North West London Acute Provider Group

READING ROOM: BOARD IN COMMON (PUBLIC)

READING ROOM: BOARD IN COMMON (PUBLIC)

28 April 2026

11:00 GMT+1 Europe/London

AGENDA

6. LEARNING FROM DEATHS - INDIVIDUAL TRUST REPORTS

7.1.2a ICHT Trust report
7.1.2b CWFT Trust report
7.1.2c LNWH Trust report
7.1.2.d THHFT Trust report

REFERENCES

Only PDFs are attached

- 06.1.2a READING-ROOM_ICHT_Learning from Death Q3 25-26.pdf
- 06.1.2b READING-ROOM_CWFT Learning from deaths Q3 2025_26.pdf
- 06.1.2c READING-ROOM_LNWH Learning from Deaths Q3 2025-26.pdf
- 06.1.2d READING-ROOM_THH Lerning from deaths Q3 2025_26.pdf

NWL Acute Provider Collaborative Board in Common (Public)
28/04/2026
Item number: 7.1.2a READING ROOM
This report is: Public

ICHT Learning from Deaths report, quarter 3 2025/26

Author: Heena Asher & Shona Maxwell
Job title: General Manager & Chief of Staff

Accountable director: Professors Julian Redhead & Raymond Anakwe
Job title: Medical Directors

Purpose of report

Purpose: Assurance

This report presents the data from Imperial College Healthcare NHS Trust's (ICHT) Learning from Deaths programme for quarter three (Q3) of 2025/26. It is a statutory requirement to present this information to the public board, achieved through this committee, with an overarching summary paper from the four NWL acute provider group (APG) trusts presented to the APG quality committee and then Board in common.

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) and Executive Management Board
27/01/2026
The committee noted the findings and approved the report for onward submission.

ICHT Quality Committee
05/02/2026
The committee noted the report.

Executive summary and key messages

1.1. Mortality rates remain statistically significantly low.

1.2. All deaths underwent Medical Examiner review, with cases raising concerns referred for Structured Judgement Review (SJR). Completed SJRs 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.

1.2.1. Seven SJRs identified sub-optimal care which might or would reasonably have been expected to have made a difference to the outcome. These are all investigated through the patient safety incident investigation framework (PSIRF) to confirm the learning response and actions. Once complete reviews are triangulated at the death review panel to confirm the final harm level. The number further investigated through the PSIRF route is higher at ICHT than others in the APC however it is important to note our lower-than-average harm levels and low HSMR.

1.3. Focus remains on improving the quality and consistency of morbidity & mortality (M&M) meetings as a key mechanism to support learning, with sustained improvements in several specialties and work continuing to embed standardised templates and processes.

1.4. 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, low mortality rates are positive reflections of the care delivered.

1.5. The template for this report, and the data included, is being reviewed to ensure standardisation across the APG. The proposed template includes the statutory requirements but does include wider processes that are important at trust level. Areas of divergence in process remain making comparison challenging which is being taken forward by the Medical Directors. This report is in the format used when presented to quality committee. We have included additional charts and data which are part of the new APG template while we work through what our reporting will look like in future.

Impact assessment

☒ Quality

Improving how we learn from deaths will support 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 programme, no new issues for escalation.

Main Report

2. Learning and Improvements

2.1. Learning from Deaths (LFD) is a standard agenda item on Divisional Quality and Safety meetings where investigations and learning are shared and widely disseminated.

2.2. Forty-seven structured judgment reviews (SJRs) were completed, 40 for deaths in Q3, and 7 from Q2. Of these, twenty-eight (59%) specifically identified patients received good or excellent care including communication with the next of kin.

2.3. Twelve cases (25%) identified good documentation, teamwork and senior decision making (Critical Care highlighted positively). However, seven cases (14%) highlighted issues with care, communication with next of kin, and need for improved documentation. This variation is the focus within specialties/directorates.

2.4. Seven cases identified sub-optimal care which might or would reasonably have been expected to make a difference to the outcome (CESDI 2 or 3), similar to previous quarters but higher than other APC trusts. No themes identified, but cases are being reviewed through our incident investigation framework to identify further learning and improvement.

3. Key themes

3.1. Mortality rates

3.1.1 Mortality rates remain statistically significantly low. Rolling 12-month HSMR, based on data to September 2025 was 76.5 (compared to 75.1 in the previous quarter) and is sixth lowest when compared nationally. SHMI is the lowest at 71.34, based on data to August 2025. See appendix B for graphs detailing our performance.

North West London Acute Collaborative SHMI indicators

Trust	Provider spells	Observed deaths	Expected deaths	SHMI	LCL 95%CI	UCL 95%CI
LNWH	105,900	2,655	3,120	85.12	85.45	117.03
THH	47,735	905	990	91.14	84.75	117.99
ICHT	118,125	2,180	3,060	71.34	85.44	117.04
CWFT	86,825	1,715	2,240	76.44	85.32	117.21

SHMI by APC provider, September 2024 to August 2025, Source: NHS Digital, published 8th January 2026

North West London Acute Collaborative HSMR indicators

Trust	Provider spells	Observed deaths	Expected deaths	HSMR	Lower CI	Upper CI
LNWH	201,475	1924	2067.8	93.0	88.9	97.3
THH	80,900	635	636.2	99.8	92.2	107.9
ICHT	146,935	1,640	2144.5	76.5	72.8	80.3
CWFT	155,730	1,240	1578.0	78.6	74.3	83.1

Trust HSMR (41 diagnostic groups), October 2024 to September 2025, Source: Telstra,

3.1.2 There was an increase in HSMR in-month for September 2025, as a trust we remain statistically significantly low, but our three main sites were within expected range. This is under review, with a potential increase in stroke-related deaths identified. A summary of findings will be included in the next report. All sites are below the NHS benchmark of 100.

3.2. Diagnostic group reviews

3.2.1 The table below summarises the review of an alert in the acute myocardial infarction (AMI) diagnostic group for July 2025 data, which we were notified of in Q3.

Group	Observed deaths	Expected deaths	HSMR
Acute Myocardial Infarction (AMI)	85	77	110.5
Learning: This previously flagged in September 2024 and was reviewed with no concerns identified. New alert for July 2025 data, cardiology have completed reviews of the patients identifiable (n=15). All deaths were found to be unavoidable. HSMR now reduced to 103.8 (Dec 25 update).			

3.3.1 Four other alerts currently under review. Outcomes will be included in this report once complete. See appendix C for details.

3.3. Directorate reviews

3.3.2 There was an increase in deaths within the urgent and emergency care directorate in Q1 with no increase in incidents causing moderate and above harm. There was an increase in CESDI 2 cases associated with care in ED (the death didn't always happen there), with four reported. Three of these cases are pending review at DRP, any themes or areas of concern will be summarised in this report once the reviews have been completed.

3.4. Medical Examiner reviews

3.4.1. The Medical Examiner (ME) service reviewed all 439 deaths in Q3, referring 95 directly to the coroner (33 inquests) and independent scrutiny of the remaining 345.

3.4.2. The largest percentage of coronial referrals were death resulting from violence, trauma, or injury (48%), reflecting the major trauma centre at SMH. Followed by medical procedures or treatments (21%), some involving complications after elective admission and others that occurred prior to transfer. No issues currently require escalation.

3.4.3. Weekly review continues of all referrals to ensure investigations and file preparation begin as early as possible. The increase in referrals and inquest listing over the last 3 years continues to cause resource implications, delays and adjournment requests.

3.4.4. The ME service reviewed 244 non-acute deaths, similar to last.

3.4.5. We issued 74.4% of urgent MCCDs within 24 hours and 79.2% of non-urgent MCCDs within three days, an improvement from Q2 (67.6% and 66.7% respectively).

3.4.6. Efforts continue to enhance timeliness with the new medical examiner rota, monitoring and escalating delays to directorate leadership. Focus remains on managing the increasing community referrals while ensuring timely reporting, working with the providers to share outcomes for the non-acute deaths, with regular review meetings in place.

3.5. Structured Judgement reviews (SJR)

3.5.1. The table below shows the number of deaths over the last 12 months, cases reviewed by the medical examiner (screened) and the number which were referred for a SJR.

	No. of deaths	No. of cases screened	No. of cases flagged for SJR	No. case with completed SJR	% cases Screened	% of SJRs completed
Q4 24/25	518	518	67	67	100%	100%
Q1 25/26	440	440	54	54	100%	100%
Q2 25/26	424	424	67	67	100%	100%
Q3 25/26	439	439	42	42	100%	100%
Totals	**1821**	**1821**	**223**	**223**	**100%**	**100%**

3.5.2. The percentage of deaths referred for SJR has reduced this quarter (10% from 17%), driven by a reduction in deaths deemed 'unexpected' (this trigger reduced to 13 from 23%) and in elective admission cases (this trigger reduced to 10% from 15% - 21%).

3.5.3. SJR referral rate has been noted to be lower than other APC trusts. Although standardised referral triggers were agreed, CWFT and LNWH retained local triggers including coronial referrals. We use the incident investigation framework for deaths

accepted for inquest given the limited case note review methodology that SJR involves meaning our referral rate is lower. For Q3, ten deaths with inquests are undergoing incident investigation. This approach supports our PFD prevention approach with detailed action plans then available for submission to inquest. A review of the APC triggers is underway again with the Medical Directors.

3.5.4. Twenty-three (62%) SJRs found no suboptimal care (CESDI 0) lower than other quarters this year. Reviews identified evidence of excellent care, good communication and documentation in many cases. Eight (22%) found some suboptimal care that did not affect the patient outcome (CESDI 1), higher than other quarters (12-13%).

3.5.5. Seven (22%) reviews found that suboptimal care may have made a difference to the outcome (CESDI 2), with none that identified it would reasonably be expected to have made a difference to the outcome (CESDI 3). All cases are progressed to incident investigations to confirm final harm levels.

3.5.6. CESDI 2/3 outcomes are higher than the other APC trusts. Following review, we have confirmed others amend the SJR outcome when further investigations are completed. At ICHT, the reports are triangulated at the death review panel (DRP) to confirm the harm level and whether the death was due to poor care. All outcomes are included in this report, but the CESDI is not changed. The table below shows a breakdown of grades.

Period	CESDI 0	CESDI 1	CESDI 2	CESDI 3
Q4 24/25	50	13	3	1
Q1 25/26	41	7	5	1
Q2 25/26	53	8	5	1
Q3 25/26	26	9	7	0
Total	**170**	**37**	**20**	**3**

3.5.7. For the 23 CESDI 2 or 3 cases reported in the last 12 months, the full review process has been completed for 4 (see appendix D). Of these, three have been confirmed as low/no harm, with one confirmed that poor care contributed to the patient's death, with the harm level agreed as death/extreme harm. Actions taken include: (1) circulation of the rapid tranquilisation guideline in older adults via teaching and training huddles; (2) review departmental introduction of a sedation monitoring tool to aid observation and recording of sedation levels; (3) verbal orders SOP awareness raising.

3.5.8. The table below shows what the final CESDI score would be for these cases if it were to be amended based on the final decision at DRP with only 1 of 4 remaining at 2 or above.

Ref	Original CESDI	Final CESDI
MM30094	CESDI 2	CESDI 0
MM29961	CESDI 2	CESDI 1
MM30974	CESDI 3	CESDI 0
MM30644	CESDI 2	CESDI 3

3.5.9. The remaining 19 are under investigation/awaiting final triangulation of the investigation report; outcomes will be confirmed in a future report. A clinical case manager from the MDO has taken over leadership of the outstanding cases to expedite investigation and presentation to DRP as soon as possible. A timeline for completion is in place.

