all that apply

- ☐ Equity
- ☒ Quality
- ☐ People (workforce, patients, families or careers)
- ☐ Operational performance
- ☐ Finance
- ☐ Communications and engagement
- ☐ Council of governors

Strategic priorities

Tick all that apply

- ☐ Achieve recovery of our elective care, emergency care, and diagnostic capacity (APC)
- ☐ Support the ICS's mission to address health inequalities (APC)
- ☐ Attract, retain, develop the best staff in the NHS (APC)
- ☒ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation (APC)
- ☐ Achieve a more rapid spread of innovation, research, and transformation (APC)
- ☐ Help create a high-quality integrated care system with the population of north west London (ICHT)
- ☐ Develop a sustainable portfolio of outstanding services (ICHT)
- ☐ Build learning, improvement and innovation into everything we do (ICHT)

Click to describe impact

Main Report

1. Learning and Improvements

The Trust's Mortality Surveillance programme offers assurance to our patients, stakeholders, and the Board that high standards of care are being provided and that any gaps in service delivery are being effectively identified, escalated, and addressed. This report provides a Trust-level quarterly review of mortality learning for Q2 2025/26.

All in-hospital deaths are scrutinised by the Trust's Medical Examiner Service; this initial screening provides an independent review of care and is the basis for triggering cases for enhanced (level 2) review by the Consultant Mortality Validators and the specialities involved.

The Trust undertakes in-depth (level 2) mortality review for cases meeting the following criteria:

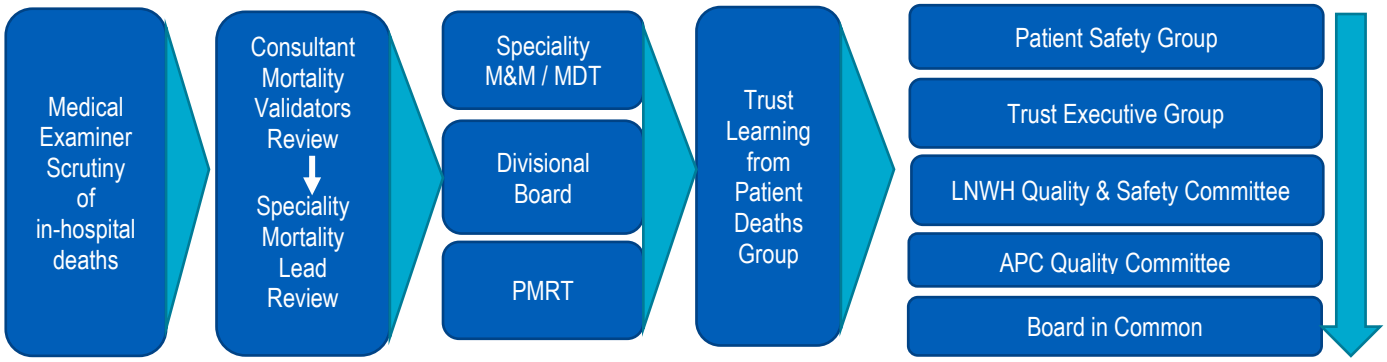
National triggers:

- Potential learning identified at Medical Examiner scrutiny.
- Significant concerns raised by the bereaved.
- Deaths of patients with learning disability
- Deaths of patients under a mental health section
- Unexpected deaths
- Maternal deaths
- Deaths of infants, children, young people, and still births
- Deaths within a specialty or diagnosis / treatment group where an 'alarm' has been raised (e.g. via the Summary Hospital-level Mortality Indicator or other elevated mortality alert, the CQC or another regulator)

Additional Local triggers:

- Deaths post elective surgery (at most recent admission)
- Deaths accepted by the coroner for inquest / investigation.

The Learning from Patient Deaths Group (LfPDG) challenges assurance regarding performance and outcomes from the Trust's learning from deaths approach as outlined below:



The Learning from Patient Deaths Group (LfPDG) provides leadership to this programme of work and is supported by standing items on relative risk of mortality, potential learning from medical

examiners, learning from inquests, and divisional learning from mortality review. The LfPDG is a sub-group of the Patient Safety Group and is aligned to the remit of the Quality and Safety Committee.

2. Relative Risk

The Trust uses the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) to monitor the relative risk of mortality. Both tools are used to determine the relative risk of mortality for each patient and then compare the number of observed deaths to the number of expected deaths; this provides a relative risk of mortality ratio.

Population demographics, hospital service provision, intermediate / community service provision has a significant effect on the numbers of deaths that individual hospital sites should expect; the SHMI and HSMR are designed to reduce this impact and enable a comparison of mortality risk across the acute hospital sector. By monitoring relative risk of mortality, the Trust is able to make comparisons between peer organisations and seek to identify improvement areas where there is variance.

2.1. Summary Hospital-level Mortality Indicator (SHMI)

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI calculation includes 100% of in-hospital deaths (excluding still-births) and those deaths that occur within 30 days of discharge. The SHMI is composed of 144 different diagnosis groups, and these are aggregated to calculate the overall SHMI value for each organisation.

