North West London Acute Provider Group

NWL APG BOARD IN COMMON - PUBLIC - READING ROOM

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28 July 2026

11:15 GMT+1 Europe/London

AGENDA

4.1.3 LEARNING FROM DEATHS Q4 - INDIVIDUAL TRUST REPORTS

REFERENCES

Only PDFs are attached

- CWFT Q4 2025-26 Learning from Deaths Report 11-Jun-26.pdf
- ICHT Learning from Death Quarter Four.pdf
- LNWH Q4 2025-26 Learning from Deaths Report 10-Jun-26.pdf
- THH Q4 2025-26 Learning from Deaths Report 17-Jun-26.pdf

NWL Acute Provider Collaborative Quality Committee

Select meeting date

Item number:

This report is: Confidential

Learning from Deaths Report, Quarter 4 2025/26

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Purpose of report (for decision, discussion or noting)

Purpose: Assurance

This report presents the data from the Chelsea and Westminster NHS Foundation Trust (CWFT) Mortality Surveillance Group, Learning from Deaths programme for Quarter 4 (Q4) of 2025/26. It is a statutory requirement to present this information to the public board. This is achieved through presentation to CWFT's standing (quality) committee, with an overarching summary paper drawing out key themes and learning from the individual reports across the four NWL Acute Provider Group (APG) trusts presented to the APG quality committee and subsequently to the Board in Common.

Report history

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

CWFT Patient Safety Group 27/05/2026 For Assurance

CWFT Trust Mortality Surveillance Group 05/06/2026 For Approval	CWFT Executive Management Board 10/06/2026 For noting	CWFT Standing Committee 30/06/2026 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 75.26 for the period December 2024 – November 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 April 2025 and March 2026 of the last financial year, a total of 1,310 in-hospital adult and child deaths were recorded within the Trust's mortality review system (Datix). Of these, 96% were screened, and 41% underwent a full mortality case review.

During 2025/26, one case was graded CESDI 3 (suboptimal care identified where different care would reasonably be expected to have made a difference to the outcome), and one case was graded CESDI 2 (suboptimal care identified where different care might have made a difference to the outcome); both cases were reviewed under the PSIRF framework.

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, and develop the best staff in the NHS (APC)
- ☒ Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation (APC)
- ☐ Achieve a more rapid spread of innovation, research, and transformation (APC)
- ☒ 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 Q4 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 December 2024 – November 2025 is 75.26 (where a number below 100 represents lower than expected risk of mortality).

North West London Acute Provider Group SHMI indicators

Trust	Provider spells	Observed deaths	Expected deaths	SHMI	LCL 95%CI	UCL 95%CI
LNWH	106,425	2,595	3,105	83.54	85.06	117.56
ICHT	116,795	2,155	2,995	71.94	85.05	117.58
CWFT	84,835	1,695	2,255	75.26	84.94	117.73
THH	45,595	870	980	88.53	84.38	118.51

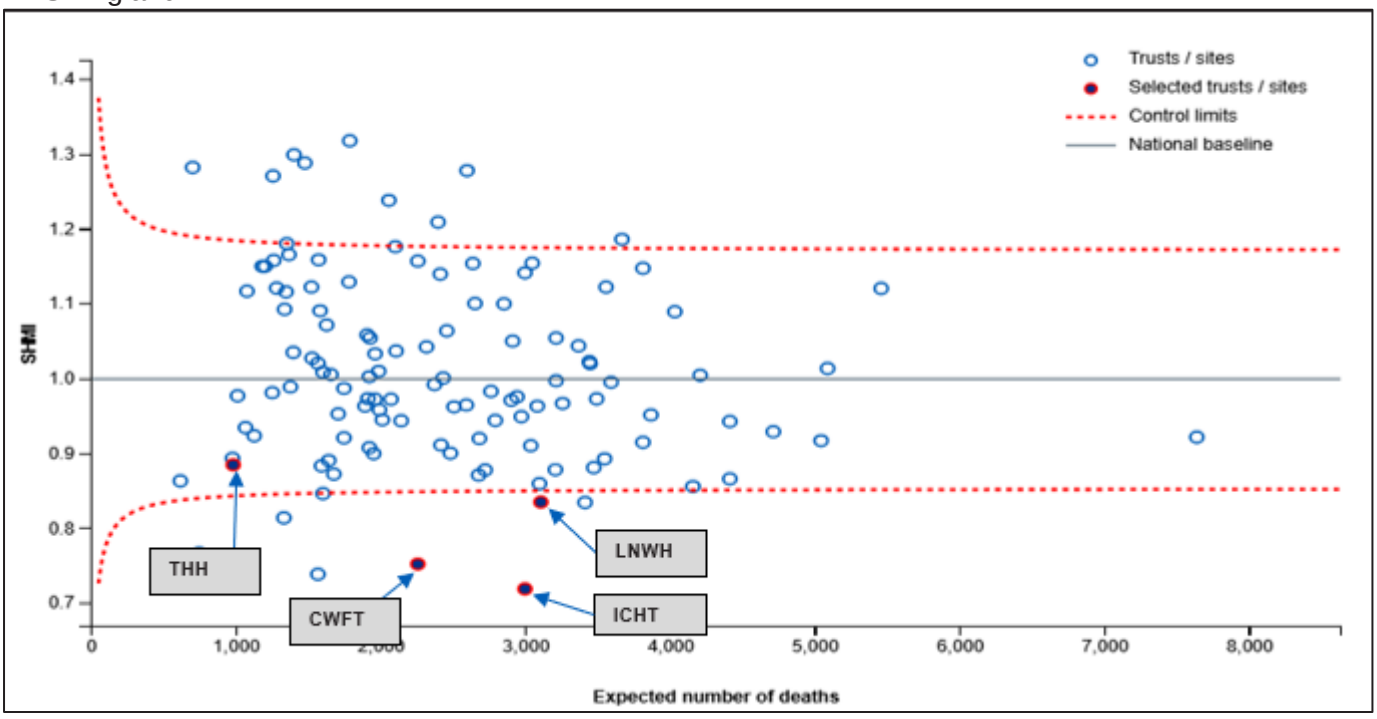
SHMI by APC provider, December 2024 to November 2025, Source: NHS Digital, published 9th April 2026

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
CWH	38,955	700	965	72.45	90.34	110.36
WMH	43435	995	1,285	77.62	91.59	108.93

SHMI by Trust site, December 2024 to November 2025, Source: NHS Digital, published 9th April 2026

NHS England Acute Trust's SHMI



SHMI by acute provider, December 2024 to November 2025, Source: NHS Digital, published 9th April 2026

2.2. Hospital Standardised Mortality Ratio (HSMR)

The Trust's HSMR for the period January 2025 – December 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

HSMR (41 diagnostic groups) by Trust, January 2025–December 2025, Source: Telstra, exported 20th April 2026

2.3. Relative risk by diagnostic group

Variable Life Adjusted Display (VLAD) data show long-term trends in outcomes by tracking a running total of "lives saved" (expected deaths minus observed deaths). They use the same risk methodology as SHMI, and include control limits that trigger and reset the data when outcomes significantly improve or worsen (odds of death halved or doubled).

During Q4, the Mortality Surveillance Group (MSG) discussed and monitored a VLAD alert for the SHMI diagnostic group '30 – Secondary Malignancies'. This group is not an outlier for either SHMI or HSMR at the 95% confidence interval. Cases flagged via the VLAD were reviewed and rationalised, with the observed increase in deaths considered most likely reflective of case mix complexity, including a higher proportion of patients with metastatic disease, rather than immediate concerns regarding quality of care. While no urgent escalation was required, it was agreed that APG benchmarking and further analysis of end-of-life and palliative care context would be undertaken to strengthen assurance and support the overall narrative.

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.

3.1. Medical Examiner Scrutiny

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

During Q4 2025/26, the Medical Examiner service scrutinised 100% (n=366) of in-hospital adult and child deaths, identifying 68 cases with potential learning for the Trust and 10 for external organisations, alongside 100 cases where positive feedback was recorded.

Learning and positive feedback identified through Medical Examiner scrutiny is routinely shared with the patient is named consultant, the Divisional Mortality Review Group, and the Trust-wide Mortality Surveillance Group, with a full consultant-led mortality review undertaken in all cases where potential learning is identified.

Thematic learning is reported to the Mortality Surveillance Group, Executive Management Board, and Quality Committee via the annual Medical Examiner's report.