3.5.10. Overall, moderate and above harm levels are within national average with no cause for concern.

4. Other mortality review processes

4.1. PMRT

4.1.1. 20 perinatal deaths were reported to MBRRACE-UK during Q3, of which 15 (one late fetal loss, nine stillbirths and five neonatal deaths) were eligible for full review using the Perinatal Mortality Review Tool (PMRT) framework.
4.1.2. No cases met the threshold for referral to Maternity and Newborn Safety Investigations (MNSI).
4.1.3. Of the 15 PMRT eligible cases, four have been discussed across three multidisciplinary review meetings and none have received a grading of C, where care issues may have made a difference or D, where care issues would likely have made a difference.
4.1.4. During Q3, 16 cases were reviewed, four which occurred in Q3, and the remaining occurred in previous quarters. Of these, one case was graded as C due to a missed opportunity for appropriate follow-up of an abnormal finding. A second case was graded as D, where a large-for-gestational-age baby was not recognised, leading to a missed opportunity to offer earlier delivery (PSII underway). Immediate actions taken, including reinforcement of guidance on aspirin risk assessment at booking.
4.1.5. Data is provided a quarter in arrears to account for review timelines (the national target is within 6 months). Data for quarter two is therefore included in appendix E.

4.2. LeDeR

4.2.1. Four SJRs have been completed in this quarter for patients with a learning disability. All four found no sub-optimal care. See appendix F.
4.2.2. The Safeguarding team have completed LeDeR referrals for all in line with guidance.

4.3. CDOP

4.3.1. There were 10 deaths reported in Q3 for WLCH. CDOP referrals have been made, and detailed investigations will now take place which can take several months. All deaths are reviewed through the medical examiner/SJR process in addition to the CDOP process.

5. Areas of focus

5.1. Ethnicity

5.1.1. To improve data quality and reduce the proportion of deaths with unknown ethnicity we have integrated data from the NWL Whole System Integrated Care (WSIC) platform (reduced from 17% to 7.5%), with continued improvements seen since (see Appendix B).
5.1.2. Next steps are to include data relating to hospital services used by patients to reveal differences in access or use of services and to add additional demographic details, to expand the data set and widen the analysis.

5.2. Specialty Mortality and Morbidity meetings

5.2.1. The LFD forum continues to monitor compliance with Specialty M&M guidance.
5.2.2. Improvements in documentation are being seen, with evidence that these are occurring regularly in areas including Cardiology, Renal and Stroke/ Neurosciences directorates. Marked improvements in Urgent & Emergency Medicine and Critical Care this quarter.
5.2.3. Work is underway to embed standardised templates and processes and develop improvement trajectories, with divisional action plans in place and monitored through the performance and accountability review meetings and the LFD forum.

6. Conclusion

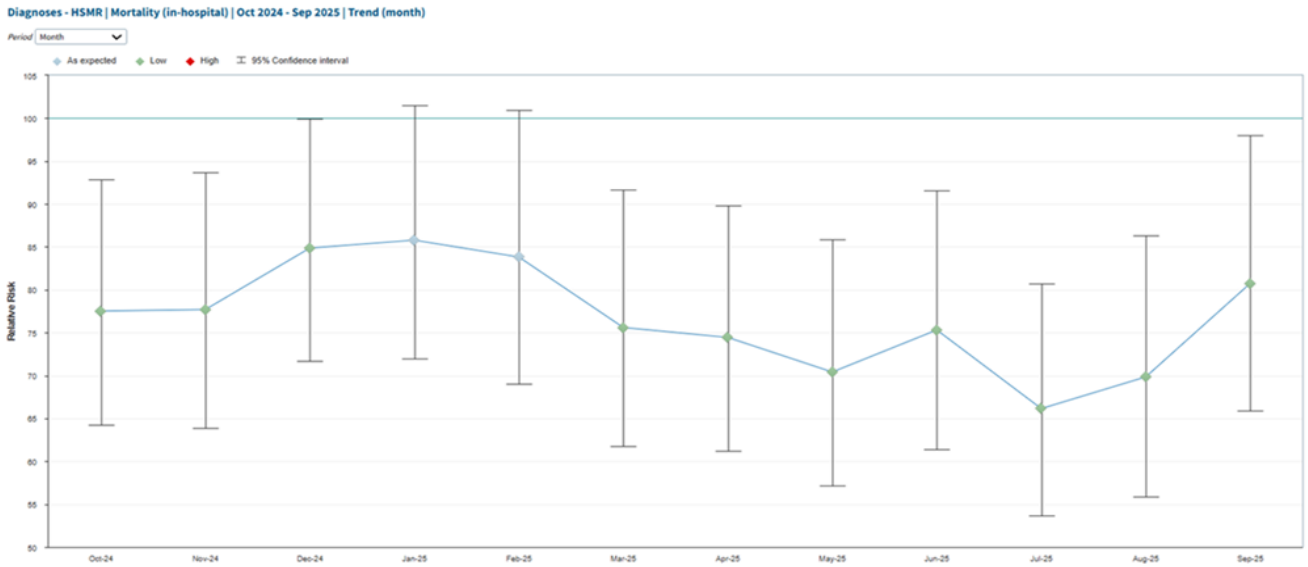
6.1 Mortality rates remain statistically significantly low. When considered with our harm profile and the outcomes of SJRs we can provide assurance to the committee that we are providing safe care for most of our patients. Where care issues are found we have a robust process for referral for more in-depth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

Appendix A – Performance scorecard

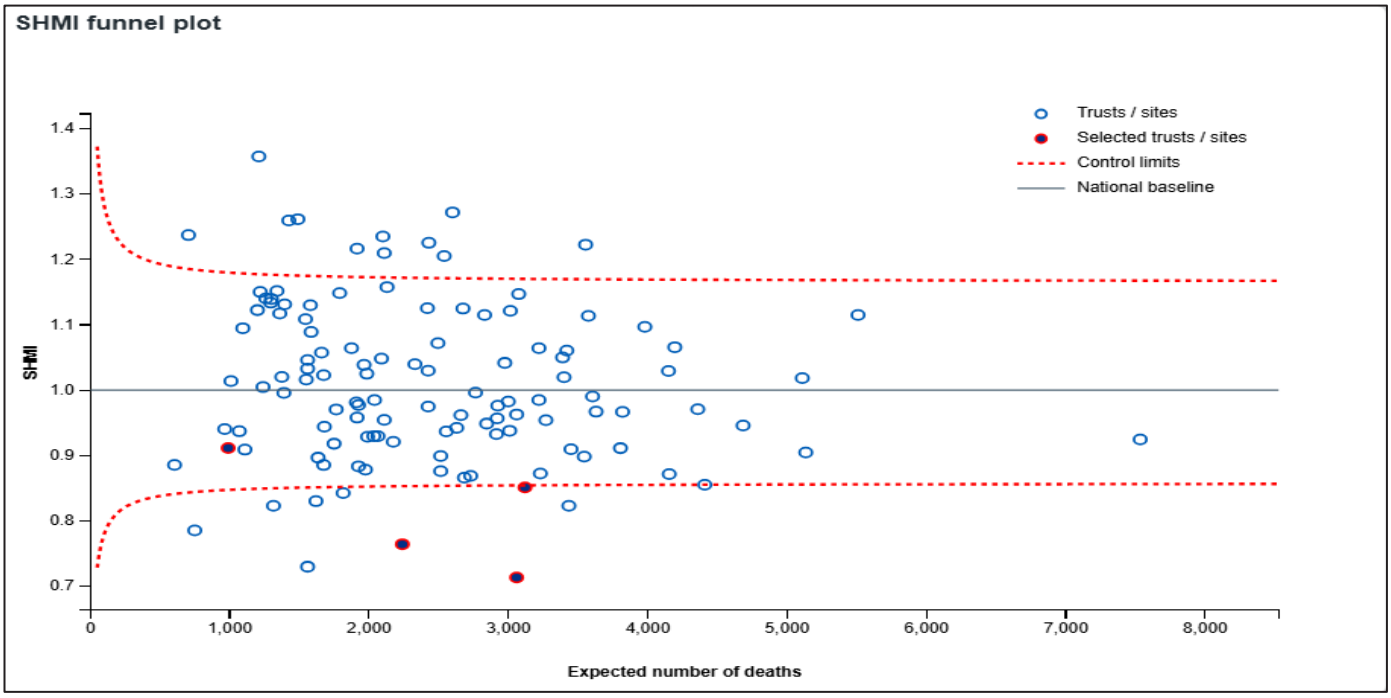
Financial Year	2025-2026		
Financial Quarter	Q1	Q2	Q3
No. Deaths	440	424	439
No. Adult Deaths	418	399	405
Adult Deaths per 1000 Elective Bed Days	0.04	0.04	0.04
No. Child Deaths	6	10	13
No. Neonatal Deaths	8	7	10
No. Stillbirths	8	8	12
ME Reviewed Deaths (excl Stillbirths) in Qtr	428	406	420
% ME Reviewed Deaths - Deaths (excl Stillbirths) in Qtr	99%	98%	98%
SJRs Requested for Deaths in Qtr	54	66	40
% SJRs Requested for Deaths in Qtr of total adult deaths in Qtr	13%	17%	10%
No. SJRs Completed in period	67	60	47
SJRs Completed for Deaths in Qtr	54	66	40
% SJRs Completed for Deaths in Qtr	100%	100%	100%
No. LeDeR Completed	0	6	3
Requests made by a Medical Examiner - SJRs Requested for Deaths in Qtr	6	14	15
% Requests made by a Medical Examiner - SJRs Requested for Deaths in Qtr	11%	21%	38%
Concerns raised by family / carers - SJRs Requested for Deaths in Qtr	13	12	11
% Concerns raised by family / carers - SJRs Requested for Deaths in Qtr	24%	18%	28%
Patients with learning disabilities - SJRs Requested for Deaths in Qtr	1	7	4
% Patients with learning disabilities - SJRs Requested for Deaths in Qtr	2%	11%	10%
Patients with severe mental health issues - SJRs Requested for Deaths in Qtr	4	4	2
% Patients with severe mental health issues - SJRs Requested for Deaths in Qtr	7%	6%	5%
Unexpected deaths - SJRs Requested for Deaths in Qtr	20	15	5
% Unexpected deaths - SJRs Requested for Deaths in Qtr	37%	23%	13%
Elective admission deaths - SJRs Requested for Deaths in Qtr	8	14	4
% Elective admission deaths - SJRs Requested for Deaths in Qtr	15%	21%	10%
Requests made by speciality mortality leads / through local Mortality and Morbidity review processes - SJRs Requested for Deaths in Qtr	5	5	5
% Requests made by speciality mortality leads / through local Mortality and Morbidity review processes - SJRs Requested for Deaths in Qtr	9%	8%	13%
CESDI 0 - No suboptimal care - Completed SJRs for Deaths in Qtr	41	52	25
% CESDI 0 - No suboptimal care - Completed SJRs for Deaths in Qtr	76%	79%	62%
CESDI 1 - Some sub optimal care which did not affect the outcome - Completed SJRs for Deaths in Qtr	7	8	8
% CESDI 1 - Some sub optimal care which did not affect the outcome - Completed SJRs for Deaths in Qtr	13%	12%	22%
CESDI 2 - Suboptimal care – different care might have made a difference to outcome (possible avoidable death) - Completed SJRs for Deaths in Qtr	5	5	7
% CESDI 2 - Suboptimal care – different care might have made a difference to outcome (possible avoidable death) - Completed SJRs for Deaths in Qtr	9%	8%	19%
CESDI 3 - Suboptimal care - would reasonably be expected to have made a difference to the outcome (probably avoidable death) - Completed SJRs for Deaths in Qtr	1	1	0
% CESDI 3 - Suboptimal care - would reasonably be expected to have made a difference to the outcome (probably avoidable death) - Completed SJRs for Deaths in Qtr	2%	2%	0%