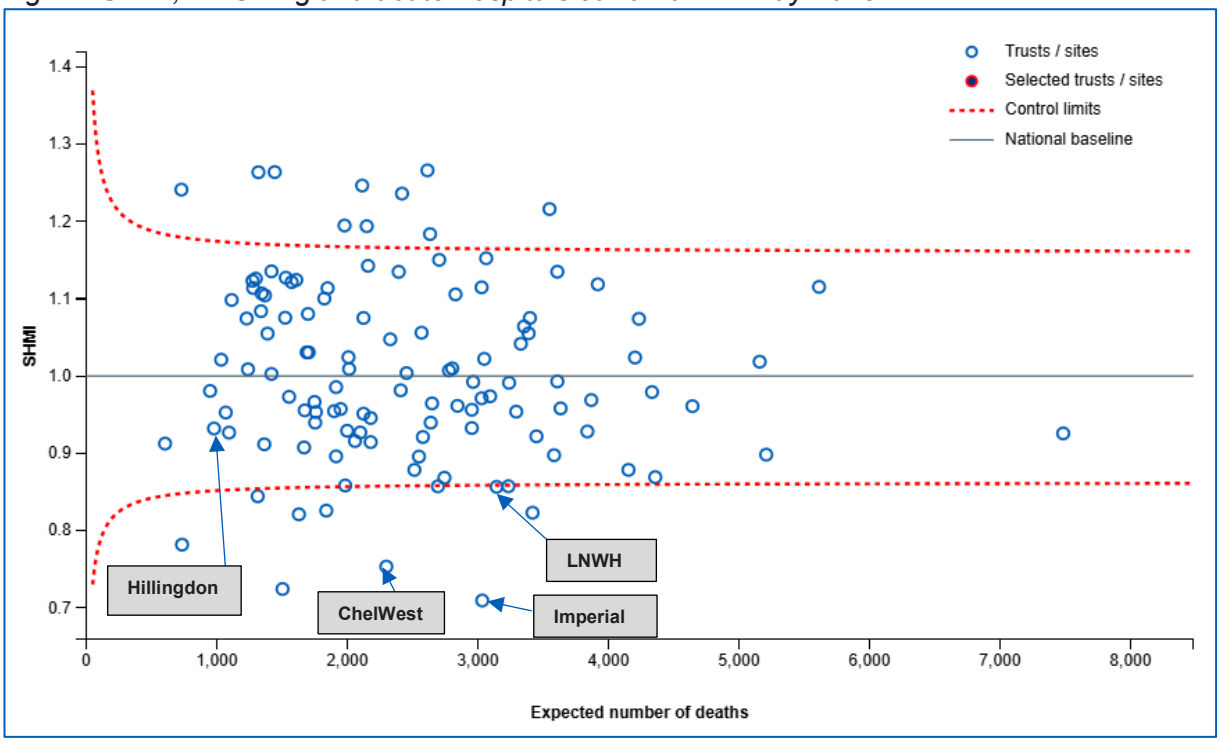
The Trust is the 9th best performing acute provider in England in relation to the SHMI relative risk of mortality indicator. The Trust-wide SHMI for the period July 2024 – June 2025 is 85.92 (where a number below 100 represents lower than expected risk of mortality).

North West London Acute Collaborative SHMI indicators

Trust	Provider spells	Observed deaths	Expected deaths	SHMI	LCL 95%CI	UCL 95%CI
LNWH	105685	2690	3130	85.92	85.65	116.76
THH	48775	920	990	93.05	84.94	117.74
ICHT	118365	2180	3035	71.73	85.64	11 6.77
CWFT	89,540	1720	2275	75.50	85.52	116.93

SHMI by APC provider, July 2024 to June 2025, Source: NHS Digital, published 13th November 2025

Fig 1 – SHMI, NHS England acute hospitals June 2024 – May 2025



This positive assurance is reflected across the Trust as the organisation's principal sites continue to operate below the nationally expected relative risk of mortality:

- Northwick Park Hospital: 89.04 (2,100 expected, 1,870 observed, 78,400 provider spells)
- Ealing Hospital: 80.34 (1,005 expected, 805 observed, 23,264 provider spells)

The Trust continues to operate below the national relative risk of mortality and SHMI remains low across the last year of rolling 12-month updates.

2.2. Hospital Standardised Mortality Ratio (HSMR)

The HSMR compares the number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on the type of cases treated. The HSMR calculation includes about 80% of in-hospital deaths (including still-births), it excludes deaths post discharge. The model no longer adjusts for palliative care as a variable in the model.

The Trust-wide HSMR for the period July 2024 – June 2025 is 96.5 (where a number below 100 represents lower than expected risk of mortality).

North West London Acute Collaborative HSMR indicators

Trust	Provider spells	Observed deaths	Expected deaths	HSMR	Lower CI	Upper CI
LNWH	201763	2,003	2075.4	96.5	92.3	100.8
THH	83790	655	636.5	102.9	95.2	111.1
ICHT	244530	1600	2129.9	75.1	71.5	78.9
CWFT	160590	1220	1547.3	78.8	74.5	83.4

HSMR (41 diagnostic groups) by APC provider, July 2024 to June 2025, Source: Telstra

LNWH HSMR Trend (41 diagnostic groups)

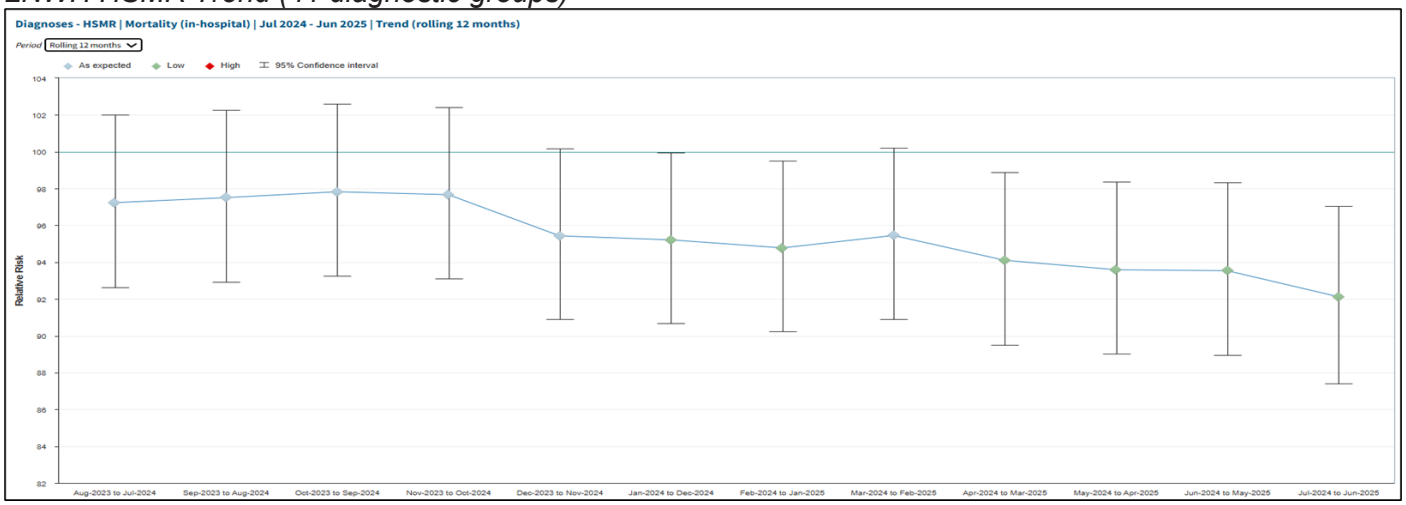


Fig 2: Data Source: Telstra, HSMR trend (41 diagnostic groups), July 2024 to June 2025.