3.2. Adult and Child Mortality Review (Level 2 review)

Over the last four financial quarters; 1310 in-hospital adult or child deaths were recorded within the Trust's mortality review system, of these 96% have been screened and 41% have had full mortality case review.

Period	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
Q1 25/26	297	164	128	5	**98%**	**43%**
Q2 25/26	299	168	126	5	**98%**	**42%**
Q3 25/26	348	186	151	11	**97%**	**43%**
Q4 25/26	366	205	130	31	**92%**	**36%**
Totals	1310	723	535	52	**96%**	**41%**

Adult and Child In hospital death by review status, April 2025 to March 2026

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.

3.3. 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, 450 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
Q1 25/26	107	16	0	0
Q2 25/26	83	22	1	0
Q3 25/26	108	19	0	1
Q4 25/26	84	9	0	0
Totals	**382**	**66**	**1**	**1**

Closed mortality cases by CESDI grade, April 2025 to March 2026

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.
In the period (April 2025 – March 2026), two cases of CESDI grade 2 and 3 met the criteria and were 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.

3.4. Learning from adult and child mortality review

Key themes / issues / improvements identified via adult & child mortality review during Q4 include:

Theme	Key Learning	Key Actions
Escalation & Patient Flow	Delays in escalation and transfer result in patients being managed in inappropriate settings.	• Review DRU criteria and SOPs • Strengthen escalation pathways and oversight • Ensure treatment is initiated irrespective of bed availability
TEPs & End-of-Life Care	TEPs are often delayed, not reviewed, or poorly documented, leading to care misaligned with patient wishes.	• Embed early and dynamic TEP completion • Improve documentation of escalation decisions • Promote early palliative care involvement
Documentation Quality	Inaccurate, inconsistent documentation (incl. copy/paste) is a recurring safety and medico-legal risk.	• Reinforce standards for contemporaneous documentation • Reduce copy/paste practices • Standardise documentation of clinical reasoning and procedures
Communication	Poor communication with patients and families, including inconsistent interpreter use and NOK documentation issues.	• Mandate use of professional interpreters • Introduce structured family communication processes • Improve recording of NOK details and discussions
Medication Safety	Errors include opioid duplication and delays in time-critical medications, particularly out of hours.	• Strengthen prescribing and administration processes • Reinforce end-of-life medication guidance • Improve reliability of time-critical prescribing
Recognition of Deterioration	Delays in recognising and responding to deterioration, including delayed investigations and escalation.	• Improve escalation protocols and training • Ensure timely diagnostics (e.g. imaging) • Clarify monitoring guidance (e.g. telemetry/NIV)
Risk Assessment	Inconsistent documentation (e.g. skin integrity, falls) impacts early recognition of deterioration.	• Reinforce falls prevention and pressure care standards
Procedural Safety	Harm arising from routine procedures (e.g. catheterisation, NG tubes) due to poor practice or documentation.	• Deliver targeted training on procedural safety • Standardise procedural documentation (who, when, complications)
Operational/System Factors	Bed pressures, ward moves and staffing impact continuity of care and escalation.	• Escalate systemic risks via Trust governance forums • Mitigate impact through improved planning and oversight

Learning themes summary table, April 2025 to March 2026

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 through the PMRT process. The national standard is to complete PMRT reviews within six months. However, PMRT reporting timelines do not align with the reporting cycle for this paper; therefore, the data presented below is one quarter in arrears.

During the three-month period ending December 2025 (Q3), 21 cases were identified as requiring PMRT review, including post-neonatal deaths not reported via MBRRACE-UK.

	No. reported	Not supported for review	Review in progress	Review completed	Grading of care: No. with issues in care likely to have made a difference to outcome
Stillbirths and late fetal losses	14	3	3	7	**0**
Neonatal and post-natal deaths	13	2	7	4	**0**

PMRT review status by case category (Q3 2025/26), October 25 – December 25

Learning from PMRT reviews is reported to the Divisional Mortality Review Group and the Mortality Surveillance Group. Where suboptimal care with potential impact on outcome is identified, cases are escalated through the incident management framework as appropriate.

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 Q4 2025/26:

Ref	Month of Death	Process stage	Specialty	CESDI grade
MM16310	Jan	Closed	Cardiology	Grade 0
MM16372	Jan	Closed	ICU	Grade 0
MM16551	Feb	Awaiting Specialty Review	Care Of Elderly	Grade 1
MM16722	Feb	Closed	ICU	Grade 0
MM16871	Mar	Awaiting Screening	Diabetes/Endocrine	TBC
MM16891	Mar	Awaiting Divisional Review	Acute Medicine	Grade 1

Learning from Life and Death Review cases, January 2026 – March 2026

6. Prevention of future deaths (PFD)

During the 2025/26 financial year, the Trust received one Prevention of Future Deaths (PFD) notice, issued in Q4, January 2026, following the inquest into the death of Sidra Aliabase.

Summary of PFD report: A premature neonate (27+1 weeks) receiving care in NICU died following a preventable medication incident and subsequent failure to recognise and respond to deterioration. The patient was incorrectly prescribed sodium acid phosphate instead of sodium chloride at approximately five times the appropriate dose, resulting in severe hypocalcaemia and bradycardia. This was compounded by multiple missed opportunities across clinical teams to identify the prescribing error, review abnormal blood results, and escalate concerns in a timely manner. Communication failures, including lack of escalation to senior clinicians and incomplete handover of critical information, further delayed appropriate intervention. While the patient had underlying clinical vulnerability, the coroner concluded that the death resulted from iatrogenic harm due to a fundamental failure in basic care, contributed to by neglect, with systemic issues identified in prescribing processes, clinical oversight, and multidisciplinary communication

Trust response: Following the inquest into the death of Sidra Aliabase, the Trust has responded to the Prevention of Future Deaths report, acknowledging a number of system and process failures and setting out a programme of improvement. Key issues identified included gaps in multidisciplinary communication—particularly with external cardiology services—insufficient early antenatal and neonatal planning for infants at risk of long QT syndrome, inconsistent use of specialist cardiology input, and safety risks associated with electronic prescribing systems.

In response, the Trust has strengthened governance and clinical processes to mitigate recurrence. This includes revising antenatal and neonatal pathways to support earlier multidisciplinary care planning, developing a specific guideline for the management of long QT syndrome, and reinforcing referral pathways to ensure appropriate use of in-house cardiology expertise. Additionally, prescribing safety has been prioritised through system escalation with the electronic patient record supplier, enhanced training, simulation and induction programmes, and the introduction of regular prescribing audits within NICU.

These actions are being monitored through established governance routes, including the Mortality Surveillance Group and Quality Committee, with a continued focus on embedding learning, strengthening system reliability, and improving patient safety across the organisation.

Further information relating to this PFD can be found here: Sidra Aliabase: Prevention of future deaths report - Courts and Tribunals Judiciary

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.

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:

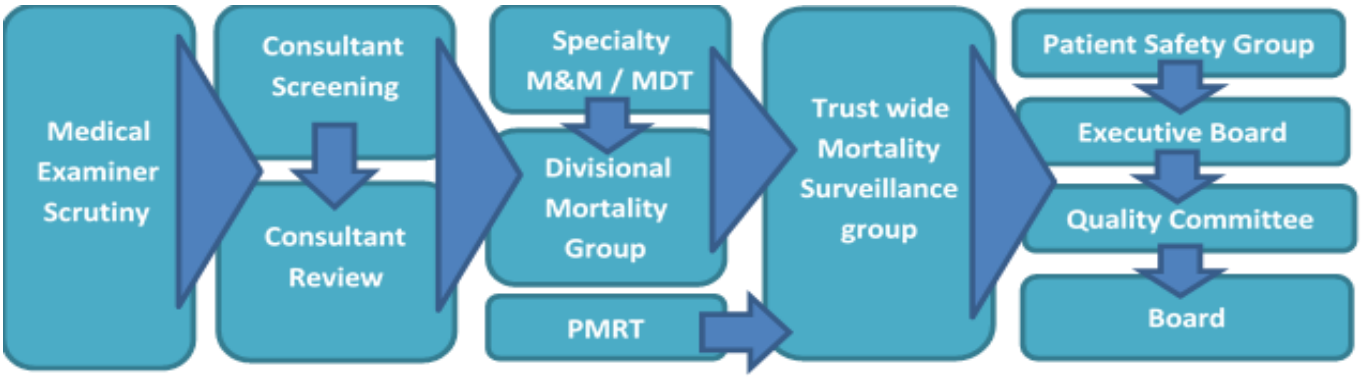
National triggers:

- 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.