Appendix B – Mortality rates

Rolling 12-month HSMR – October 2024 – September 2025



SHMI by acute provider – September 2024 – August 2025



SHMI by acute provider, September 2024 to August 2025, Source: NHS Digital, published 8th January 2026

SHMI by site (not all NHS sites are included in the SHMI calculation)

Site	Provider spells	Observed deaths	Expected deaths	SHMI	LCL 95%CI	UCL 95%CI
CXH	28,215	1,085	1,485	73.14	92.18	117.83
HH	13,440	320	435	73.91	85.82	119.98
SMH	49,640	740	1,085	68.31	90.89	118.17

SHMI by Trust site, September 2024 to August 2025, Source: NHS Digital, published 8th January 2026

Appendix C – Open diagnostic alerts under review

Group	Observed deaths	Expected deaths	HSMR
Coma, stupor and brain damage	32	24.4	131.1
Residual codes	82	23.5	348.4
Intracranial injury	75	57.8	129.7
Nervous system congenital abnormalities	3	0.5	621.6

Appendix D – CESDI 2 and 3 cases

(cases highlighted in green are those which have completed the full review process with outcomes and harm levels confirmed at death review panel)

Mortality Ref	CESDI grade	Incident Ref	Site	Area	Datix sub-category	Incident investigation status	Quarter of death	Quarter of review at DRP	Poor care confirmed – Y/N	Death due to poor care – Y/N	Final harm level	Final CESDI grade as agreed at DRP
MM30094	2	273368	HH	Medicine for the elderly	Complication of treatment/procedure	IIR complete	Q4 24/25	Q1 24/25	N	N	No harm	CESDI 0
MM29961	2	270787	CXH	Emergency medicine	Transfer delay	IIR complete	Q4 24/25	Q2 25/26	Y	N	Low harm	CESDI 1
MM29907	3	268877	SMH	Vascular surgery	Fall on level ground	PSII nearing completion – final panel being arranged	Q4 24/25	N/A	TBC	TBC	TBC (currently severe)	N/A
MM29883	2	272129	CXH	General surgery	Failure to follow procedure/guideline	PSII completed in January – case scheduled for next DRP	Q4 24/25	N/A	TBC	TBC	TBC (currently moderate)	N/A
MM31156	2	292412	CXH	Emergency medicine	Unexpected cardiac arrest	TBC – being reviewed at IIRG on 23/01/26	Q1 25/26	N/A	TBC	TBC	TBC (currently no harm)	N/A
MM30997	2	280829	CXH	ENT	Suboptimal care of the deteriorating patient	PSII nearing completion – final panel being arranged	Q1 25/26	N/A	TBC	TBC	TBC (currently moderate)	N/A
MM30974	3	280985	HH	Renal	Operations/procedures – unexpected outcome	IIR complete	Q1 25/26	Q2 25/26	N	N	No harm	CESDI 0

MM30671	2	279298	SMH	Emergency medicine	Delayed diagnosis	PSII nearing completion – final panel being arranged	Q1 25/26	N/A	TBC	TBC	TBC (currently moderate)	N/A
MM30644	2	277401	SMH	Emergency medicine	Unexpected cardiac arrest	IIR	Q1 25/26	Q3 25/26	Y	Y	Death	CESDI 3
MM30592	2	275426	SMH	Emergency medicine	Inappropriate admission	Part of an MDT review looking at 4 cases where there were delays in review and assessment of neuro-observations in ED – nearing completion (final draft report expected end of Jan)	Q1 25/26	N/A	TBC	TBC	TBC (currently moderate)	N/A
MM31824	2	296413	CXH	Stroke	Complication of treatment/procedure	M&M review complete (confirmed as no harm at IIRG) – case scheduled for next DRP	Q2 25/26	N/A	TBC	TBC	TBC (currently no harm	N/A
MM31771	2	290270	HH	Cardiology	Medication – wrong patient	PSII underway	Q2 25/26	N/A	TBC	TBC	TBC (currently moderate)	N/A
MM31670	3	289445	HH	Renal	Unexpected cardiac arrest	IIR nearing completion (amendments required post presentation at IIRG)	Q2 25/26	N/A	TBC	TBC	TBC (currently severe)	N/A
MM31455	2	286779	CXH	Urology	Unexpected cardiac arrest	M&M review underway	Q2 25/26	N/A	TBC	TBC	TBC (currently no harm)	N/A
MM31362	2	288140	CXH	Oncology	Complication of treatment/procedure	PSII underway	Q2 25/26	N/A	TBC	TBC	TBC (currently moderate)	N/A
MM31348	2	285448	HH	Cardiology	Complication of treatment/procedure	M&M review complete (confirmed as no harm at IIRG) – case scheduled for next DRP	Q2 25/26	N/A	TBC	TBC	TBC (currently no harm)	N/A
MM32481	2	298774	CXH	Neurosurgery	Unexpected cardiac arrest	IIR in progress	Q3 25/26	N/A	TBC	TBC	TBC (currently death)	N/A
MM32296	2	294913	HH	Haematology	Collapse	Triage form completed – IIRG confirmed no harm and local investigation –	Q3 25/26	N/A	TBC	TBC	TBC (currently no harm)	N/A

						case scheduled for next DRP						
MM32223	2	296419	HH	Cardiology	Complication of treatment/procedure	IIR underway	Q3 25/26	N/A	TBC	TBC	TBC (currently death)	N/A
MM32097	2	293348	CXH	Gastroenterology	Communication failure across teams	IIR underway	Q3 25/26	N/A	TBC	TBC	TBC (currently low harm)	N/A
MM32087	2	294095	SMH	Emergency medicine	Delayed diagnosis	AAR underway	Q3 25/26	N/A	TBC	TBC	TBC (currently moderate harm)	N/A
MM32035	2	293340	HH	Anaesthetics	Cardiac arrest despite continued intervention	M&M review complete (confirmed as no harm at IIRG) – case scheduled for next DRP	Q3 25/26	N/A	TBC	TBC	TBC (currently no harm)	N/A
MM32028	2	293290	SMH	Acute medicine	Fall on level ground	IIR closed – case scheduled for next DRP	Q3 25/26	N/A	TBC	TBC	TBC (currently severe harm)	N/A

Appendix E – PMRT reviews quarter two

During the 3-month period ending September 2025 there were 20 cases reported to MBRRACE-UK of which 17 were eligible for full review using PMRT. Three cases met the criteria for notification only - one termination of pregnancy and two neonatal deaths due to the timing the deaths occurred.

	No. reported	Not supported for review	Review in progress	Review completed	Grading of care: number with issues in care likely to have made a difference to outcome
Stillbirths and late fetal losses	12	0	11	1	**2**
Neonatal and post-natal deaths	5	2	2	3	**2**

PMRT review status by case category (Q2 2025/26), July 25 – September 25

There were four PMRT reviews which identified issues in care likely to have made a difference to the outcome. Three of which are being investigated as PSIIs and one by MNSI.

Learning from PMRT reviews is reported through our maternity and neonatal quality assurance report, as well as to the learning from deaths forum. Where sub-optimal care that could have impacted the outcome is identified cases are reviewed through the incident management framework as required.

Appendix F – Life and death (LeDer) reviews

Life and Death Reviews reported in Q3 2025/26:

Ref	Month of Death	Process stage	Specialty	CESDI grade
MM31969	Oct	Closed	Stroke	CESDI 0
MM32134	Nov	Awaiting Specialty Review	ED	CESDI 0
MM32248	Nov	Awaiting Specialty Review	Respiratory	CESDI 0
MM32559	Dec	Closed	MfE	CESDI 0

Learning from Life and Death Review cases, October 2025 December 2025

Appendix G – Ethnicity data

Financial Year 25/26 (M9)	Cerner Data		Combined dataset (WSIC and Cerner)	
	No. Deaths	% Deaths	No. Deaths	% Deaths
Totals	1385	100.0%	1385	100.0%
-	27	1.9%	24	1.7%
Asian - Any Other Asian Background	80	5.8%	80	5.8%
Asian or Asian British - Bangladeshi	6	0.4%	6	0.4%
Asian or Asian British - Indian	89	6.4%	114	8.2%
Asian or Asian British - Pakistani	26	1.9%	28	2.0%
Black - Any Other Black Background	23	1.7%	37	2.7%
Black or Black British - African	46	3.3%	52	3.8%
Black or Black British - Caribbean	72	5.2%	75	5.4%
Mixed - Any Other Mixed Background	8	0.6%	12	0.9%
Mixed - White and Asian	-	-	4	0.3%
Mixed - White and Black African	6	0.4%	6	0.4%
Mixed - White and Black Caribbean	2	0.1%	9	0.6%
Other - Any Other Ethnic Group	211	15.2%	150	10.8%
Other - Chinese	7	0.5%	7	0.5%
Other - Not Known	27	1.9%	23	1.7%
Other - Not Stated	171	12.3%	81	5.8%
White - Any Other White Background	142	10.3%	218	15.7%
White - British	400	28.9%	398	28.7%
White - Irish	42	3.0%	68	4.9%

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

NWL Acute Provider Collaborative Board in Common (Public)
28/04/2026
Item number: 7.1.2 b READING ROOM
This report is: Public

Learning from Deaths Report CWFT , Quarter 3 2025/26

Author: Zohra Ali
Job title: Associate Director of Quality Governance

Author: Stacey Humphries
Job title: Head of Clinical Governance

Accountable director: Sanjay Krishnamoorthy
Job title: Site Medical Director, WM

Purpose of report (for decision, discussion or noting)

Purpose: Assurance

This report presents the data from the Trust's Learning from Deaths programme for Quarter three (Q3) of 2025/26. It is a statutory requirement to present this information to the public board, this is 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.

Report history

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

CWNHSFT Trust Mortality Surveillance Group 06/03/2026 For Approval	CWNHSFT Executive Management Board 25/02/2026 For noting	CWNHSFT Quality Committee 02/03/2026 For noting

Executive summary and key messages

The Trust is one of the best-performing acute (non-specialist) providers in England in relation to relative risk of mortality, with a Trust-wide Summary Hospital-level Mortality Indicator (SHMI) of 76.44 for the period September 2024 to August 2025 (where a value below 100 indicates lower than expected mortality) (Source: NHS Digital). This provides positive assurance, reflected across the Trust, with both hospital sites continuing to operate significantly below the expected relative risk of mortality.

Between January 2025 and December 2025, a total of 1,322 in-hospital adult and child deaths were recorded within the Trust's mortality review system (Datix). Of these, 96% were screened, and 42% underwent a full mortality case review.

No cases were identified where sub-optimal care would reasonably be expected to have made a difference to the patient's outcome. Six cases of sub-optimal care graded as CESDI 2 (where sub-optimal care was identified and different care might have made a difference to the outcome) were identified and escalated for consideration of the appropriate learning response.

Where opportunities for improvement are identified, learning is reviewed at Divisional Mortality Review Groups and escalated to the Trust-wide Mortality Surveillance Group to provide assurance on actions taken. This process ensures appropriate scrutiny, oversight, and the effective sharing and cascading of learning across the Trust.

Impact assessment

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

Strategic priorities

- ☐ 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)
- ☒ Deliver high quality patient centred care (CWFT)
- ☐ Be the employer of Choice (CWFT)
- ☐ Deliver better care at lower cost (CWFT

Main Report

1. Introduction

The Mortality Surveillance programme offers assurance to patients, stakeholders, and the Board that high standards of care are being provided and that gaps in service delivery are being effectively identified, escalated, and addressed. This report provides a Trust-level review of mortality learning for Q3 2025/26.