The HSMR metric outlined above is made up of the 41 diagnostic groups; these are aggregated to calculate the Trust's overall relative risk of mortality. As can be seen all the monthly HSMRs for the Trust have been within the expected range. The Learning from Patient Deaths Group monitors expected and observed deaths across diagnostic groups; where statistically significant variation (triggering repeated CUSUM alerts) is identified the group undertakes coding and / or care review to identify any themes or potential improvement areas. There were no end of year diagnostic alerts.

2.3 CUSUM Diagnosis Alerts

A cumulative sum (CUSUM) statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time (on spell discharge). The chart has upper and lower thresholds and breaching this upper threshold triggers an alert at either a 99% or 99.9% detection threshold. These alerts tigger with a given month rather than reflecting on the whole year, as follows:

Haemorrhoids: 2 mortalities were noted (were 0.1 was expected), a coding review is being initiated to ensure primary diagnostic group is accurately identified. Further clinical review is not indicated.

Cardiac Arrest and Ventricular Fibrillation diagnosis group is in the HSMR basket of 41 high mortality diagnosis groups. LNWUH had 23 deaths against an expected 16.7 across the year. The alert refers to the 3 deaths that occurred in January 2025; all three were investigated and found to have received no sub-optimal care, one of which had an out of hospital cardiac arrest.

Other Psychoses diagnosis group is not in the HSMR basket of 41 high mortality diagnosis groups. LNWUH had 6 deaths against an expected 3.2 across the year. The alert refers to 3 deaths that occurred in January 2025. All three were investigated and found to have received no sub-optimal care and the principal presentations were disorientation, that was unspecified.

3.0 Mortality Review

3.1 In-depth (level 2) mortality review

Mortality case review provides clinical teams with the opportunity to review expectations, outcomes and potential improvements with the aim of:

- Identifying sub-optimal or excellent care
- Identifying service delivery problems
- Developing approaches to improve safety and quality
- Sharing concerns and learning with colleagues

Learning from review is shared at specialty mortality review groups (M&Ms / MDTs); where issues in care, trends or notable learning is identified action is steered through the Divisional Quality Boards / Governance Groups and the Trust-wide Learning from Patient Deaths Group (LfPDG).

During the 12-month period October 2024 to 30 September 2025, 2,288 in-hospital adult or child deaths were recorded within the Trust's mortality review system (Datix), of these 100% have been screened. Screening identified 392 (17%) cases that would benefit from in-depth (level 2) review. Of these 377 have completed this in-depth review process, which is consistent with the last reporting period.

	No. of deaths	No. of cases screened	No. of cases flagged for level 2 review	No. case with completed level 2 review	% cases Screened	% of level 2 reviews completed
Q3 24/25	599	599	95	94	100%	**99%**
Q4 24/25	667	667	96	95	100%	**99%**
Q1 25/26	535	535	104	101	100%	**97%**
Q2 25/26	487	487	97	87	100%	**87%**
Totals	**2,288**	**2,288**	**392**	**377**	**100%**	**95%**

Tab 4: Adult & child mortality review status by financial quarter, October 2024 to 30 September 2025

The Consultant Mortality Validators undertake level 2 in-depth mortality reviews and identify cases that need Speciality Mortality Leads to conduct a further in-depth review. Speciality Mortality Leads have 4 months from the date of death to complete these reviews. Compliance is monitored by the Divisional Boards / Governance meeting, Learning from Patient Deaths Group, and overseen by the Trust Executive Group and Quality & Safety Committee.

Hospitals	No. of deaths	No. of cases screened	No. flagged for level 2 review	No. of completed level 2 reviews	% cases Screened	% of level 2 reviews completed
Northwick Park & St Marks	1,506	1,506	265	252	100%	**95%**
Ealing	778	778	125	123	100%	**98%**
Central Middlesex	4	4	2	2	100%	**100%**
Totals	**2,288**	**2,288**	**392**	**377**	**100%**	**96%**

Tab 5: Adult & child mortality review status by site, October 2024 to 30 September 2025

The following key trends arising from process compliance monitoring have been noted:

- This quarter the proportion of in-patients identified for in-depth (Level 2) review increased to 20% this quarter (Q2) in comparison to the previous quarter at 19%. This rise has been observed each quarter and although is in line with yearly trends, this continues to be monitored.

- 'Unexpected Deaths' was the most common trigger for an in-depth mortality review accounting for 22% (21 cases) of requests. This trigger has continued to fall each quarter, as the trust has continued to educate staff around the use of this classification. The next most common trigger for an in-depth review was 'Medical Examiner Requests' at 20% (19 cases). Followed closely by 'Family/carer Concern' at 19% (18 cases).

- Of the 87 mortality reviews conducted during Q2, 85% found no sub-optimal care (CESDI Grade 0), comparable to 83% the previous quarter.

The Divisional Mortality Leads provide scrutiny to mortality cases to identify themes and escalate any issues of concerns. Key themes / issues identified via mortality review this quarter, which are consistent with the previous quarters learning:

- **Recognition and Escalation of care:** this remains a recurrent issue, with inconsistent adherence to escalation protocols (e.g. NEWS, MET calls, Sickle Cell Call), with missed opportunities for timely senior or specialist review.

- **Communication and Documentation:** documentation of clinical decision making, escalation and handover was found to be incomplete, especially at shift changes or during rapid deterioration. Communication with families/NOK was variable, with delays in updating families about deterioration or death and inconsistent documentation of Treatment escalation plans (TEP) and DNACPR decisions. Falls risk assessments and pressure sore management suggested the need for a more consistent implementation. Language barriers were also found this quarter, with the inconsistent use of interpreters that can impact both patient and family understanding. Family concerns often related to communication, delays or perceived lack of involvement in care decisions.