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
CWH – Chelsea and Westminster Hospital
WMH – West Middlesex Hospital

ICHT Standing Committee
23/06/2026
Item number: #
This report is: Public

ICHT Learning from Deaths report, quarter 4 2025/26

Author: Heena Asher & Marius Venter
Job title: General Manager & Associate Medical Director

Accountable director: Professor Raymond Anakwe & Dr David O'Callaghan
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 four (Q4) 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)
18/05/2026
The committee noted the findings from our learning from deaths programme and approved the report for onward submission.
The importance of M&M meetings was discussed, and an action added for divisions to ensure improvement plans will meet target compliance.

ICHT Executive Management Board
26/05/2026
The committee noted the report and approved it for onward submission.

Executive summary and key messages

1.1. Mortality rates remain statistically significantly low.

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

1.3. Six 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. This level of scrutiny is important to ensure all issues are considered and questions from the bereaved are highlighted and answered. The number further investigated through the PSIRF route is higher at ICHT than others in the APG however it is important to note our lower-than-average harm levels and low HSMR. The low number of issues found that affected the outcome, low mortality rates are positive reflections of the care delivered.

1.4. Specialty level M&M meetings are an important mechanism for identifying risks and learning and in escalating cases requiring further investigation, however frequency, effectiveness and consistency is variable. A review of existing improvement plans and trajectories by divisions has been requested, with the aim of achieving 90% compliance by March 2027. These will be reviewed at EMBQ in June and trajectories confirmed.

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 not 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. 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 (APG)

☒ 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. A key focus is embedding specialty M&M meetings. Divisions have been asked to review their plans to address the current gaps to target, which will be presented to EMBQ in June.

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. Fifty structured judgment reviews (SJRs) were completed in Q4. Of these, 64% specifically identified patients received good or excellent care including communication with the next of kin.

2.3. 30% identified good documentation, teamwork and senior decision making, with critical care highlighted positively again.

2.4. This quarter, six SJRs identified that sub-optimal care might or would reasonably have been expected to have made a difference to the patient's outcome (CESDI 2 or 3). This is similar to previous quarters. No overall common themes have been identified, and patient safety investigations are underway, the outcome of which will be reported in future reports.

3. Key themes

3.1. Mortality rates

3.1.1 Mortality rates remain statistically significantly low. Rolling 12-month HSMR, based on data to December 2025 was 74.8 (compared to 76.5 in the previous quarter) and is second lowest when compared nationally. SHMI is the lowest at 71.94, based on data to November 2025. See appendix B for graphs detailing our performance.

North West London Acute Collaborative HSMR indicators

Trust	Provider spells	Observed deaths	Expected deaths	HSMR	Lower CI	Upper CI
LNWH	53,600	1,359	1,577	86.2	81.6	90.9
ICHT	49,445	1,200	1,604	74.8	70.6	79.1
CWFT	35,135	970	1,252	77.44	72.6	82.5
THH	18,300	460	511	89.85	81.8	98.4

HSMR (41 diagnostic groups) by Trust, January 2025–December 2025, Source: Telstra, exported 20th April 2026

North West London Acute Collaborative SHMI indicators

Trust	Provider spells	Observed deaths	Expected deaths	SHMI	LCL 95%CI	UCL 95%CI
LNWH	106,425	2,595	3,105	83.54	85.06	117.56
ICHT	116,795	2,155	2,995	71.94	85.05	117.58
CWFT	84,835	1,695	2,255	75.26	84.94	117.73
THH	45,595	870	980	88.53	84.38	118.51

SHMI by APC provider, December 2024 to November 2025, Source: NHS Digital, published 9th April 2026

3.1.2 There was an in-month increase in HSMR for September 2025. While the Trust remains statistically significantly low overall, all three main sites were within the expected range. This prompted further review, with an initial focus on a potential rise in stroke-related deaths. Subsequent investigation, including a retrospective review of three years of data, indicates that the number of stroke deaths recorded in September 2025 is not unprecedented. Comparable monthly totals were identified (e.g. December 2023 recorded 27 deaths, and January 2023 and April 2025 recorded 25 deaths), suggesting that the observed increase is within expected variation rather than an exceptional spike.

3.1.3 This quarter all sites remain at low relative risk and are below the NHS benchmark of 100.

SHMI by site

Site	Provider spells	Observed deaths	Expected deaths	SHMI	LCL 95%CI	UCL 95%CI
SMH	48,330	770	1065	72.22	84.48	118.38
CXH	27,920	1050	1460	71.81	84.72	118.03
HH	13,415	310	425	72.87	83.18	120.23

SHMI by Trust site, December 2024 to November 2025, Source: NHS Digital, published 9th April 2026

3.2. Diagnostic group reviews

3.3.1 There were no new alerts for Q4. Four alerts from previous quarters remain under review; outcomes will be reported once complete.

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

3.3. Medical Examiner reviews

3.3.1. The Medical Examiner (ME) service reviewed all 432 deaths in Q3, referring 90 directly to the coroner (27 inquests) and independent scrutiny of the remaining 342.

3.3.2. The largest percentage of coronial referrals were across two areas, death resulting from violence, trauma, or injury (29%), reflecting the major trauma centre at SMH and death associated with medical procedures or treatments (31%), some involving complications after elective admission and others that occurred prior to transfer to ICHT. While no issues currently require escalation, this continues to be monitored.

3.3.3. 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.

3.3.4. The ME service continue to scrutinise all non-coronial deaths in community boroughs of Hammersmith & Fulham and Westminster. This quarter, we reviewed 267 non-acute deaths, a slight increase compared to last (n=244).

3.3.5. In Q4, we issued 78.4% of urgent MCCDs within 24 hours and 72.2% of non-urgent MCCDs within three days, similar to Q3.

3.3.6. 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.

3.4. Structured Judgement reviews (SJR)

3.4.1. 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
Q1 25/26	441	441	54	54	100%	100%
Q2 25/26	424	424	67	67	100%	100%
Q3 25/26	439	439	42	42	100%	100%
Q4 25/26	432	432	50	50	100%	100%
Totals	**1736**	**1736**	**213**	**213**	**100%**	**100%**

3.4.2. The percentage of inpatient deaths referred for a SJR has slightly increased from last quarter to 12% compared to previous.

3.4.3. Our 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 (but our PSIRF investigations are higher). This approach supports our PFD prevention approach with detailed action plans then available for submission to inquest. A review of the APG triggers is underway again with the Medical Directors.

3.4.4. Thirty-six (72%) SJRs found no suboptimal care (CESDI 0), compared to 61% in Q3. Reviews identified evidence of excellent care, good communication and documentation in many cases. Eight (16%) found some suboptimal care that did not affect the patient outcome (CESDI 1).

3.4.5. Ten percent (n=5) of deaths found that suboptimal care may have made a difference to the outcome (CESDI 2), a slight decrease from previous quarter of (n=7). No common themes were identified. One case found sub-optimal care which 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.

3.4.6. 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	Total	CESDI 0	CESDI 1	CESDI 2	CESDI 3
Q1 25/26	54	41	7	5	1
Q2 25/26	67	53	8	5	1
Q3 25/26	42	26	9	7	0
Q4 25/26	50	36	8	5	1
Total	**213**	**156**	**33**	**22**	**3**

3.4.7. For the 22 CESDI 2 or 3 cases reported in the last 12 months, the full review process has been completed for 4 (see appendix C). Of these, three have been confirmed as 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.

3.4.8. 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
MM30974	CESDI 3	CESDI 0
MM30644	CESDI 2	CESDI 3
MM32035	CESDI 2	CESDI 0
MM32028	CESDI 2	CESDI 0

3.4.9. The remaining 18 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, with nine cases now complete and due to be presented to DRP in Q1.

3.4.10. There was one death from 2024/25 which was reviewed at DRP in Q4 2025/26. This was confirmed as moderate harm with poor care identified, however the poor care did not

contribute to the patient's death. If the CESDI score was amended for this case it would be CESDI 1.