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.

2.1. Summary Hospital-level Mortality Indicator (SHMI)

The Trust's SHMI for the period September 2024 – August 2025 is 76.44 (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	105,900	2,655	3,120	85.12	85.45	117.03
THH	47,735	905	990	91.14	84.75	117.99
ICHT	118,125	2,180	3,060	71.34	85.44	117.04
CWFT	86,825	1,715	2,240	76.44	85.32	117.21

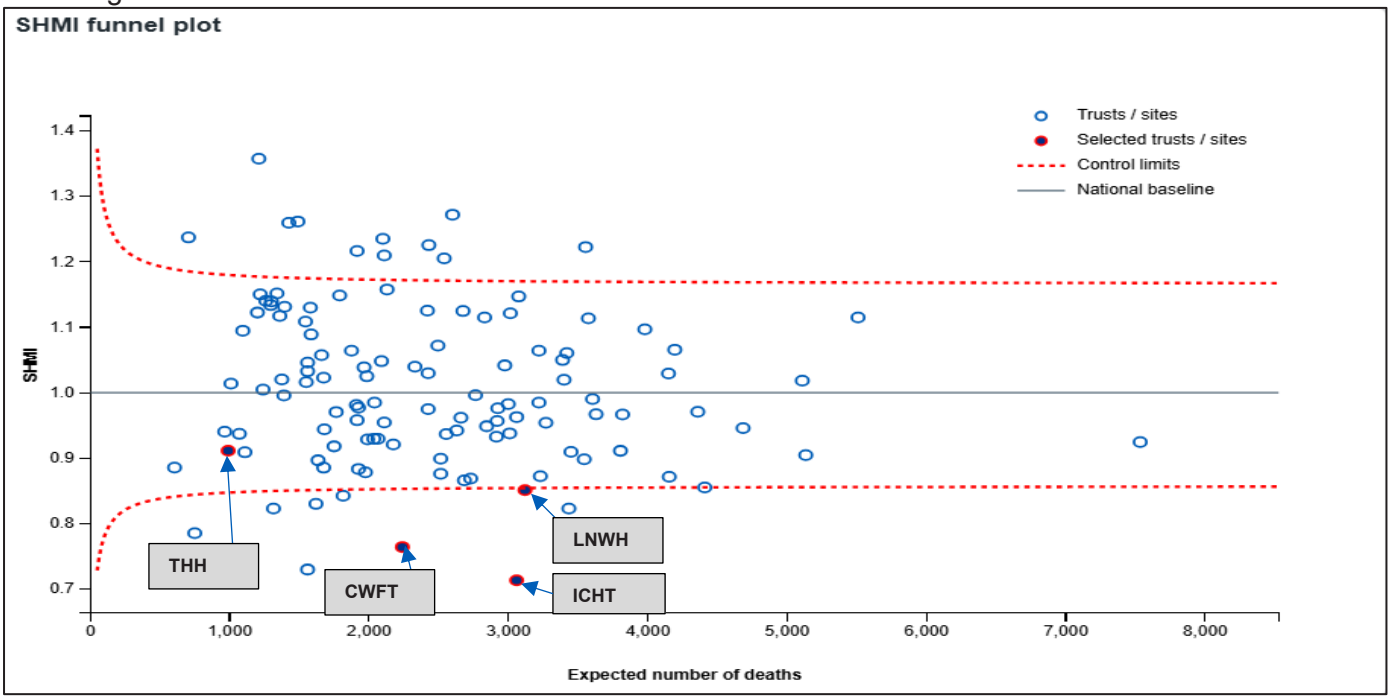
SHMI by APC provider, September 2024 to August 2025, Source: NHS Digital, published 8th January 2026

SHMI by site (not all NHS sites are included in the SHMI calculation)

Site	Provider spells	Observed deaths	Expected deaths	SHMI	LCL 95%CI	UCL 95%CI
CW	39,535	700	955	73.61	84.50	118.35
WM	44,945	1,010	1,280	78.76	84.76	117.98

SHMI by Trust site, September 2024 to August 2025, Source: NHS Digital, published 8th January 2026

NHS England acute Trust's SHMI



SHMI by acute provider, September 2024 to August 2025, Source: NHS Digital, published 8th January 2026

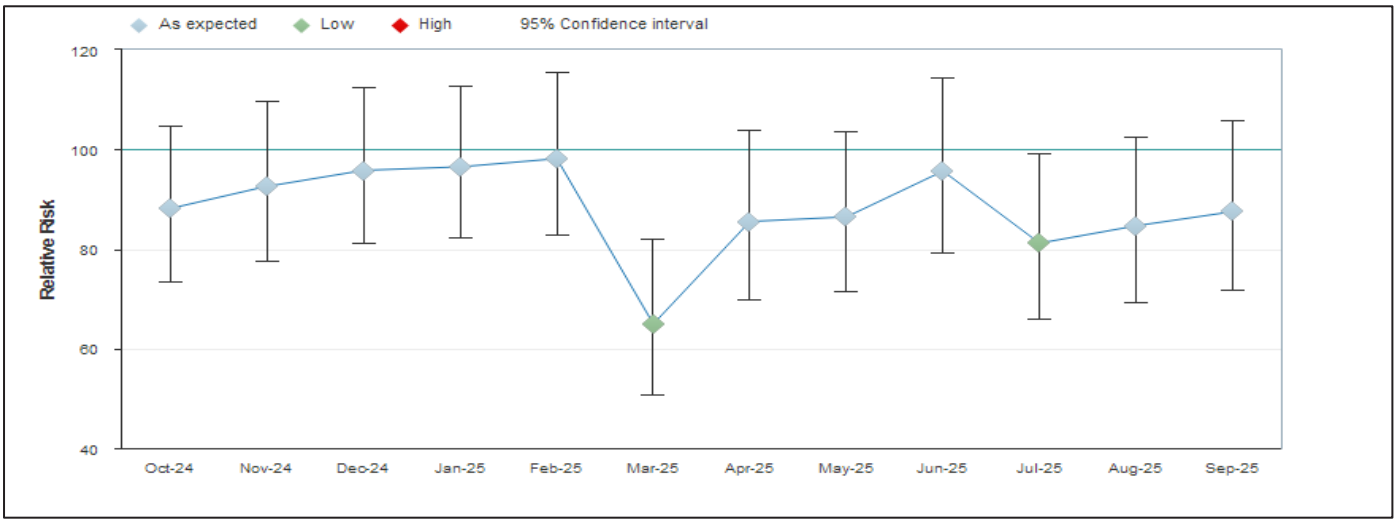
2.2. Hospital Standardised Mortality Ratio (HSMR)

The Trust's HSMR for the period October 2024 – September 2025 is 78.6 (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	201,475	1924	2067.8	93.0	88.9	97.3
THH	80,900	635	636.2	99.8	92.2	107.9
ICHT	146,935	1,640	2144.5	76.5	72.8	80.3
CWFT	155,730	1,240	1578.0	78.6	74.3	83.1

Trust HSMR (41 diagnostic groups), October 2024 to September 2025, Source: Telstra,



2.2.1. Relative risk by diagnostic group

Cumulative sum (CUSUM) alerts are used to indicate patterns of higher than expected mortality at diagnostic group. No alerts were received for diagnostic groups during this reporting period (Q3).

3. Adult and Child Mortality Review

All in-hospital adult and child deaths are screened to identify cases requiring more in-depth (level 2) mortality review. Mortality review provides clinical teams with the opportunity to review expectations, outcomes and potential improvements following in-hospital deaths.

Over the last four financial quarters; 1322 in-hospital adult or child deaths were recorded within the Trust's mortality review system, of these 96% have been screened and 42% 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
Q4 24/25	378	199	170	9	**98%**	**45%**	**2%**
Q1 25/26	297	165	125	7	**98%**	**42%**	**2%**
Q2 25/26	299	168	114	17	**94%**	**38%**	**6%**
Q3 25/26	348	188	142	18	**95%**	**41%**	**5%**
Totals	**1322**	**720**	**551**	**51**	**96%**	**42%**	**4%**

Mortality Leads are required to complete Level 2 mortality reviews within 45 working days of the date of death. Compliance with this process is monitored through Divisional Mortality Review Groups and the Mortality Surveillance Group, with oversight provided by the Patient Safety Group, Executive Management Board, and Quality Committee.

3.1. CESDI Grading of Care

Outcome 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.

During the past 12 months, 454 full mortality reviews have been closed following discussion at specialty, divisional or Trust wide mortality review groups.

CESDI grades by financial quarter

Period	CESDI 0	CESDI 1	CESDI 2	CESDI 3
Q4 24/25	126	28	5	0
Q1 25/26	104	15	0	0
Q2 25/26	71	18	1	0
Q3 25/26	78	8	0	0
Total	379	69	6	0

Closed mortality cases by CESDI grade, January to December 2025

The Patient Safety Incident Response Framework (PSIRF) requires deaths assessed to be, more likely than not, due to problems in care to undergo an enhanced learning response. Therefore level 2 mortality reviews identified as CESDI 2 and 3 are subject to additional scrutiny via the incident investigation framework. See appendix 2 for a listing of linked cases.

3.2. Learning from adult and child mortality review

Key themes / issues / improvements identified via adult & child mortality review this quarter:

- **Treatment escalation planning and end-of-life care:** Recurrent opportunities to improve the timeliness, clarity, and accessibility of Treatment Escalation Plans (TEPs), particularly for frail patients, those with advanced malignancy, and prolonged admissions. Clear consultant ownership and improved communication remain priorities.
- **Communication, compassion, and dignity:** Instances of unclear communication and sub-optimal end-of-life environments highlighted the need to reinforce compassionate care, privacy, and dignity, especially during periods of operational pressure.
- **Diagnostics and imaging:** Learning from missed or delayed diagnoses emphasised the importance of robust imaging pathways, effective escalation, and senior oversight, including clear guidance that urgent imaging should not be delayed unnecessarily.
- **Medicines safety:** Themes focused on high-risk medication omissions and prescribing in frail or renally impaired patients, reinforcing the importance of clear documentation and use of incident reporting for thematic learning.
- **Systems and processes:** Identified gaps included access to clinical guidance, equipment familiarity, and the need for Trust-wide policies (e.g. procedural sedation), highlighting opportunities for standardisation and training.

- **Transfers of care:** Some cases reflected risks at points of transition, including discharge and cross-organisational working, requiring continued focus on coordination and escalation.
- **Data quality and digital enablers:** Accurate documentation, including next-of-kin details on CERNER, remain a patient safety priority due to its direct impact on communication.

4. 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 1 quarter behind. During the 3 month period ending September 2025 11 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: number with issues in care likely to have made a difference to outcome
Stillbirths and late fetal losses	7	2	3	2	**0**
Neonatal and post-natal deaths	8	2	2	4	**0**

PMRT review status by case category (Q2 2025/26), July 25 – September 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 via the incident management framework as required.

5. Learning from Life and Death Reviews Programme

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.

Life and Death Reviews reported in Q3 2025/26:

Ref	Month of Death	Process stage	Specialty	CESDI grade
MM15996	Nov	Closed	ICU	CESDI 0
MM16010	Nov	Awaiting Specialty Review	Diabetes/Endocrine	
MM16131	Dec	Closed	ICU	CESDI 0
MM16211	Dec	Closed	Care Of Elderly	CESDI 0
MM16121	Dec	Closed	Respiratory	CESDI 0

Learning from Life and Death Review cases, October 2025 - December 2025

6. Prevention of future deaths (PFD)

The Trust has not been issued with a Prevention of Future Deaths (PFD) notice during Q3 2025/26.