- **Multidisciplinary Team (MDT) Working:** positive examples of MDT working were evident and there were cases where key teams (Learning Disability, Haematology, Rheumatology) were not involved early enough. Reviews suggested the need for improved coordination between acute and community care, especially for discharge planning and end-of-life care.

3.2 CESDI Grading of Care

Outcome, avoid ability and / or suboptimal care provision is defined using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categories that have been adopted by the Trust for use when assessing deaths:

- Grade 0: No suboptimal care or failings identified, & the death was unavoidable.
- Grade 1: A level of suboptimal care identified during hospital admission, but different care or management would NOT have made a difference to the outcome & death was unavoidable.
- Grade 2: Suboptimal care identified, & different care MIGHT have made a difference to the outcome, i.e. the death was possibly avoidable.
- Grade 3: Suboptimal care identified, & different care WOULD REASONABLY BE EXPECTED to have made a difference to the outcome, i.e. the death was probably avoidable.

CESDI grades October 2024 to 30 September 2025

Period	CESDI 0	CESDI 1	CESDI 2	CESDI 3
Q3 24/25	72	19	3	0
Q4 24/25	75	19	0	1
Q1 25/26	84	15	1	1
Q2 25/26	74	10	3	0
Total	305	63	7	2

Tab 5: Closed mortality cases by CESDI grade, October 2024 to 30 September 2025

During this 12-month period 7 cases of sub-optimal care might have made a difference to the patient's outcome (CESDI 2) and 2 cases where sub-optimal care would reasonably be expected to have made a difference to outcome were identified. Cases graded as CESDI 2 or 3 are discussed at the Trust wide Learning from Patient Deaths Group and are presented to the Trust's Emerging Incident Review Group for confirmation of learning response (e.g. SI / PSII).

The graph below illustrates the distribution of CESDI grades across the three sites, reflecting the nature of events being reviewed by Mortality Leads. As in previous quarters Northwick Park & St Marks has the highest number of sub-optimal care with 51 cases, followed by Ealing with 18 cases and 0 cases in Central Middlesex. This suggests that most cases where different care might have made a difference to outcome were focused on the Northwick Park / St Mark's site, reflecting the volume of spells this site delivers.

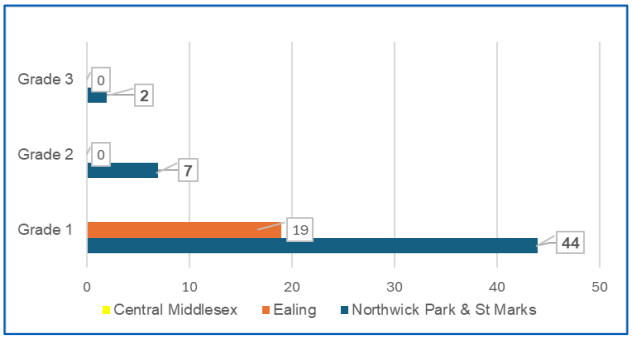


Fig 7 – CESDI Grade by Site, October 2024 to 30 September 2025

Ethnicity & Gender

The ethnicity data shows a consistent picture in terms of the proportion of deaths by ethnicity during Q2 2025/26 as in previous quarters. Further analysis is provided in appendix B.