3.4.11. Overall, moderate and above harm levels are lower than national average with no cause for concern.

4. Other mortality review processes

4.1. PMRT

4.1.1. 19 perinatal deaths were reported to MBRRACE-UK during Q4, of which 16 (two late fetal losses, six stillbirths and 8 neonatal deaths) were eligible for full review using the Perinatal Mortality Review Tool (PMRT) framework. 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	8	0	7	1	**0**
Neonatal and post-natal deaths	8	2	6	1	**0**

PMRT review status by case category (Q4 2025/26), January 26 – March 26

4.1.2. One met the threshold for referral to Maternity and Newborn Safety Investigations (MNSI).

4.1.3. Of the 16 eligible cases reported in Q4, two were discussed across two multidisciplinary panel meetings with the remaining 14 reviews scheduled to take place during Q1 of FY 2026/27 and neither case were graded C or D.

4.1.4. There were seven multidisciplinary PMRT review panels held in Q4 during which 15 cases were formally reviewed which included cases reported in previous quarters. One case was assigned a grade of D for two reasons: firstly, concerns relating to the care provided to the baby immediately after birth at another trust, and secondly, the death following surgery at ICHT; investigations are still ongoing for this case. Another case was graded C which reflected the mother's feedback regarding her experiences of poor communication with the maternity team following admission to Labour Ward.

4.2. LeDeR

4.2.1. Eight SJRs have been completed in this quarter for patients with a learning disability. Seven found no sub-optimal care and one confirmed some suboptimal care (CESDI 1) which has been reviewed by the specialty.

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

Life and Death Reviews reported in Q4 2025/26:

Ref	Month of Death	Process stage	Specialty	CESDI grade
MM32630	Jan	Awaiting Specialty Review	Endocrinology	CESDI 0
MM32649	Jan	Closed	Renal	CESDI 0
MM32762	Jan	Closed	Renal	CESDI 1
MM32814	Jan	Awaiting Specialty Review	MfE	CESDI 0
MM32999	Feb	Awaiting Specialty Review	Endocrinology	CESDI 0
MM33121	Mar	Awaiting Specialty Review	Respiratory	CESDI 0
MM33153	Mar	Closed	Critical Care	CESDI 0
MM33158	Mar	Awaiting Specialty Review	Major Trauma	CESDI 0

Learning from Life and Death Review cases, Jan 2026 to March 2026

4.3. **CDOP**

4.3.1. There were 10 deaths reported in Q4 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 D).

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 Oncology & Palliative Care, Renal and Critical Care. There have been marked improvements in Acute & Specialist Medicine (SMH) and Children's services achieving 100% this quarter.

5.3. Specialty level M&M meetings are an important mechanism for identifying risks and learning and in escalating cases requiring further investigation, however frequency, effectiveness and consistency is variable. A review of existing improvement plans and trajectories by divisions has been requested, with the aim of achieving 90% compliance by March 2027. These will be reviewed at EMBQ in June and trajectories confirmed.

6. Conclusion

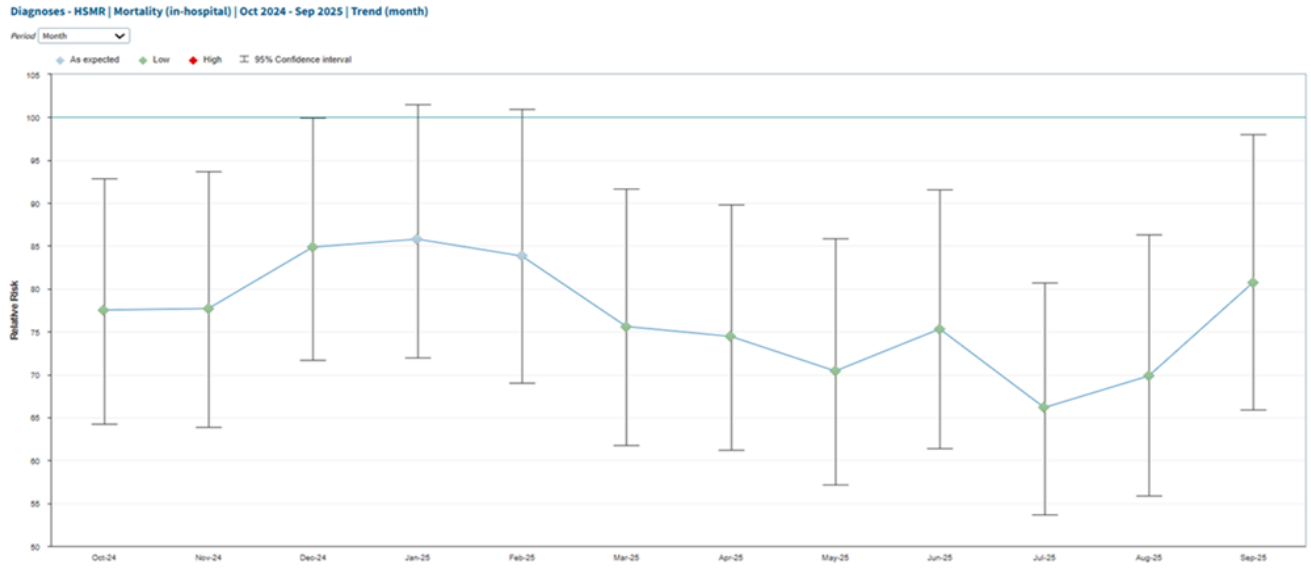
6.1 Mortality rates remain statistically significantly low. When considered with our harm profile and the outcomes of SJRs we can provide assurance to the committee that we are providing safe care for most of our patients. Where care issues are found we have a robust process for referral for more in-depth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