To note, a Prevention of Future Deaths (PFD) report was issued in January 2026. The Trust is developing its response, with a further update to be provided separately by Legal services and full details reported in the Q4 2025/26 report.

7. 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 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.

Glossary

LNWH – London North West University Healthcare NHS Trust
THH – The Hillingdon Hospital NHS Foundation Trust
ICHT – Imperial College Healthcare NHS Trust
CWFT – Chelsea and Westminster NHS Foundation Trust
CW – Chelsea and Westminster Hospital
WM – West Middlesex Hospital

Appendix 1: Mortality review process

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. We undertake in-depth (level 2) mortality review for cases meeting the following criteria:

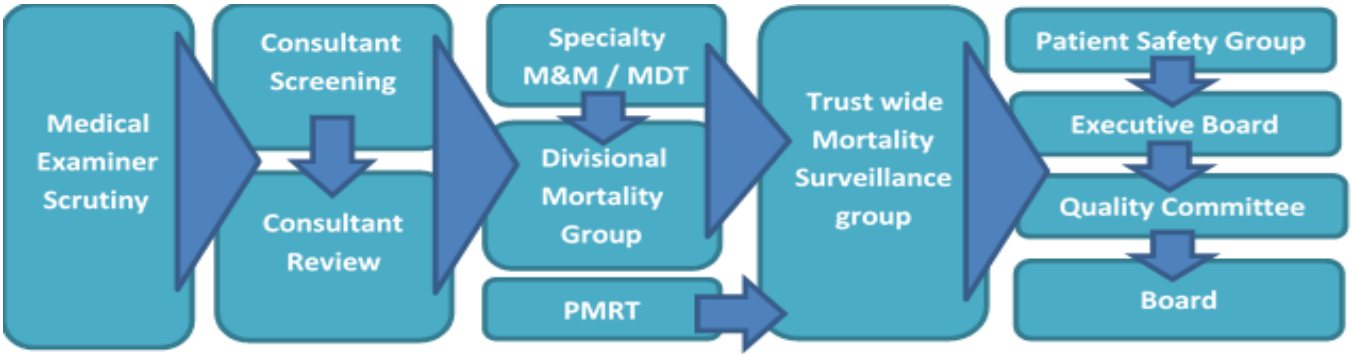
National triggers:

- 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 CWFT triggers:

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

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.

Appendix 2: Case linked to incident framework

Mortality Ref	CESDI grade	Incident Ref	Site	Area	Category	Incident investigation status
MM14029	CESDI 2	INC148457	CWH	Emergency Department	Failure / Delay to act on results	After Action Review (AAR) - Completed
MM14297	CESDI 2	INC150424	WMH	Emergency Department	Failure to act on escalation	Patient Safety Incident Investigation (PSII) - Completed
MM14295	CESDI 2	INC150582	WMH	Neurology	Death: Unexpected / unexplained	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)
MM15288	CESDI 2	INC160721	CWH	General Surgery	Death: Unexpected / unexplained	Patient Safety Incident Investigation (PSII) - Completed

CESDI grade 2 and 3 cases linked to an incident learning response in last 12 months, January 2025 – December 2025.

Learning from incident investigations linked to mortality review is submitted to the Patient Safety Group and the Trust Executive Group for shared learning and consideration of whether further Quality Improvement Projects, deep-dives, or targeted action is required.

NWL Acute Provider Collaborative Board in Common (Public)
28/04/2026
Item number: 7.1.2 READING ROOM
This report is: Public

Learning from Deaths Report, Quarter 3 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 Trust's Learning from Deaths programme for Quarter three (Q3) of 2025/26. It is a statutory requirement to present this information to the public board, this is 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.

Report history

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

Learning from deaths group	**Trust Executive Group**	**LNWH Quality Committee**
17/02/2026	18/02/2026	26/02/2026
For approval	For approval	For noting

Executive summary and key messages

The Trust uses the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) to monitor the relative risk of mortality. The HSMR for the period October 2024 to September 2025 is 93.0; this is statistically low. The SHMI for period September 2024 – October 2025 also remains statistically low at 85. These are the most up to date HSMR and SHMI figures available at the time this report was submitted to the Trust Executive Group (February 26).

During the 12-month period to end of December 2025; 100% in-hospital adult and child deaths were recorded within the Trust's mortality review system and screened. 414 deaths were identified for level 2 mortality review of which 388 have been completed at time of reporting (94%).

During Q3 2025/26; 9 cases had areas of sub-optimal care, treatment or service delivery identified. The majority of these cases (8) concluded that there had been a level of suboptimal care but that different care or management would not have made a difference to the outcome (CESDI 1). In one (1) case was initially found that different care might have made a difference to the outcome, a comprehensive investigation into this case has been triggered through the Trust Incident Response Framework.

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

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

Strategic priorities

- ☐ 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)
- ☒ Provide high-quality, timely and equitable care in a sustainable way (LNWH)
- ☐ Be a high-quality employer where all our people feel they belong and are empowered to provide excellent services and grow their careers (LNWH)
- ☐ Base our care on high-quality, responsive, and seamless non-clinical and administrative services (LNWH
- ☐ Build high-quality, trusted ways of working with our local people and partners so that together we can improve the health of our communities (LNWH)

Key risks arising from report

The Trust is exploring opportunities to develop business intelligence tools to link higher risk cohorts (as identified within the HSMR) to patient level information; this will increase the Trust's responsiveness to alerts and support review of diagnostic groups with higher than expected mortality risk.

Main Report

1. Introduction

The Mortality Surveillance programme offers assurance to patients, stakeholders, and the Board that high standards of care are being provided and that gaps in service delivery are being effectively identified, escalated, and addressed. This report provides a Trust-level review of mortality learning for Q3 2025/26.

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.

2.1. Summary Hospital-level Mortality Indicator (SHMI)

The Trust's SHMI for the period September 2024 - August 2025 is 85.12 (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	105,900	2,655	3,120	85.12	85.45	117.03
THH	47,735	905	990	91.14	84.75	117.99
ICHT	118,125	2,180	3,060	71.34	85.44	117.04
CWFT	86,825	1,715	2,240	76.44	85.32	117.21

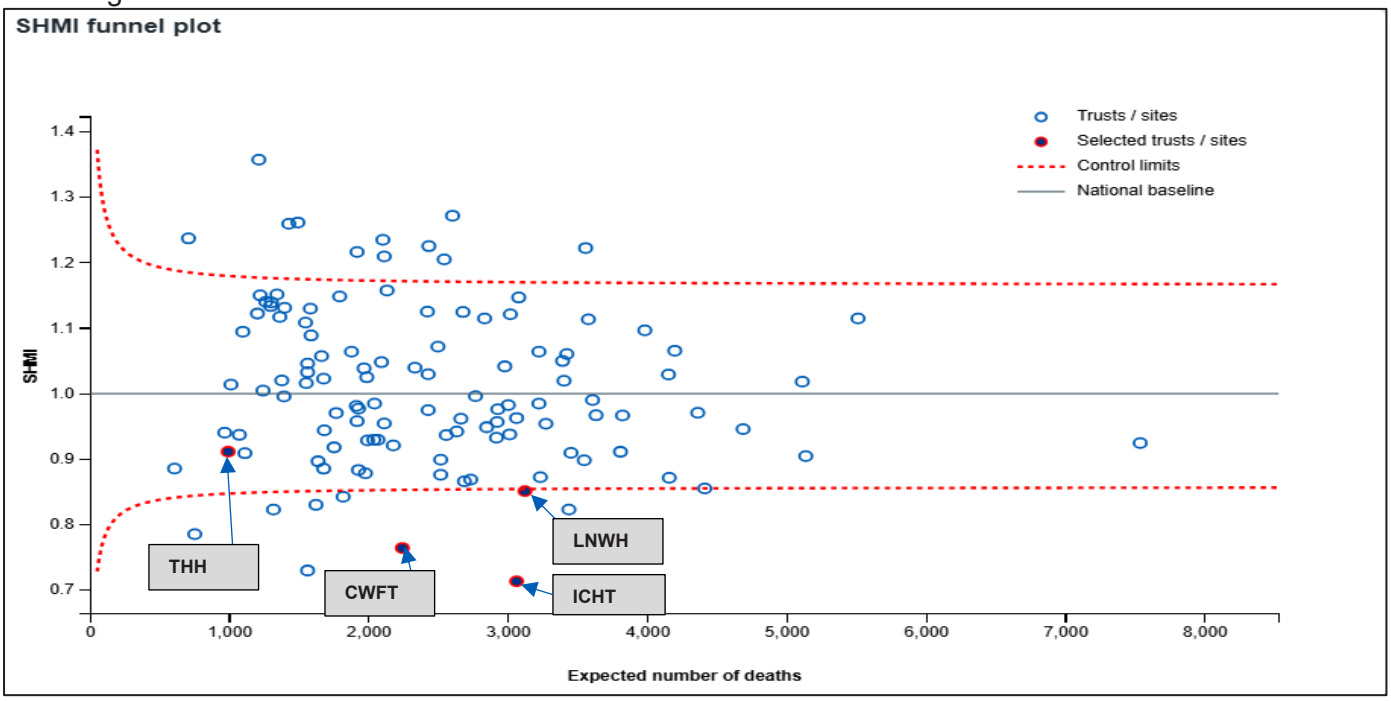
SHMI by APC provider, September 2024 to August 2025, Source: NHS Digital, published 8th January 2026

SHMI by site (not all NHS sites are included in the SHMI calculation)

Site	Provider spells	Observed deaths	Expected deaths	SHMI	LCL 95%CI	UCL 95%CI
NPH	78,930	1,875	2,100	89.46	85.06	117.56
EH	22,970	775	1,000	77.24	84.55	118.28

SHMI by Trust site, September 2024 to August 2025, Source: NHS Digital, published 8th January 2026

NHS England acute Trust's SHMI



SHMI by acute provider, September 2024 to August 2025, Source: NHS Digital, published 8th January 2026

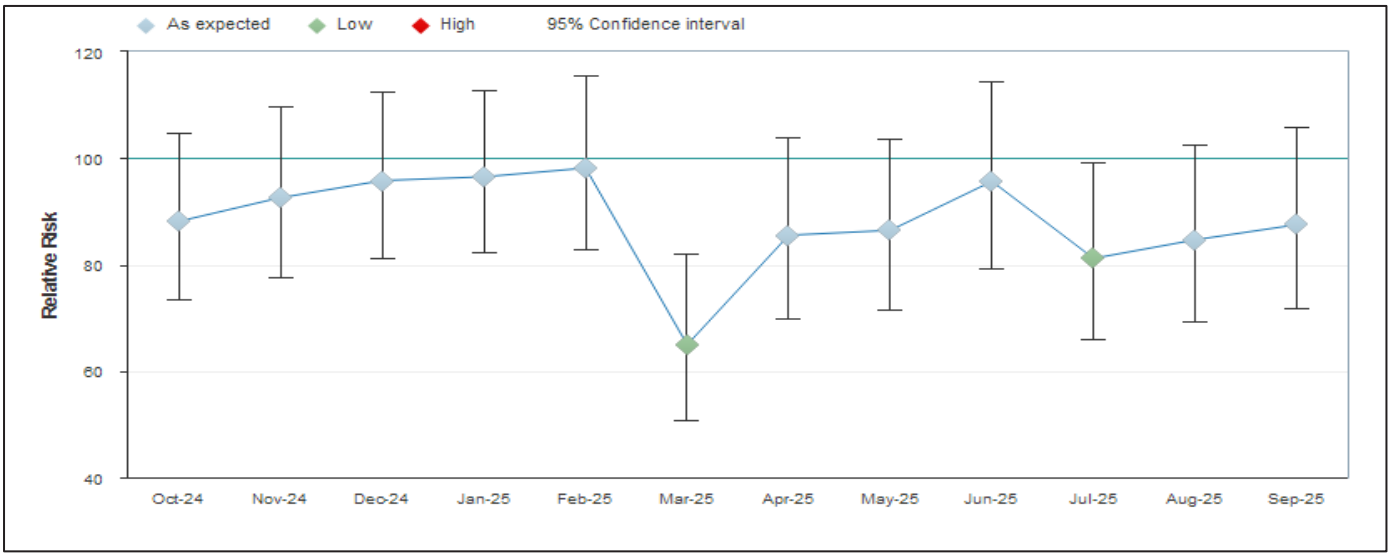
2.2. Hospital Standardised Mortality Ratio (HSMR)

The Trust's HSMR for the period October 2024 – September 2025 is 93.0 (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	201,475	1924	2067.8	93.0	88.9	97.3
THH	80,900	635	636.2	99.8	92.2	107.9
ICHT	146,935	1,640	2144.5	76.5	72.8	80.3
CWFT	155,730	1,240	1578.0	78.6	74.3	83.1

Trust HSMR (41 diagnostic groups), October 2024 to September 2025, Source: Telstra,



Trust rolling HSMR (41 diagnostic groups), October 2024 to September 2025, Source: Telstra,

2.2.1. Relative risk by diagnostic group

Cumulative sum (CUSUM) alerts are used to indicate patterns of higher-than-expected mortality at diagnostic group. Alerts were received for the following diagnostic groups during this reporting period (Q3).