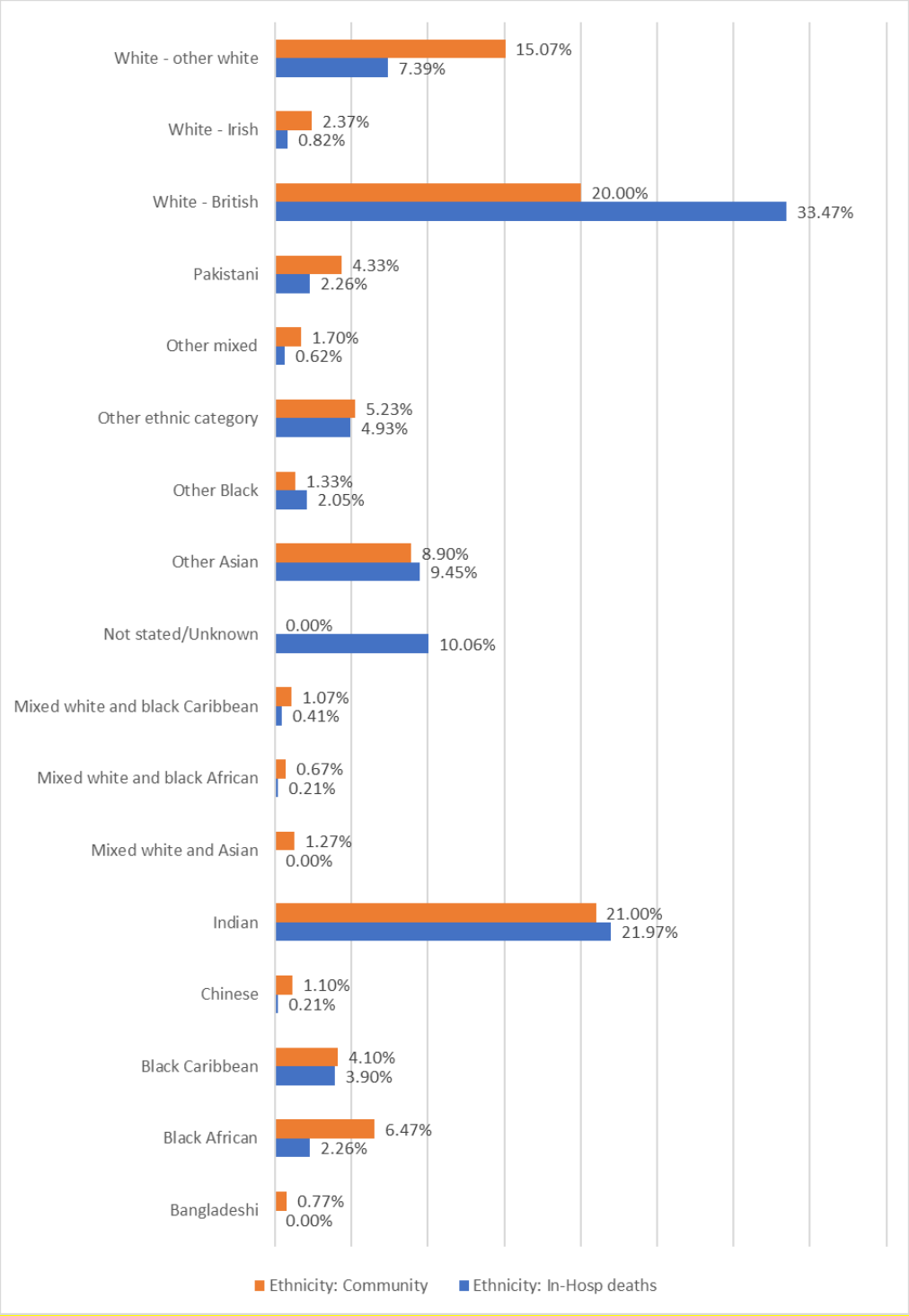


Fig 8 – Ethnicity breakdown, Q2 2025/26

In proportion to the community population for Brent, Ealing and Harrow, there remains more in-hospital mortality in the White British, Indian and Other Asian demographic groups than others.

As in previous quarters White British remains is the most frequently identified ethnicity associated with in-hospital mortality, account for 33.47% during Q2, this is lower than during Q1 which was 32.58%. We continue to note that the local populations of Brent, Ealing, Harrow recognises only 20% of the population as having this ethnicity. This suggests a higher rate of in-hospital deaths compered to community deaths for this group. Indian is the second most frequent ethnicity associated within in-hospital death at 21.97%, consistent with the last quarter at 21.54%.

All other ethnic groups had in-hospital mortality rates that were either proportional or lower than their community representation.

During this 12-month period, the CESDI Grade 1 cases continue to predominantly involve individuals of White British (17) ethnicity followed by Indian (15). The profile of CESDI Grade 2 cases is split evenly across 7 ethnicity brackets. These findings align with the demographic composition of the population in Brent, Ealing, and Harrow, where Indian and White British groups are the largest resident populations. CESDI Grade 3 is evenly split with just two cases, one is Indian, and the other is White Other.

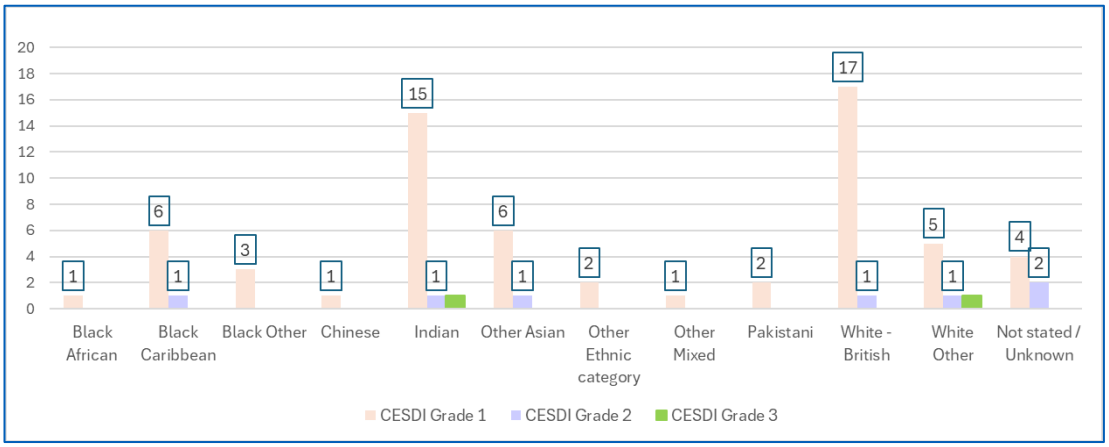


Fig 9: Closed mortality cases by CESDI grade and Ethnicity, October 2024 to 30 September 2025

As in previous reporting period the analysis of CESDI grades by gender indicates the same trend each 12-month period, that the care of male patients overall is more likely to have elements of sub-optimal care identified than female patients.

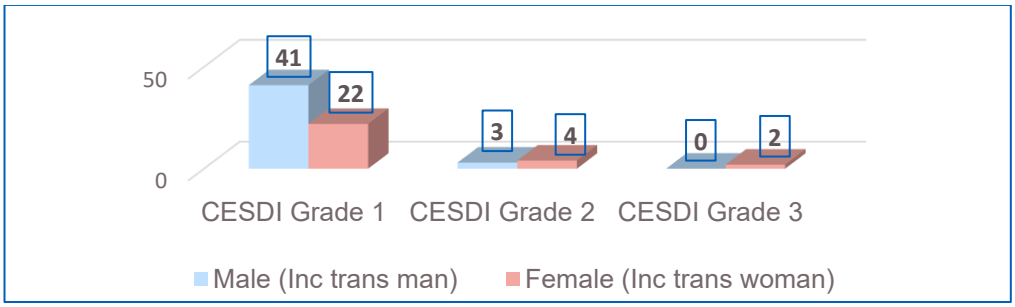


Fig 10: Closed mortality cases by CESDI grade and Gender, October 2024 to 30 September 2025

9.0 Conclusion

The outcome of the Trust's mortality surveillance programme continues to provide a rich source of learning that is supporting the organisations improvement objectives. The Trust continues to be recognised as having a low relative risk of mortality (SHMI) across NHS England.

We can provide assurance to the committee that we are providing safe care for the majority of patients. Where care issues are found, we have robust processes for referral for more in-depth review, and these processes are triangulated against other data provided within the trust under the PSIRF framework.

Efforts to enhance and standardise our processes for learning from patient deaths are ongoing. We are also actively working in partnership with other members of the APC to ensure consistency, facilitate shared learning, and identify opportunities for collective improvement.