Appendix A – Performance scorecard

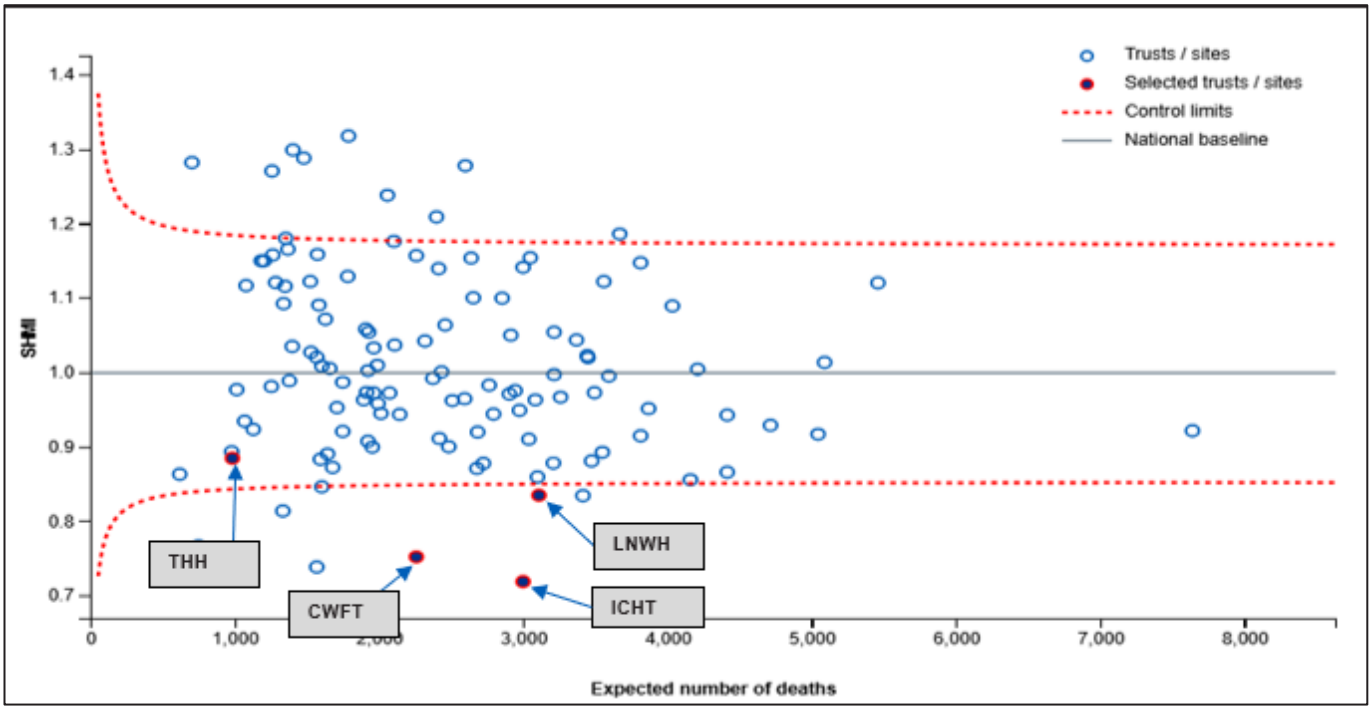
Financial Year	2025-2026			
Financial Quarter	Q1	Q2	Q3	Q4
No. Deaths	441	424	439	432
No. Adult Deaths	419	399	404	410
Adult Deaths per 1000 Elective Bed Days	0.04	0.04	0.04	0.04
No. Child Deaths	6	10	13	6
No. Neonatal Deaths	8	7	10	8
No. Stillbirths	8	8	12	8
ME Reviewed Deaths (excl Stillbirths) in Qtr	429	406	421	418
% ME Reviewed Deaths - Deaths (excl Stillbirths) in Qtr	99%	98%	99%	99%
SJRs Requested for Deaths in Qtr	54	67	42	50
% SJRs Requested for Deaths in Qtr of total adult deaths in Qtr	13%	17%	10%	12%
No. SJRs Completed in period	68	59	47	50
SJRs Completed for Deaths in Qtr	54	67	42	50
% SJRs Completed for Deaths in Qtr	100%	100%	100%	100%
No. LeDeR Completed	0	6	3	4
Requests made by a Medical Examiner - SJRs Requested for Deaths in Qtr	6	14	16	15
% Requests made by a Medical Examiner - SJRs Requested for Deaths in Qtr	11%	21%	38%	30%
Concerns raised by family / carers - SJRs Requested for Deaths in Qtr	13	12	11	9
% Concerns raised by family / carers - SJRs Requested for Deaths in Qtr	24%	18%	26%	18%
Patients with learning disabilities - SJRs Requested for Deaths in Qtr	1	7	4	8
% Patients with learning disabilities - SJRs Requested for Deaths in Qtr	2%	10%	10%	16%
Patients with severe mental health issues - SJRs Requested for Deaths in Qtr	4	5	2	2
% Patients with severe mental health issues - SJRs Requested for Deaths in Qtr	7%	7%	5%	4%
Unexpected deaths - SJRs Requested for Deaths in Qtr	20	15	5	6
% Unexpected deaths - SJRs Requested for Deaths in Qtr	37%	22%	12%	12%
Elective admission deaths - SJRs Requested for Deaths in Qtr	8	14	4	6
% Elective admission deaths - SJRs Requested for Deaths in Qtr	15%	21%	10%	12%
Requests made by speciality mortality leads / through local Mortality and Morbidity review processes - SJRs Requested for Deaths in Qtr	5	6	6	12
% Requests made by speciality mortality leads / through local Mortality and Morbidity review processes - SJRs Requested for Deaths in Qtr	9%	9%	14%	24%
CESDI 0 - No suboptimal care - Completed SJRs for Deaths in Qtr	41	53	26	36
% CESDI 0 - No suboptimal care - Completed SJRs for Deaths in Qtr	76%	79%	62%	72%
CESDI 1 - Some sub optimal care which did not affect the outcome - Completed SJRs for Deaths in Qtr	7	8	9	8
% CESDI 1 - Some sub optimal care which did not affect the outcome - Completed SJRs for Deaths in Qtr	13%	12%	21%	16%
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	5
% CESDI 2 - Suboptimal care – different care might have made a difference to outcome (possible avoidable death) - Completed SJRs for Deaths in Qtr	9%	7%	17%	10%
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	1
% 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%	1%	0%	2%

Appendix B – Mortality rates

Rolling 12-month HSMR – January 2025 – December 2025



SHMI by acute provider – December 2024 to November 2025



SHMI by acute provider, December 2024 to November 2025, Source: NHS Digital, published 9th April 2026

Appendix C – CESDI 2 and 3 cases (Q4 2024/25 – Q4 2025/26)

(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 – awaiting feedback from NOK	Q4 24/25	N/A	TBC	TBC	TBC (currently severe)	N/A
MM29883	2	272129	CXH	General surgery	Failure to follow procedure/guideline	PSII complete	Q4 24/25	Q4 25/26	Y	N	Moderate harm	CESDI 1
MM31156	2	292412	CXH	Emergency medicine	Unexpected cardiac arrest	Closed for local investigation (confirmed as no harm) – for DRP in Q1 26/27	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 complete (confirmed as low harm) – for DRP in Q1 26/27	Q1 25/26	N/A	TBC	TBC	TBC (currently low harm)	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 complete (confirmed as moderate harm) – scheduled for DRP in Q1 26/27	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	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) – scheduled for DRP in Q1	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 closed (confirmed as severe harm) – scheduled for DRP in Q1	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) – scheduled for DRP in Q1	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 – case scheduled for next DRP	Q3 25/26	N/A	TBC	TBC	TBC (currently no harm)	N/A

MM32223	2	296419	HH	Cardiology	Complication of treatment/procedure	IIR complete (confirmed as moderate harm) – to be scheduled for DRP in Q1	Q3 25/26	N/A	TBC	TBC	TBC (currently moderate harm)	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)	Q3 25/26	Q4 25/26	N	N	No Harm	CESDI 0
MM32028	2	293290	SMH	Acute medicine	Fall on level ground	IIR closed	Q3 25/26	Q4 25/26	N	N	No Harm	CESDI 0
MM32657	2	304246	CXH	Endocrinology	Sub-optimal care of the deteriorating patient	M&M review underway	Q4 25/26	N/A	TBC	TBC	TBC (currently death)	N/A
MM32710	2	301080	SMH	Hepatology	Aspiration	IIR closed – to be scheduled for next DRP	Q4 25/26	N/A	TBC	TBC	TBC (currently severe)	N/A
MM32864	3	303730	CXH	Imaging	Unexpected cardiac arrest	IIR underway	Q4 25/26	N/A	TBC	TBC	TBC (currently severe	N/A
MM32906	2	303102	CXH	Endoscopy	Unexpected cardiac arrest	PSII underway	Q4 25/26	N/A	TBC	TBC	TBC (currently death)	N/A
MM32928	2	305361	CXH	General surgery	Failure to recognise the deteriorating patient	M&M review underway	Q4 25/26	N/A	TBC	TBC	TBC (currently severe)	N/A
MM33170	2	307362	SMH	Acute Medicine	Sub-optimal care of the deteriorating patient	M&M review underway	Q4 25/26	N/A	TBC	TBC	TBC (currently moderate harm)	N/A

Appendix D – Ethnicity data

Financial Year 25/26	Cerner Data		Combined dataset (WSIC and Cerner)	
	No. Deaths	% Deaths	No. Deaths	% Deaths
Totals	1736	100.0%	1736	100.0%
-	43	2.5%	43	2.5%
Asian - Any Other Asian Background	100	5.8%	99	5.7%
Asian or Asian British - Bangladeshi	9	0.5%	9	0.5%
Asian or Asian British - Indian	108	6.2%	138	7.9%
Asian or Asian British - Pakistani	32	1.8%	41	2.4%
Black - Any Other Black Background	30	1.7%	43	2.5%
Black or Black British - African	58	3.3%	69	4.0%
Black or Black British - Caribbean	91	5.2%	97	5.6%
Mixed - Any Other Mixed Background	14	0.8%	14	0.8%
Mixed - White and Asian	4	0.2%	8	0.5%
Mixed - White and Black African	6	0.3%	11	0.6%
Mixed - White and Black Caribbean	3	0.2%	14	0.8%
Other - Any Other Ethnic Group	254	14.6%	167	9.6%
Other - Chinese	10	0.6%	10	0.6%
Other - Not Known	29	1.7%	21	1.2%
Other - Not Stated	215	12.4%	93	5.4%
White - Any Other White Background	171	9.9%	273	15.7%
White - British	504	29.0%	505	29.1%
White - Irish	55	3.2%	81	4.7%

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 Executive Management Board
17/06/2026
Item number: #
This report is: Public

Learning from Deaths Report, Quarter 4 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 four (Q4) 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.

Patient Safety Group 28/04/2026 Approved	**Learning from Patient Deaths Group** 19/05/2026 Approved	Committee name Click or tap to enter a date. What was the outcome?

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 January 2025 to December 2025 is 86.2; this remains statistically low. The SHMI for period December 2024 – November 2025 also remains statistically low at 83.54. These are the most up to date HSMR and SHMI figures available at the time this report. The Trust's mortality indicators (SHMI and HSMR) remain statistically lower than expected, demonstrating strong overall performance. The Trust is the 7th best performing acute provider in England in relation of the SHMI relative risk.