Group	Vol	Observed deaths	Expected deaths	HSMR
Cardiac arrest and ventricular fibrillation	46	31	19.3	160.8
Learning: the Trust has previously undertaken a detailed review of this diagnostic group to understand the nature of the cases being recorded. This analysis confirmed that the activity classified within this group predominantly relates to patients experiencing out-of-hospital cardiac arrests. These cases typically arrive via emergency services and present with urgent clinical needs. No elements of sub-optimal care were identified in the review of this alert.				
Other psychoses	257	6	3.2	188.8
Learning: the Trust had 6 observed deaths against an expected 3.2 across the year. The alert refers to three deaths that occurred in January 2025. All three cases were investigated and found to have received no sub-optimal care.				
Residual codes unclassified	3718	145	54.7	265.2
Learning: Residual codes unclassified are applied within the HSMR model where a primary diagnostic group cannot be identified; this alert relates to 145 cases that have been categorised this way within the external model, internal coding review has concluded that these gaps are not present within the Trust internal record system. Business Information support is being provided to support the identification of patient level data associated with these alerts; this will enable the review of coding upload arrangement or other factors resulting in these HSMR analysis gaps.				

2.3. Learning from relative risk of mortality

The Trust's mortality indicators (SHMI and HSMR) remain statistically lower than expected, demonstrating strong overall performance. The Trust remains 9th best performing acute provider in England in relation of the SHMI relative risk.

3. Adult and Child Mortality Review

All in-hospital adult and child deaths are screened to identify cases requiring more in-depth (level 2) mortality review. Mortality review provides clinical teams with the opportunity to review expectations, outcomes and potential improvements following in-hospital deaths.

Over the last four financial quarters, 2,264 in-hospital adult or child deaths were recorded within the Trust's mortality review system, of these 100% have been screened and 94% have had full mortality case review.

	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
Q4 24/25	668	668	96	95	100%	**99%**
Q1 25/26	535	535	104	103	100%	**99%**
Q2 25/26	487	487	97	94	100%	**97%**
Q3 25/26	573	573	117	96	100%	**82%**
Totals	**2,264**	**2,264**	**414**	**388**	**100%**	**94%**

Mortality Leads have 4 months from the date of death to complete level 2 mortality reviews. 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.

3.1. CESDI Grading of Care

Outcome 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.

During the past 12 months, 388 full mortality reviews have been closed following discussion at specialty, divisional or Trust wide mortality review groups.

CESDI grades by financial quarter

Period	CESDI 0	CESDI 1	CESDI 2	CESDI 3
Q4 24/25	75	19	0	1
Q1 25/26	84	16	2	1
Q2 25/26	76	14	4	0
Q3 25/26	87	8	1	0
Total	**322**	**57**	**7**	**2**

Closed mortality cases by CESDI grade, January to December 2025

The Patient Safety Incident Response Framework (PSIRF) requires deaths assessed to be, more likely than not, due to problems in care to undergo an enhanced learning response. Therefore level 2 mortality reviews identified as CESDI 2 and 3 are subject to additional scrutiny via the incident investigation framework. See appendix 2 for a listing of linked cases

3.2. Learning from adult and child mortality review

Key themes / issues / improvements identified via adult & child mortality review this quarter:

- Recognition and Escalation of care: challenged in timely recognition and escalation remain evident, with Treatment Escalation Plans often not completed early enough in the admission process, even for patients presenting with multiple complex comorbidities. These findings have been shared with the End-of-Life Care Group and continue to form a central focus for the educational programme they have developed to improve end-of-life care. This programme addresses the early identification of patients in the last year of life, strengthening communication with patients and families, supporting individuals to die in their preferred place of care, and enhancing the quality of care provided to those dying on our wards. Progress on this educational programme, along with other related initiatives, is reported to the Clinical Effectiveness Group twice a year.

- Communication and Documentation: this continues to be a key area for improvement. Delayed, unclear or incomplete communication with families and Next of Kin has led to avoidable distress, complaints and escalations. Strengthening the timeliness and quality of communication is being supported by the training being delivered by the End-of-Life Care Group, to ensure concerns are address proactively and more efficiently.

- Specialist Input and Multidisciplinary Team (MDT) Working: several cases highlighted delays in consultant review or in seeking specialist advice. These issues have been discussed within the relevant specialties, and shared learning has been disseminated through the monthly Surgery & St Marks Divisional Mortality Review meetings. This approach ensure that recurring theses are promptly identified and acted upon.

4. 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 1 quarter behind. During the 3-month period ending September 2025 5 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: number with issues in care likely to have made a difference to outcome
Stillbirths and late fetal losses	3	0	0	3	3 x Grade C
Neonatal and post-natal deaths	2	0	0	2	1 x Grade C

PMRT review status by case category (Q2 2025/26), July 25 – September 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 via the incident management framework as required.

5. Learning from Life and Death Reviews Programme

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.

Life and Death Reviews reported in Q3 2025/26:

Ref	Month of Death	LeDeR Process stage	Specialty	Trust review outcome CESDI grade
M64576	November	Review not yet started	Cardiology	CESDI 0
M64734	November	Review not yet started	Respiratory Medicine	CESDI 0
M64900	November	Review not yet started	Rheumatology	CESDI 0
M65621	December	Review not yet started	Acute Medicine	CESDI 0

Learning from Life and Death Review cases, October 2025 to December 2025

6. Prevention of future deaths (PFD)

The Trust has not been issued with a Prevention of Future Deaths (PFD) notice during Q3 2025/26.

7. 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. Where care issues are identified, 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 enabling themes and associated learning to be identified. We are also actively working in partnership with other members of the APG to ensure consistency, facilitate shared learning, and identify opportunities for collective improvement.

Glossary

LNWH – London North West University Healthcare NHS Trust
THH – The Hillingdon Hospital NHS Foundation Trust
ICHT – Imperial College Healthcare NHS Trust
CWFT – Chelsea and Westminster NHS Foundation Trust
NPH – Northwick Park Hospital
EH – Ealing Hospital

Appendix 1: Mortality review process

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. We undertake in-depth (level 2) mortality review for cases meeting the following criteria:

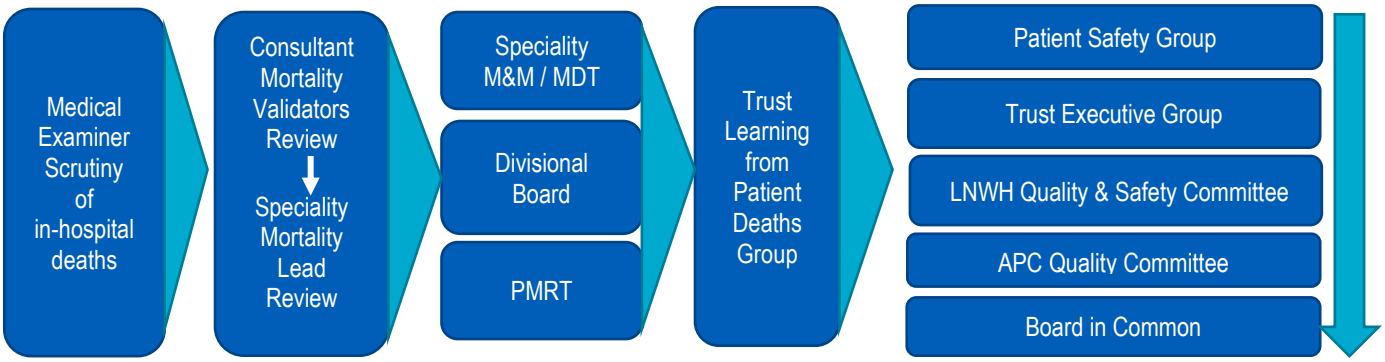
National triggers:

- 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 LNWH 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.

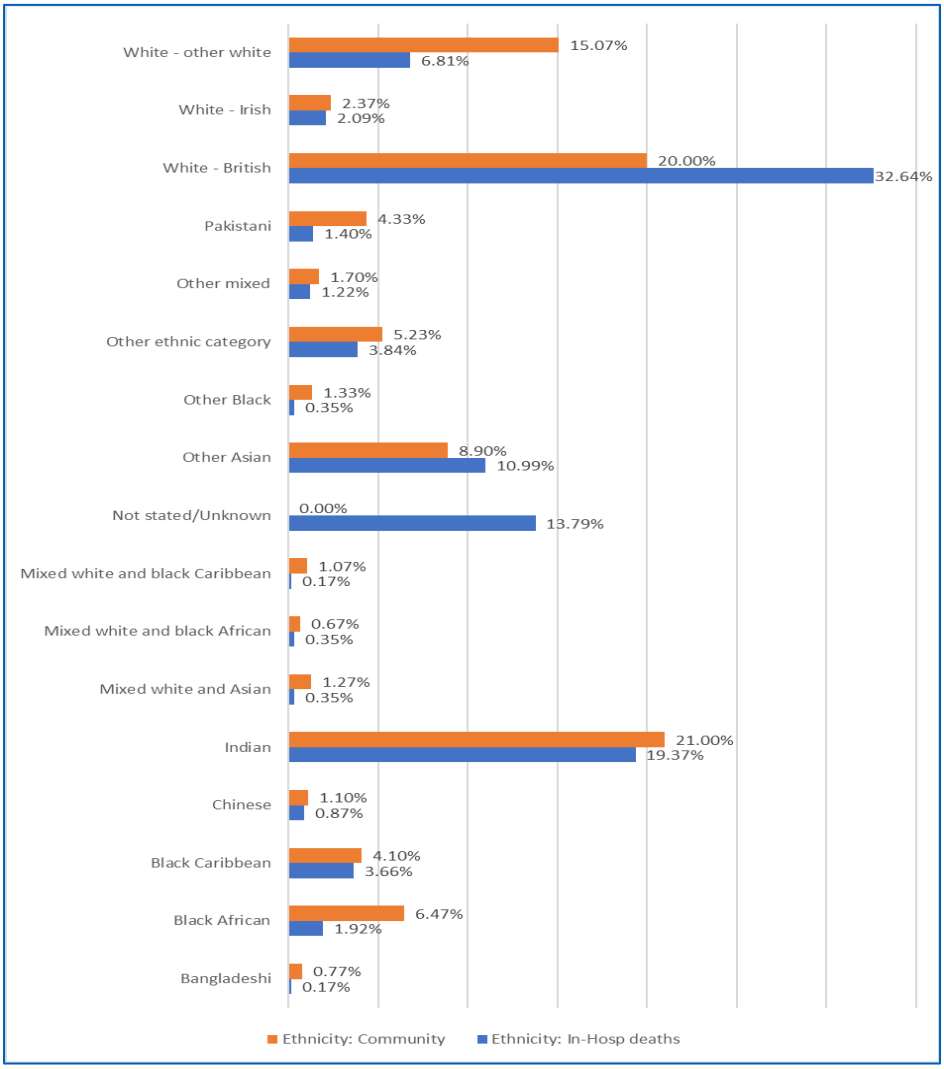
Appendix 2: Case linked to incident framework