10. Glossary

Medical Examiners are responsible for reviewing every inpatient death before the medical certificate cause of death (MCCD) is issued, or before referral to the coroner in the event that the cause of death is not known or the criteria for referral has been met. The Medical Examiner will request a Structured Judgement Review if required or if necessary refer a case for further review and possible investigation through our incident reporting process via the quality and safety team. The ME will also discuss the proposed cause of death including any concerns about the care delivered with bereaved relatives.

Structured Judgement Review (SJR) is a clinical judgement-based review method with a standard format. SJR reviewers provide a score on the quality of care provided through all applicable phases of care and will also identify any learning. The SJR will be completed within seven days of referral.

Structured judgement reviewers are responsible for conducting objective case note reviews of identified cases. They will seek, when required, specialist input and advice from clinical colleagues, including members of the multi-disciplinary teams to ensure high quality, comprehensive review is undertaken, using the full range of medical records available to them.

Specialty M&M reviews are objective and multidisciplinary reviews conducted by specialties for cases where there is an opportunity for reflection and learning. All cases where ME review has identified issues of concern must be reviewed at specialty based multi-disciplinary Mortality & Morbidity (M&M) reviews.

Child Death Overview Panel (CDOP) is an independent review aimed at preventing further child deaths. All child deaths are reported to and reviewed through Child Death Overview Panel (CDOP) process.

Perinatal Mortality Review Tool (PMRT) is a review of all stillbirths and neonatal deaths. Neonatal deaths are also reviewed through the Child Death Overview Panel (CDOP) process. Maternal deaths (during pregnancy and up to 12 month post-delivery unless suicide) are reviewed by Healthcare Safety Investigation Branch and action plans to address issues identified are developed and implemented through the maternity governance processes.

Learning Disabilities Mortality Review (LeDeR) is a review of all deaths of patients with a learning disability. The Trust reports these deaths to the Local integrated care boards (ICBs) who are responsible for carrying out LeDeR reviews. SJRs for patients with learning disabilities are undertaken within the Trust and will be reported through the Trust governance processes.

Appendix A – Acute Provider Collaborative performance scorecard

	2024-25		2025-26	
	Q3	Q4	Q1	Q2
Total No. Deaths	599	667	535	487
Total No. Adult Deaths	596	665	531	482
No. Child Deaths	3	2	4	5
No. Neonatal Deaths	2	2	0	0
No. Stillbirths	2	2	0	0
ME Reviewed Deaths in Qtr.	599	667	535	487
% ME Reviewed Deaths - Deaths (excluding Stillbirths) in Qtr.	100%	100%	100%	100%
Deaths referred for Level 2 Review in Qtr.	95	96	104	97
% Level 2 Reviews Requested for Deaths in Qtr. of total deaths in Qtr.	16%	14%	19%	20%
Level 2 Reviews Completed for Deaths in Qtr.	94	95	101	87
% Level 2 Reviews Completed for Deaths in Qtr.	99%	99%	97%	89%
No. LeDeR Completed	12	11	7	7
Requests made by a Medical Examiner	10	20	29	19
% Requests made by a Medical Examiner	11%	21%	28%	20%
Concerns raised by family / carers	13	16	20	18
% Concerns raised by family / carers	14%	17%	19%	19%
Patients with learning disabilities	12	11	7	7
% Patients with learning disabilities	13%	12%	7%	7%
Patients with severe mental health issues	6	3	1	4
% Patients with severe mental health issues	6%	3%	1%	4%
Unexpected deaths	36	29	25	21
% Unexpected deaths	38%	30%	24%	22%
Elective admission deaths	6	6	5	5
% Elective admission deaths	6%	6%	5%	5%

	2024-25		2025-26	
	Q3	Q4	Q1	Q2
Requests made by speciality mortality leads/through local Mortality & Morbidity review processes	2	2	2	2
% Requests made by speciality mortality leads/through local Mortality & Morbidity review processes	2%	2%	2%	2%
Service or diagnosis alarms as agreed by APC mortality surveillance group	n/a	n/a	n/a	n/a
% Service or diagnosis alarms as agreed by APC mortality surveillance group	n/a	n/a	n/a	n/a
CESDI 0: No suboptimal care (cases reviewed & closed)	72	75	84	74
% CESDI 0: No suboptimal care (cases reviewed & closed)	77%	79%	83%	85%
CESDI 1: Some suboptimal care which did not affect the outcome (cases reviewed & closed)	19	19	15	10
% CESDI 1: Some suboptimal care which did not affect the outcome (cases reviewed & closed)	20%	20%	15%	11%
CESDI 2: Suboptimal care: different care might have made a difference to outcome (possible avoidable death) (cases reviewed & closed)	3	0	1	3
% CESDI 2: Suboptimal care: different care might have made a difference to outcome (possible avoidable death) (cases reviewed & closed)	3%	0	1%	3%
CESDI 3: Suboptimal care: would reasonably be expected to have made a difference to the outcome (probably avoidable death) (cases reviewed & closed)	0	1	1	0
% CESDI 3: Suboptimal care: would reasonably be expected to have made a difference to the outcome (probably avoidable death) (cases reviewed & closed)	0%	1%	1%	0%