During the 12-month period to end of March 2026; 100% in-hospital adult and child deaths were recorded within the Trust's mortality review system and screened. 425 deaths were identified for level 2 mortality review of which 400 have been completed at time of reporting (94%).

During Q4 2025/26; 9 cases had areas of sub-optimal care, treatment or service delivery identified. The majority of these cases (8), graded the care as a CESDI Grade 1, concluding that while there had been a level of suboptimal care, different care or management would not have made a difference to the outcome. In one case (CESDI Grade 2), it was 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 process.

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 Q4 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 December 2024 – November 2025 is 83.54 (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	106,425	2,595	3,105	83.54	85.06	117.56
ICHT	116,795	2,155	2,995	71.94	85.05	117.58
CWFT	84,835	1,695	2,255	75.26	84.94	117.73
THH	45,595	870	980	88.53	84.38	118.51

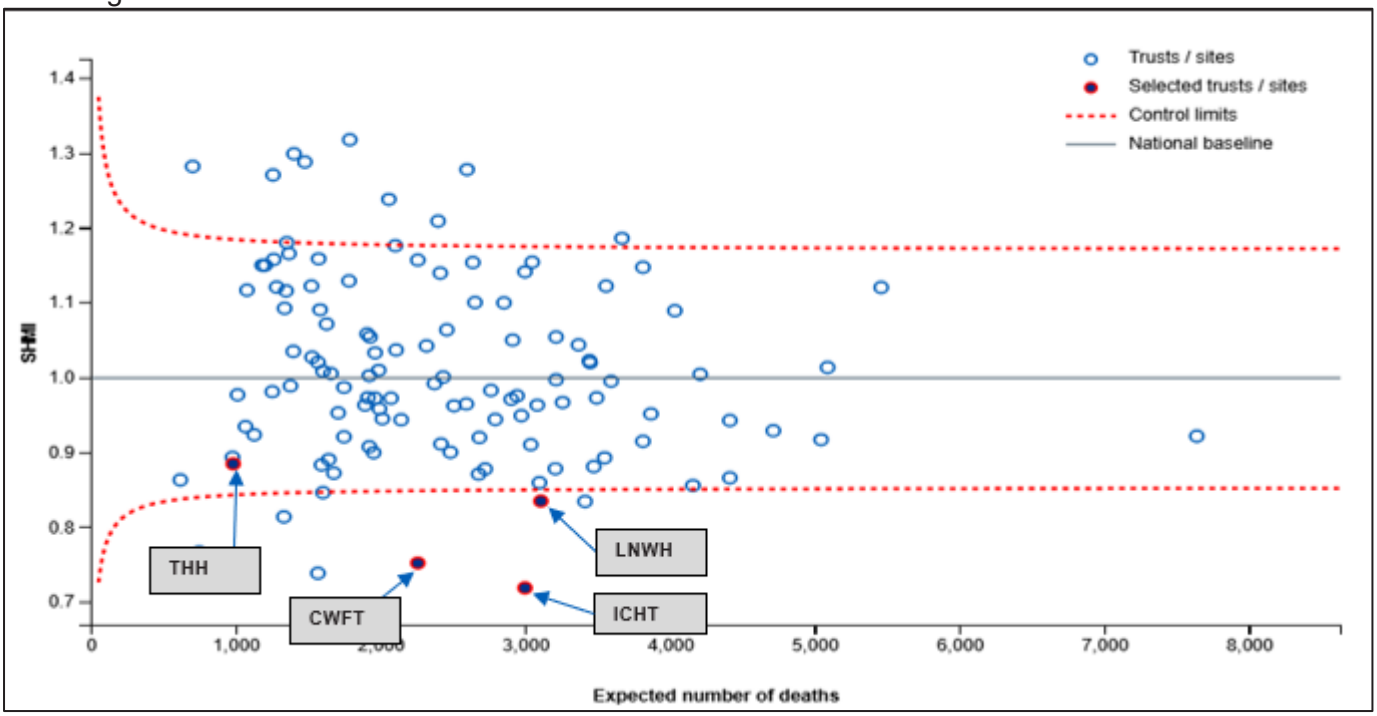
SHMI by APC provider, December 2024 to November 2025, Source: NHS Digital, published 9th April 2026

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	79,795	1,850	2,115	87.46	84.93	117.4
EH	22,625	740	975	75.96	84.39	118.49

SHMI by Trust site, December 2024 to November 2025, Source: NHS Digital, published 9th April 2026

NHS England acute Trust's SHMI



SHMI by acute provider, September 2024 to August 2025, Source: NHS Digital, published 9th April 2026

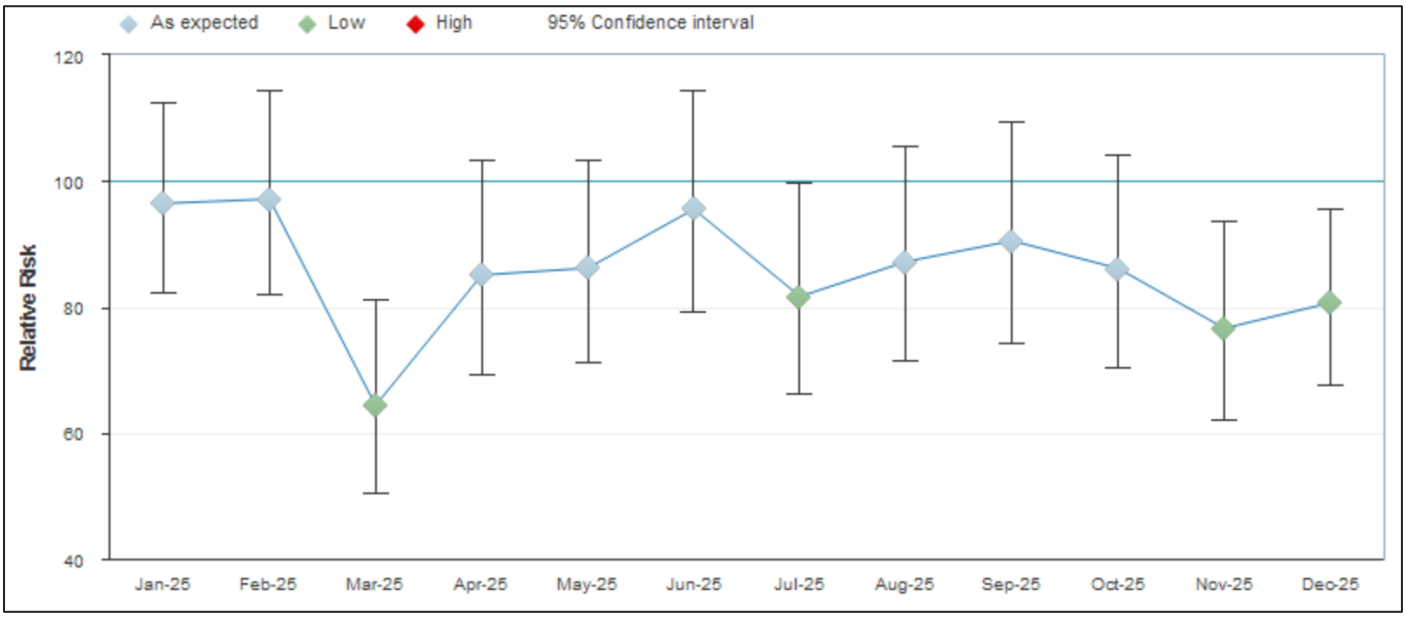
2.2. Hospital Standardised Mortality Ratio (HSMR)

The Trust's HSMR for the period January 2025 – December 2025 is 86.2 (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	53,600	1,359	1,577	86.2	81.6	90.9
ICHT	49,445	1,200	1,604	74.8	70.6	79.1
CWFT	35,135	970	1,252	77.44	72.6	82.5
THH	18,300	460	511	89.85	81.8	98.4

HSMR (41 diagnostic groups) by Trust, January 2025–December 2025, Source: Telstra, exported 20th April 2026



HSMR (41 diagnostic groups) by month, January 2025–December 2025, Source: Telstra, exported 20th April 2026

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 (Q4).