Mortality Ref	CESDI grade	Incident Ref	Site	Area	Event sub-category	Incident investigation status
M57948	3	WEB264784	NPH	Clinical Haematology	Bone marrow procedure	PSII Completed
M61100	2	WEB272804	NPH	General Surgery	Bowel perforation - Delayed surgery	PSII Completed
M61436	3	WEB275841	NPH	Elderly Care	Medication interaction Paxlovid and Apixaban	PSII ongoing
M61831	2	WEB277147	NPH	Trauma and Orthopaedics	Necrotising soft tissue infection	PSII Completed
M62154	2	WEB277592	EH	Gastro	Fall	IIR in-progress
M62658	2	WEB280060	NPH	Neonatology	Neonatal death	PMRT completed IIR in progress
M62740	2	WEB280726	NPH	Rheumatology	Possible delay in giving blood products	PSII ongoing
M63477	2	WEB282847	NPH	Stroke Services	Misplaced NG tube	PSII ongoing
M63897	2	WEB284503	NPH	Clinical Haematology	Clinical deterioration - Failure to Follow Procedure	MDT review ongoing.

CESDI grade 2 & 3 cases linked to an incident learning response in last 12 months, Jan to Dec 2025

Learning from incident investigations linked to mortality review is submitted to the Patient Safety Group and the Trust Executive Group for shared learning and consideration of whether further Quality Improvement Projects, deep-dives, or targeted action is required.

Appendix 3: Ethnicity Breakdown of community population and in-hospital mortality



NWL Acute Provider Collaborative Board in Common (Public)
28/04/2026
Item number: 7.1.2 READING ROOM
This report is: Public

The Hillingdon Hospital NHS Foundation Trust

Learning from Deaths Report, Quarter 3 2025/26

Author: Paula Perry
Job title: Clinical Governance Facilitator

Accountable director: Stella Barnes
Job title: Consultant Physician, Associate Medical Director for Quality

Purpose of report (for decision, discussion or noting)

Purpose: Assurance

This report presents the data from the Trust's Learning from Deaths programme for Quarter three (Q3) of 2025/26. It is a statutory requirement to present this information to the public board, this is achieved through presentation to our Quality and Safety Executive 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.

Report history

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

Quality and Safety Executive Committee	**Quality and Safety Committee**	**Mortality Surveillance Group**
05/02/2026	12/02/2026	11/03/2026
To be presented	To be presented	To be presented

Executive summary and key messages

- Hospital Standardised Mortality Ratio (HSMR) year to September 2025 is 97 and has been below the national benchmark of 100 for four months now.

- Standardised Hospital Mortality Indicator (SHMI) continues to improve and year to August 2025 is 91.14 which is 'within expected' range and continues the trend of improving SHMI for Hillingdon. SHMI has been falling for five consecutive updates.

- During the 12-month period January 2025 to December 2025; 661 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 82% have completed this in-depth structured judgement review.

- For the 12-month period January 2025 to December 2025 there have been two cases 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.

Impact assessment

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

Strategic priorities

☐ 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)

Key risks arising from report

[Nil to escalate]

Main Report

1. Introduction

The Mortality Surveillance programme offers assurance to patients, stakeholders, and the Board that high standards of care are being provided and that gaps in service delivery are being effectively identified, escalated, and addressed. This report provides a Trust-level review of mortality learning for Q3 2025/26.

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.

2.1. Summary Hospital-level Mortality Indicator (SHMI)

The Trust's SHMI for the period September 2024 – August 2025 is 91.14 (where a number below 100 represents lower than expected risk of mortality).

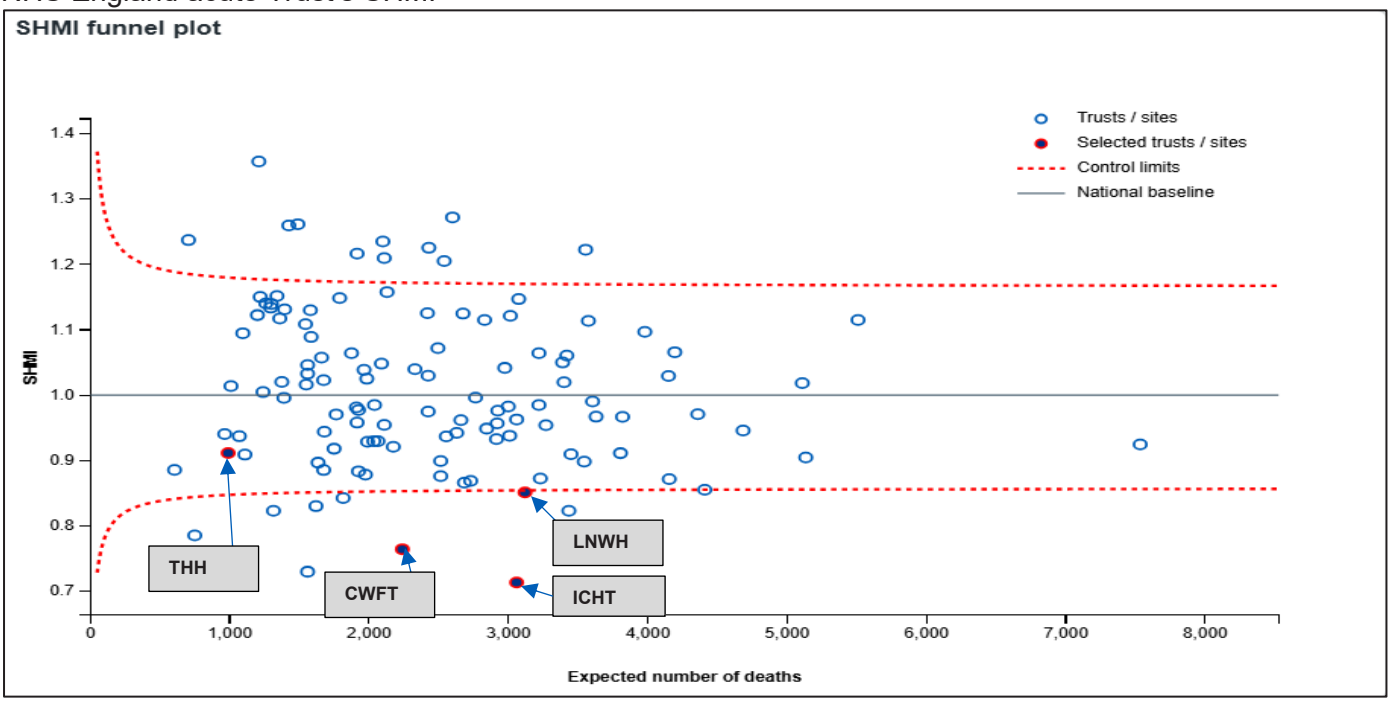
North West London Acute Collaborative SHMI indicators

Trust	Provider spells	Observed deaths	Expected deaths	SHMI	LCL 95%CI	UCL 95%CI
LNWH	105,900	2,655	3,120	85.12	85.45	117.03
THH	47,735	905	990	91.14	84.75	117.99
ICHT	118,125	2,180	3,060	71.34	85.44	117.04
CWFT	86,825	1,715	2,240	76.44	85.32	117.21

SHMI by APC provider, September 2024 to August 2025, Source: NHS Digital, published 8th January 2026

We are unable to provide a breakdown of SHMI based on the data provided by NHS England. There were no observed deaths outside of The Hillingdon Hospital in the data period available.

NHS England acute Trust's SHMI



SHMI by acute provider, September 2024 to August 2025, Source: NHS Digital, published 8th January 2026

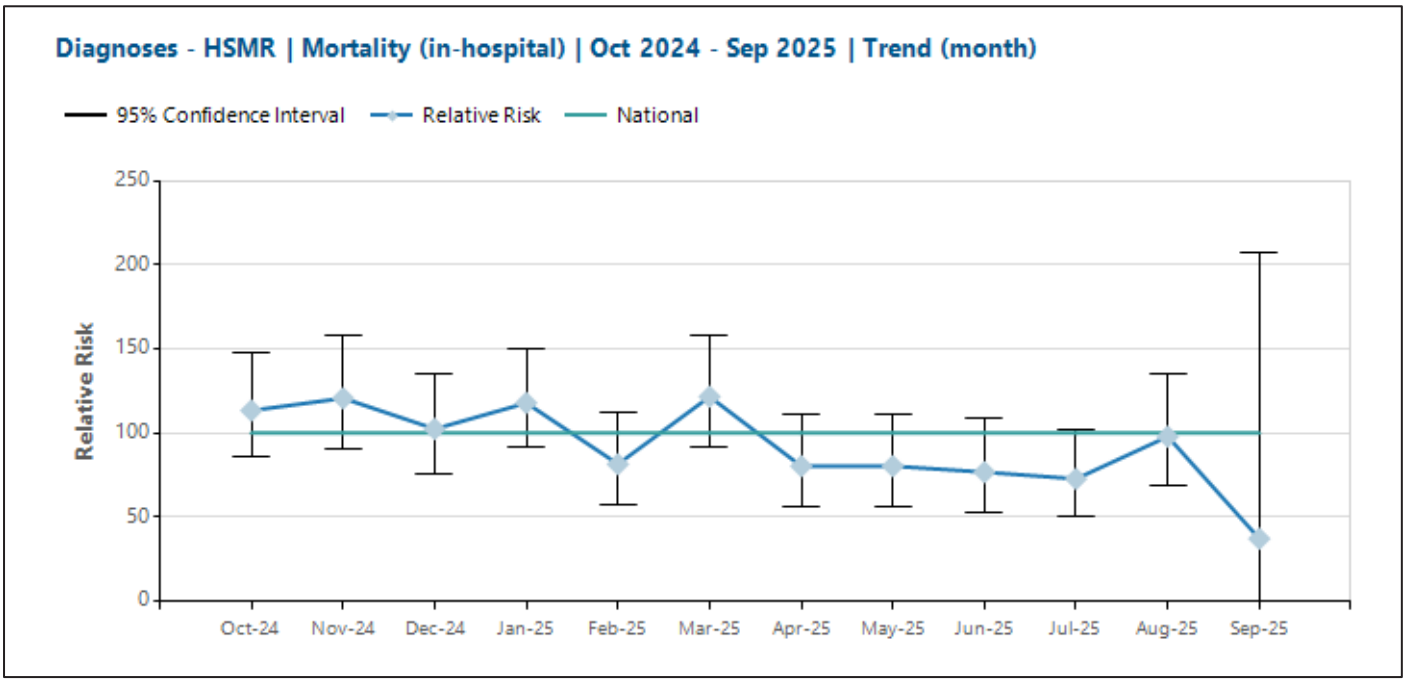
2.2. Hospital Standardised Mortality Ratio (HSMR)

The Trust's HSMR for the period October 2024 – September 2025 is 99.8 (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	201,475	1924	2067.8	93.0	88.9	97.3
THH	80,900	635	636.2	99.8	92.2	107.9
ICHT	146,935	1,640	2144.5	76.5	72.8	80.3
CWFT	155,730	1,240	1578.0	78.6	74.3	83.1

Trust HSMR (41 diagnostic groups), October 2024 to September 2025, Source: Telstra, exported an16th January 2026



2.2.1. Relative risk by diagnostic group

CUSUM alerts are different to diagnosis group alerts (the latter alert when directly concentrating on all patient activity in a diagnosis group within the year of data. CUSUMs plot patient observed vs expected mortality outcomes sequentially on discharge and alert when a level of tolerance is breached within an individual month of data). CUSUMs pick up when there is a succession of worse than expected outcomes. They alert at 99% (high) detection threshold or 99.9% (very high detection threshold and traditionally being used by the CQC as part of its monitoring exercises). *Hillingdon has no CUSUM alerts at the highest detection threshold of 99.9% outside of the Residual Codes group.*

There are three alerting diagnosis groups in the last year of data. Residual Codes, Sickle cell anaemia, and other infections including parasitic in this reporting period (Q3).