*Trust mortality reviewed data as at 21/10/2025

Appendix B: Ethnicity Q3 & Q4 2024-25 and Q1 & Q2 20254/26

	2024/25				2025/26						Community population
	Q3 n	Q3 %	Q4 n	Q4 %	Q1 n	Q1 %	Q2 n	Q2 %	Total n	Total %	Brent, Ealing, Harrow
Bangladeshi	1	0%	1	**0.19%**	1	**0.21%**	0	**0.00%**	**3**	**0.13%**	0.77%
Black African	15	3%	19	**3.56%**	12	**2.46%**	11	**2.26%**	**57**	**2.49%**	6.47%
Black Caribbean	25	4%	26	**4.87%**	16	**3.29%**	19	**3.90%**	**86**	**3.76%**	4.10%
Chinese	2	0%	0	**0.00%**	4	**0.82%**	1	**0.21%**	**7**	**0.31%**	1.10%
Indian	147	25%	118	**22.10%**	115	**23.61%**	107	**21.97%**	**487**	**21.31%**	21.00%
Mixed white and Asian	4	1%	1	**0.19%**	1	**0.21%**	0	**0.00%**	**6**	**0.26%**	1.27%
Mixed white and black African	0	0%	0	**0.00%**	5	**1.03%**	1	**0.21%**	**6**	**0.26%**	0.67%
Mixed white and black Caribbean	0	0%	0	**0.00%**	0	**0.00%**	2	**0.41%**	**2**	**0.09%**	1.07%
Not stated/Unknown	56	9%	73	**13.67%**	53	**10.88%**	49	**10.06%**	**231**	**10.11%**	N/A
Other Asian	50	8%	67	**12.55%**	48	**9.86%**	46	**9.45%**	**211**	**9.23%**	8.90%
Other Black	11	2%	14	**2.62%**	9	**1.85%**	10	**2.05%**	**44**	**1.93%**	1.33%
Other ethnic category	17	3%	24	**4.49%**	28	**5.75%**	24	**4.93%**	**93**	**4.07%**	5.23%
Other mixed	4	1%	4	**0.75%**	2	**0.41%**	3	**0.62%**	**13**	**0.57%**	1.70%
Pakistani	15	3%	12	**2.25%**	13	**2.67%**	11	**2.26%**	**51**	**2.23%**	4.33%
White - British	195	33%	237	**44.38%**	174	**35.73%**	163	**33.47%**	**769**	**33.65%**	20.00%
White - Irish	9	2%	12	**2.25%**	17	**3.49%**	4	**0.82%**	**42**	**1.84%**	2.37%
White - other white	45	8%	58	**10.86%**	36	**7.39%**	36	**7.39%**	**175**	**7.66%**	15.07%
No value	2	0%	0	**0.00%**	0	**0.00%**	0	**0.00%**	**2**	**0.09%**	N/A
Total	598	100%	666	**124.72%**	534	**109.65%**	487	**100.00%**	**2285**	**100.00%**	

More in hospital mortality in the Chinese, other Asian, and white British demographic groups than the community population for Brent, Ealing and Harrow