Diagnostic group alerts

Group	Vol	Observed deaths	Expected deaths	HSMR
Cardiac arrest and ventricular fibrillation	45	29	18.6	155.5
Learning: as previously reported, the trust has 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 predominately relates to patients experiencing out-of-hospital cardiac arrests. These cases typically arrive via emergency services and therefore present with complex and urgent clinical needs.				
Other psychoses	241	5	2.9	170.7
Learning: this alert was reported during the Q3 submission and has not changed, as it relates to 3 deaths that occurred in January 2025. All three cases were investigated and found to have receive no sub-optimal care, and the principal presentation were disorientation, that was unspecified.				
Residual codes, unclassified	14417	343	151.7	226.1
Learning: the team continue to work in collaboration with the Business Information Department, to determine whether current uploading processes are contributing to the use of unclassified codes. This work will identify opportunities to improve data accuracy and strengthen reporting arrangements going forward. **Note:** residual codes should not be thought of as a traditional alert, this is an artifact of coding. The Dr Foster methodology searches for a robust diagnosis in the first two episodes of care in a spell. If it can't locate one a residual code is assigned. These spells are subsequently recoded to their correct diagnosis code in the next month/month after in the vast majority of cases				

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 is the 7th 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.

3.1. Medical Examiner Scrutiny

During Q4 2025-26 the service has undertaken the following:-

- 100% (536) cases have been scrutinised
- 36% (221) of cases were referred to Coroner
- 23% (141) of cases referred to Coroner confirmed for Inquest / Pre Inquest review

3.2. Adult and Child Mortality Review (Level 2 / Structured judgement review)

Over the last four financial quarters, 2,215 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
Q1 25/26	536	536	104	104	100%	**100%**
Q2 25/26	487	487	97	97	100%	**100%**
Q3 25/26	574	574	117	105	100%	**90%**
Q4 25/26	618	618	107	94	100%	**88%**
Totals	**2,215**	**2,215**	**425**	**400**	**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.

3.3. 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, 400 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
Q1 25/26	85	16	2	1
Q2 25/26	77	15	5	0
Q3 25/26	93	10	2	0
Q4 25/26	85	8	1	0
Total	340	49	10	1

Closed mortality cases by CESDI grade, April 2025 to March 2026

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 3 for a listing of linked cases.

3.4. Learning from adult and child mortality review

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

- **Theme 1: Earlier and clearer Advance Care Planning and Treatment Escalation Planning.** This learning has been shared at the trust Learning from Patient Deaths Group and with both the End-of-Life Care Group and the Deteriorating Patients Group. The trusts expectation is that Treatment Escalation Planning for frail / high risk patients is assessed on admission to support earlier decision making and care.

- **Theme 2: Timely recognition, review and escalation of clinical deterioration using both ECGs and NEWS scores.** Delays in review of abnormal investigations was noted, and NEWS scores were not

consistently triggering senior medical review. In most cases the outcome was unchanged, but process delays create risk and require learning. Each of these cases underwent a patient safety investigation.

- **Theme 3: Quality of communication and documentation with patients, families and between teams.** Although family concerns were often addressed well, learning recurs around inconsistent documentation of Next of Kin discussions. Communication gaps during transfers or between specialties were noted and clarity over decision making and rational needs fortifying. This learning has been shared at the trust Learning from Patient Deaths Group

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 December 2025 3 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	3	3	0	**Awaiting PMRT panels**
Neonatal and post-natal deaths	3	3	3	0	**Awaiting PMRT panels**

PMRT review status by case category (Q3 2025/26), October – December 2025

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 Q4 2025/26: cases submitted awaiting confirmation NWL panel.

Ref	Month of Death	Process stage	Specialty	CESDI grade
M66241	Jan-26	Awaiting NWL panel	Elderly Care	CESDI 0
M66265	Jan-26	Awaiting NWL panel	Regional Hyper-acute Rehabilitation Unit	CESDI 0
M66268	Jan-26	Awaiting NWL panel	Acute Medicine	CESDI 0
M66271	Jan-26	Awaiting NWL panel	Acute Medicine	CESDI 0
M66659	Feb-26	Awaiting NWL panel	Respiratory Medicine	CESDI 0
M66960	Mar-26	Awaiting NWL panel	Acute Medicine	CESDI 0

Ref	Month of Death	Process stage	Specialty	CESDI grade
M67215	Mar-26	Awaiting NWL panel	Palliative Medicine	CESDI 0
M67360	Mar-26	Awaiting NWL panel	Respiratory Medicine	CESDI 0
M67591	Mar-26	Awaiting NWL panel	Elderly Care	CESDI 0

Learning from Life and Death Review cases, January 2026 March 2026

6. Prevention of future deaths (PFD)

The Trust has not been issued with a Prevention of Future Deaths (PFD) notice during Q4 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:

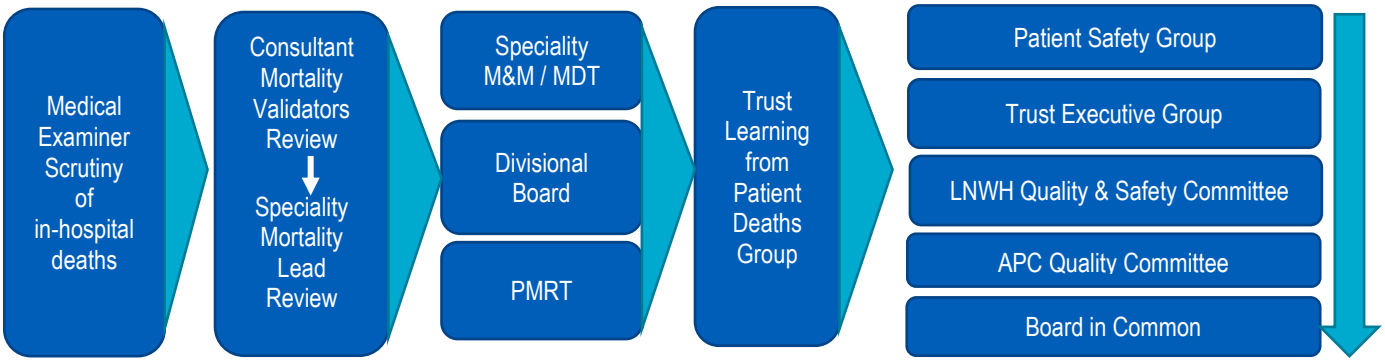
National triggers:

- 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.

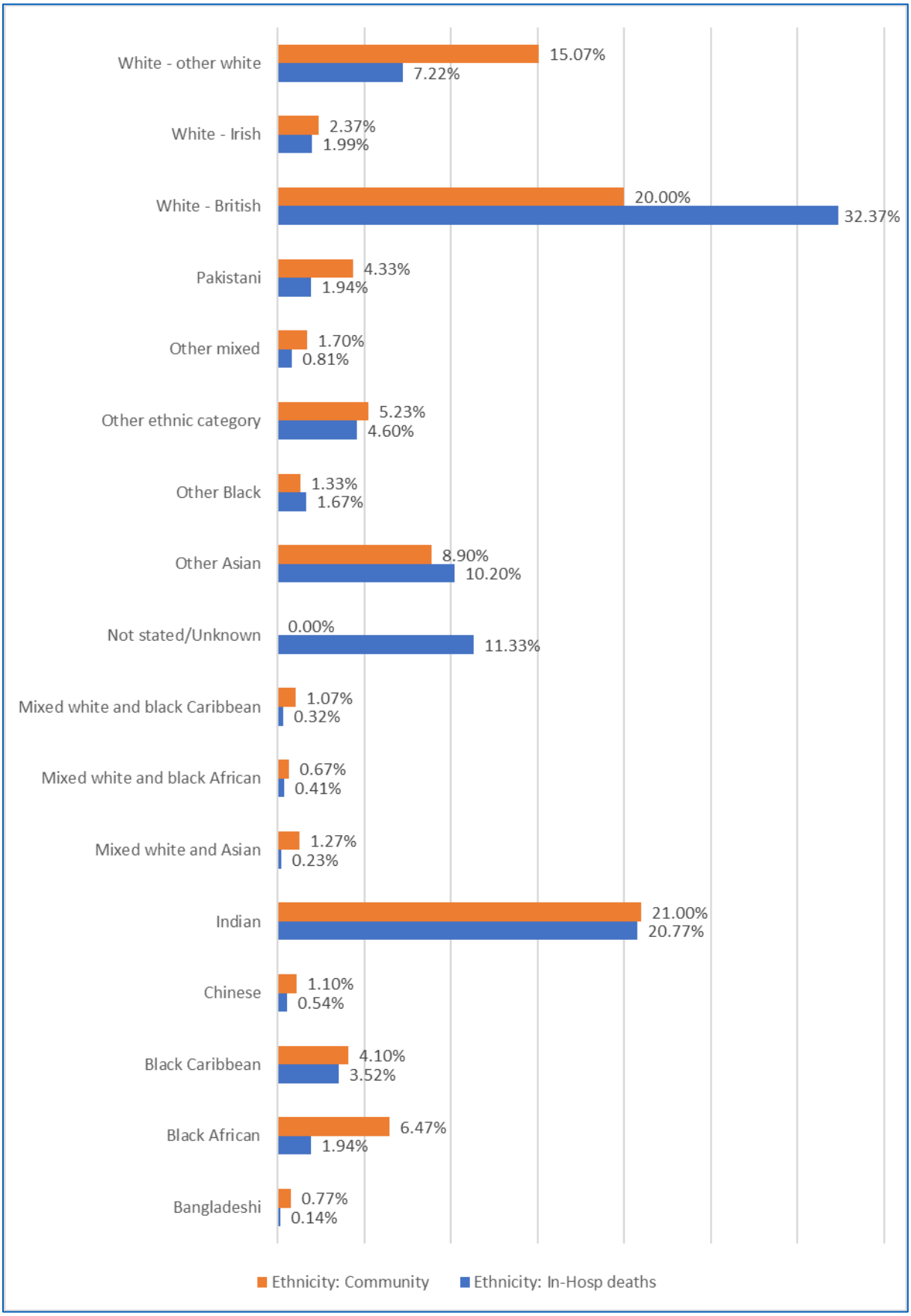
Appendix 2: Case linked to incident framework