Diagnostic group alerts

Group	Vol	Observed deaths	Expected deaths	HSMR
Other infections, including parasitic	60	3	2.1	145.7
Learning: Other infections including parasitic alerts as a CUSUM alert in January 2025. There were 3 deaths that occurred and a review of coding and care that the patients received is underway.				
Residual codes, unclassified	4183	48	23.4	204.8

Learning: Residual codes remain an issue. This resolves in lagged data and when residual codes are subsequently recoded into their accurate diagnosis group this alert disappears.				
Sickle cell anaemia	52	2	0	6661.9
Learning: Sickle cell anaemia alerted twice at 99% level, in October 2024 and March 2025. A local audit on Sickle cell has been completed. Following the audit a flow chart has been developed to provide clear instructions on the management of sickle cell and a refresher training programme has been rolled out.				

2.3. Learning from relative risk of mortality

A new diagnosis group alert for 'Thyroid disorders' was received in the last reporting data period September 2024 to August 2025. A review of the two cases was completed during Q3 which confirmed that both cases were coded correctly with a thyroid disorder in primary position and medical examiner review of the cases provided assurance that the care received by both patients was appropriate.

3. Adult and Child Mortality Review

All in-hospital adult deaths are screened to identify cases requiring more in-depth structured judgement review. Mortality review provides clinical teams with the opportunity to review expectations, outcomes and potential improvements following in-hospital deaths.

All child deaths are screened by the Trust medical examiners and reported to and reviewed through the Child Death Overview Panel (CDOP) process which is an independent review and they do not have a structured judgement review carried out. During quarter three there were four child deaths that were reported to CDOP for review.

Over the last four financial quarters; 661 in-hospital adult deaths were recorded within the Trust's mortality review system, of these 100% have been screened and 82% have had full structured judgement case review.

	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
Q4 24/25	209	209	23	22	**100%**	**96%**
Q1 25/26	144	144	10	9	**100%**	**90%**
Q2 25/26	136	136	18	18	**100%**	**100%**
Q3 25/26	172	172	14	4	**100%**	**29%**
Totals	**661**	**661**	**65**	**53**	**100%**	**82%**

Mortality reviewers have two weeks from request for structured judgement review to complete structured judgement reviews. Process compliance is monitored by the Divisional Mortality Review Groups, Mortality Surveillance Group, and overseen by the Clinical Audit & Effectiveness Group, Executive Management Board, and Quality Committee.

3.1. CESDI Grading of Care

Outcome 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.

During the past 12 months, January 2025 to December 2025 structured judgement reviews have been closed following discussion at specialty, divisional or Trust wide mortality review groups.

CESDI grades by financial quarter

Period	CESDI 0	CESDI 1	CESDI 2	CESDI 3
Q4 24/25	20	2	0	0
Q1 25/26	7	2	0	0
Q2 25/26	12	5	1	0
Q3 25/26	2	1	1	0
Total	41	10	2	0

Closed mortality cases by CESDI grade, January to December 2025

The Patient Safety Incident Response Framework (PSIRF) requires deaths assessed to be "more likely than not" due to problems in care to undergo an enhanced learning response. Therefore, structured judgement reviews identified as CESDI 2 and 3 are subject to additional scrutiny via the incident investigation framework. See appendix 3 for a listing of linked cases.

3.2. Learning from adult and child mortality review

- Failure to follow policy: Learning around hyperkalemia guidelines. A patient developed hypoglycemia during treatment for hyperkalemia. This was discussed with staff and the hyperkalemia treatment algorithm was shared to remind them of the frequency of CBG measurement.

- Communication and escalation: One case highlighted the importance of chasing, reviewing and where appropriate implementing the recommendations made by the palliative care team in managing the patient's symptoms during the end of their life. The medical team were informed of the need to prescribe a syringe driver as per palliative care recommendations, but this was not prescribed. It reflects the importance of communication between various teams to ensure that treatment plans are implemented, and issues are escalated to senior team members where necessary. In this case there were anticipatory medications prescribed, but the syringe driver was not prescribed. There were noted examples of excellent communication with families and NOK to ensure that they were kept up to date and involved in decision making around end-of-life care.

- Multidisciplinary Team (MDT) Working: positive examples of MDT working in decision making were evident. In one case there were multiple MDTs (daily Microbiology, Gastroenterology/Hepatology, Radiology) and tertiary centre involvement (Haematology, Virology) in the diagnosis and management of a rare complication of disease which unfortunately did not result in significant improvement or reverse the patient's bone-marrow suppression and new complications emerged which resulted in the patient's condition becoming critical and irreversible.

- There were no key themes identified in the CDOP reviews. However, there was learning around ensuring that families understand the role of difference emergency services and how to access them. This is a recurrent theme across NW London and robust language support has been identified as being key to this. Two children died at Hillingdon having deteriorated during their flights into Heathrow and there have been several cases of critically unwell children being brought to Hillingdon due to its proximity to the airport.

4. 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 hospitals to 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 reviews within 6 months. The reporting time scales for PMRT do not align within the timescales of this report therefore the below data is 1 quarter behind. During the 3-month period ending September 2025 two 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: number with issues in care likely to have made a difference to outcome
Stillbirths	2	0	0	2	**Case 1 – D and D Case 2 – C and B**
Late fetal losses	0	0	0	0	**0**
Neonatal and post-natal deaths	0	0	0	0	**0**

PMRT review status by case category (Q2 2025/26), July 25 – September 25

*For PMRTs, two grades are given to each case. The first grading is for care provided to the mother before the death of the baby and the second grading is for the care provided to the mother after the death of the baby.

Guide to care gradings:

Grading of care provided to the mother before the death of the baby.

• A - The review group identified no care issues which would have made no difference to the mother.
• B - The review group identified no care issues which they considered would have made no difference to the outcome for the baby.
• C - The review group identified care issues which they considered may have made a difference to the outcome of the baby.
• D – The review group identified care issues which would have made a difference to the outcome of the baby.

Grading of care provided to the mother after the death of the baby.

• A - The review group identified no care issues for the mother following the confirmation of the death of the baby.
• B - The review group identified care issues which they consider would have made no difference to the outcome for the mother.
• C - The review group identified care issues which they considered may have made a difference to the outcome of the mother.
• D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother.

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 via the incident management framework.

SMART actions are identified and monitored by the PMRT Lead Midwife and the Maternity Governance Group. The Trust has instituted a thematic review of Stillbirths using the PMRT to identify themes and trends and any further actions to strengthen learning and improve care and experience.

5. Learning from Life and Death Reviews Programme

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.

Life and Death Reviews reported in Q3 2025/26:

Ref	Month of Death	Process stage	Specialty	CESDI grade
37	October	Closed	Diabetes & Endocrinology	CESDI grade 0
39	October	SJR review in progress	Emergency Medicine	TBA
45	November	SJR review in progress	Care of the Elderly	TBA

Learning from Life and Death Review cases, October 2025 December 2025

6. Prevention of future deaths (PFD)

The Trust has not been issued with a Prevention of Future Deaths (PFD) notice during Q3 2025/26.

7. 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 to share best practice.

Glossary

LNWH – London North West University Healthcare NHS Trust
THH – The Hillingdon Hospital NHS Foundation Trust
ICHT – Imperial College Healthcare NHS Trust
CWFT – Chelsea and Westminster NHS Foundation Trust
NPH – Northwick Park Hospital
EH – Ealing Hospital

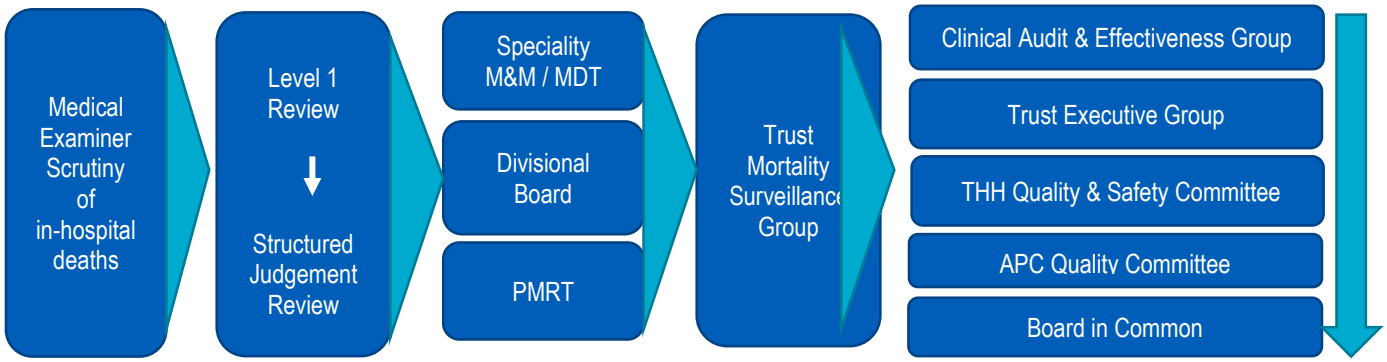
Appendix 1: Mortality review process

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 structured judgement review. We undertake in-depth structured judgement 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 and/or autism
- Deaths of patients with severe mental health issues
- Unexpected deaths
- Maternal deaths – 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.
- Deaths of infants, children, young people, and still births – These cases are reviewed through the CDOP and/or PMRT process.
- 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)

The Mortality Surveillance Group (MSG) challenges assurance regarding performance and outcomes from the Trust's learning from deaths approach as outlined below:



The Mortality Surveillance Group (MSG) 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 MSG is a sub-group of the Clinical Audit & Effectiveness Group and is aligned to the remit of the Quality and Safety Committee.

Appendix 2: Case linked to incident framework

Mortality Ref	CESDI grade	Incident Ref	Site	Area	Datix sub-category	Incident investigation status
18	2	W146740	THH	Emergency Department	Administration of duplicate drug	MDT completed
41	2	TBA	THH	General Surgery	Missed diagnosis	In PSIRF process

CESDI grade 2 and 3 cases linked to an incident learning response in last 12 months, 1st January 2025–31st December 2025

Learning from incident investigations linked to mortality review is submitted to the Patient Safety Group and the Trust Executive Group for shared learning and consideration of whether further Quality Improvement Projects, deep-dives, or targeted action is required.

Mortality Ref 18 – Discussed at IRG on 11th August 2025. A MDT review had already commenced for this incident prior to a structured judgement review being completed. Review of the completed structured judgement review alongside the MDT completed did not identify any different learning that needed to be escalated around the handover process between LAS and ED around medications already administered by emergency crews.