4.1.7 APC HEALTH AND SAFETY ANNUAL REPORT 2024/25 - APPENDIX 1

REFERENCES

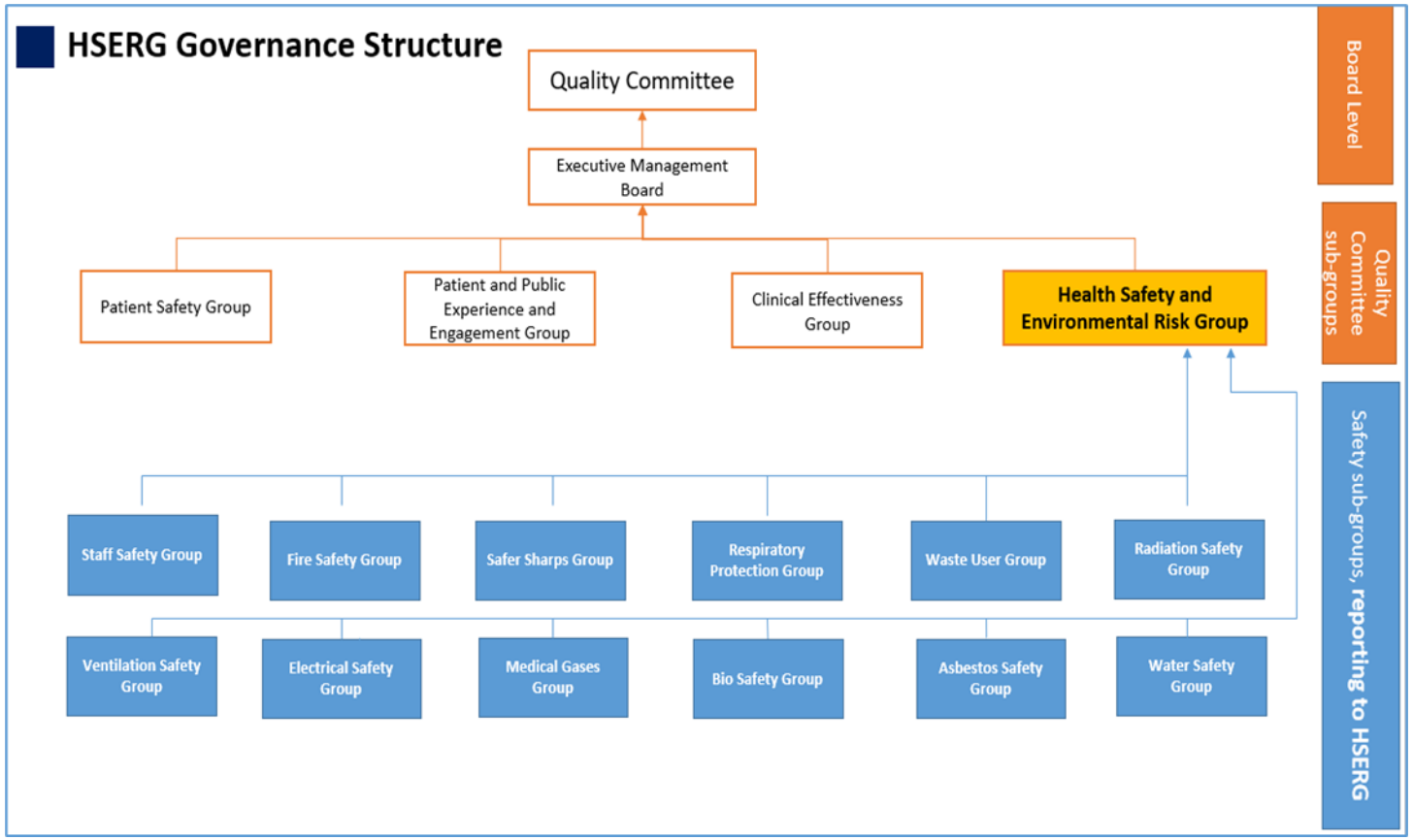
Only PDFs are attached

4.1.7 Collab H&S Annual Report - Appendix 1.pdf

Appendix 1

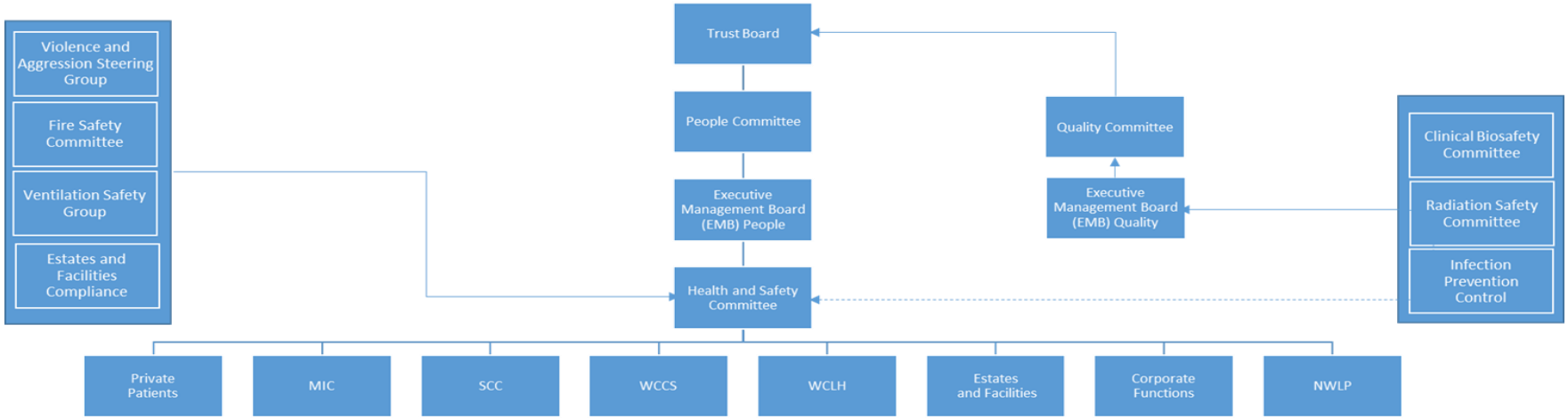
Collaborative Health and Safety Arrangements

Chelsea and Westminster Hospital NHS Foundation Trust



Graph X: CWFT HSERG Governance Structure, as at 31st March 2025

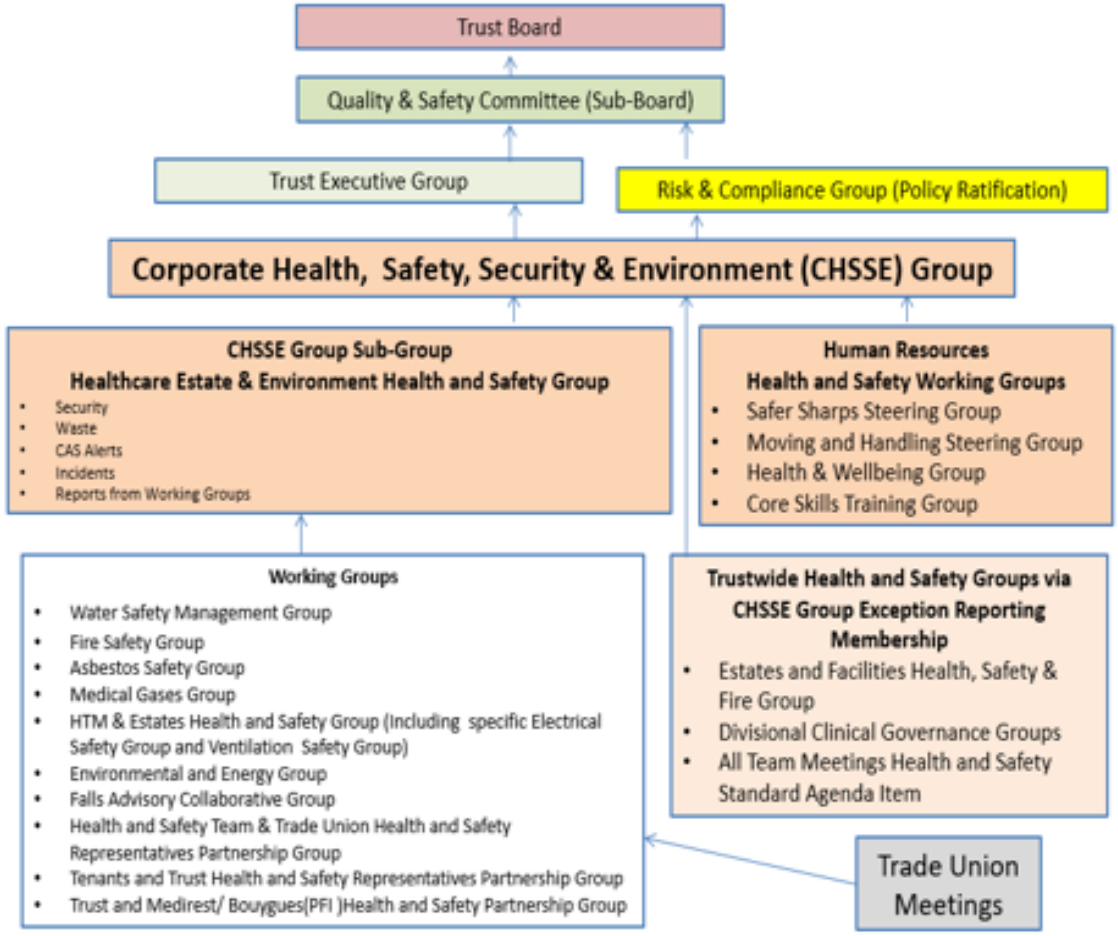
Imperial College Healthcare NHS Trust



Sub-Groups

- Estates and Facilities Compliance Quality and Safety Committee.
- Violence and Aggression Steering Group
- Water Safety Committee
- Ventilation Safety Group
- Falls Steering Group

London North West University Healthcare NHS Trust



The Hillingdon Hospitals NHS Foundation Trust