Mortality Ref	CESDI grade	Qtr	Incident Ref	Site	Area	Event sub-category	Incident investigation status
M61100	2	Q1	WEB272804	NPH	General Surgery	Bowel perforation - Delayed surgery	PSII Completed
M61436	3	Q1	WEB275841	NPH	Elderly Care	Medication interaction Paxlovid and Apixaban	PSII ongoing
M61831	2	Q1	WEB277147	NPH	Trauma & Orthopaedics	Necrotising soft tissue infection	PSII Completed
M62154	2	Q2	WEB277592	EH	Gastro	Fall	IIR in-progress
M62658	2	Q2	WEB280060	NPH	Neonatology	Neonatal death	PMRT completed IIR in progress
M62740	2	Q2	WEB280726	NPH	Rheumatology	Possible delay in giving blood products	PSII ongoing
M63477	2	Q2	WEB282847	NPH	Stroke Services	Misplaced NG tube	PSII ongoing
M63560	2	Q2	WEB283186	NPH	A&E	Diagnostic incident	IIR in-progress
M63897	2	Q3	WEB284503	NPH	Clinical Haematology	Clinical deterioration - Failure to Follow Procedure	MDT review ongoing.
M64931	2	Q3	WEB287221	NPH	A&E	Fall	SWARM Huddle Completed
M66061	2	Q4	WEB291552	EH	Intensive Care	Diagnostic incident	PSII ongoing

CESDI grade 2 and 3 cases linked to an incident learning response in last 12 months, April-25 to Mar-26

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



*Ethnicity Community is the population for Brent, Ealing and Harrow

NWL Acute Provider Collaborative Board in Common (Public)
Select meeting date
Item number: #
This report is: Public

The Hillingdon Hospital NHS Foundation Trust Learning from Deaths Report, Quarter 4 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 four (Q4) 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.

Quality and Safety Executive Committee 14/05/2026 Presented	**Standing Committee** Click or tap to enter a date. What was the outcome?	**Mortality Surveillance Group** 20/05/2026 Presented

Executive summary and key messages

The Trust uses the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) to monitor mortality. The SHMI for the period December 2024 to November 2025 is 88.53. The HSMR for the period January 2025 to December 2025 is 89.85. A value below 100 indicated lower than expected mortality and this provides positive assurance reflected across the Trust.

During the 12-month period April 2025 to March 2026; 637 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 56 cases that would benefit from in-depth structured judgement review (SJR) of which 44 have been completed at the time of reporting (79%).

During Q4 2025/26 no cases were identified where sub-optimal care would reasonably be expected to have made a difference to the patient's outcome. Two cases of sub-optimal care were graded as CESDI 2 (where sub-optimal care was identified and different care might have made a difference to the outcome) and escalated for consideration of the appropriate learning response.

Where opportunities for improvement are identified, learning is reviewed at Divisional Boards/Groups and escalated to the Mortality Surveillance Group. 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)

Key risks arising from report

Inconsistencies between coded diagnosis & clinical diagnosis that have contributed to CUSUM alerts.

Main Report

1. Introduction

The Mortality Surveillance programme offers assurance to patients, stakeholders, and the Board that high standards of care are being provided. It also provides assurance that data and expert opinion is used to interrogate any inconsistencies, concerns and opportunities for learning and improvement which are then actioned. This report provides a Trust-level review of mortality learning for Q4 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 mortality.

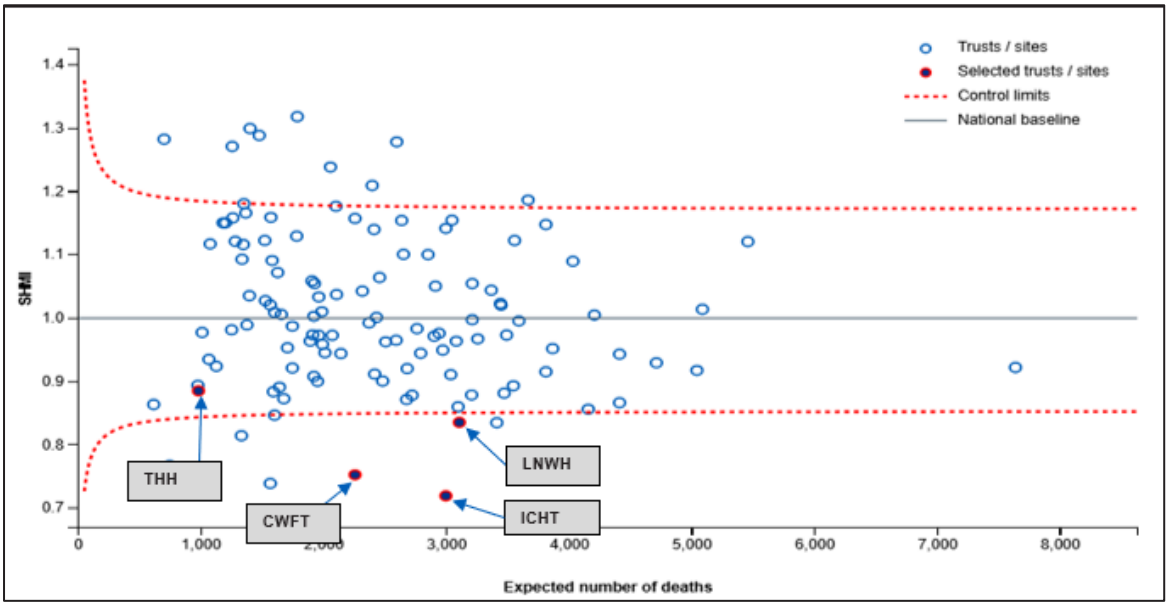
2.1. Summary Hospital-level Mortality Indicator (SHMI)

The Trust's SHMI for the period December 2024 – November 2025 is 88.53 (where a number below 100 represents lower than expected risk of mortality). The results for NWL acute provider collaborative are tabled below, however, it should be noted that NHSE who produce the SHIMI data advise that "The SHIMI cannot be used to directly compare mortality outcomes between trusts."

North West London Acute Collaborative SHMI indicators

Trust	Provider spells	Observed deaths	Expected deaths	SHMI	LCL 95%CI	UCL 95%CI
LNWH	106,425	2,595	3,105	83.54	85.06	117.56
ICHT	116,795	2,155	2,995	71.94	85.05	117.58
CWFT	84,835	1,695	2,255	75.26	84.94	117.73
THH	45,595	870	980	88.53	84.38	118.51

SHMI by APC provider, December 2024 to November 2025, Source: NHS Digital, published 9th April 2026



NHS England acute Trust's SHMI

SHMI by acute provider, September 2024 to August 2025, Source: NHS Digital, published 9th April 2026

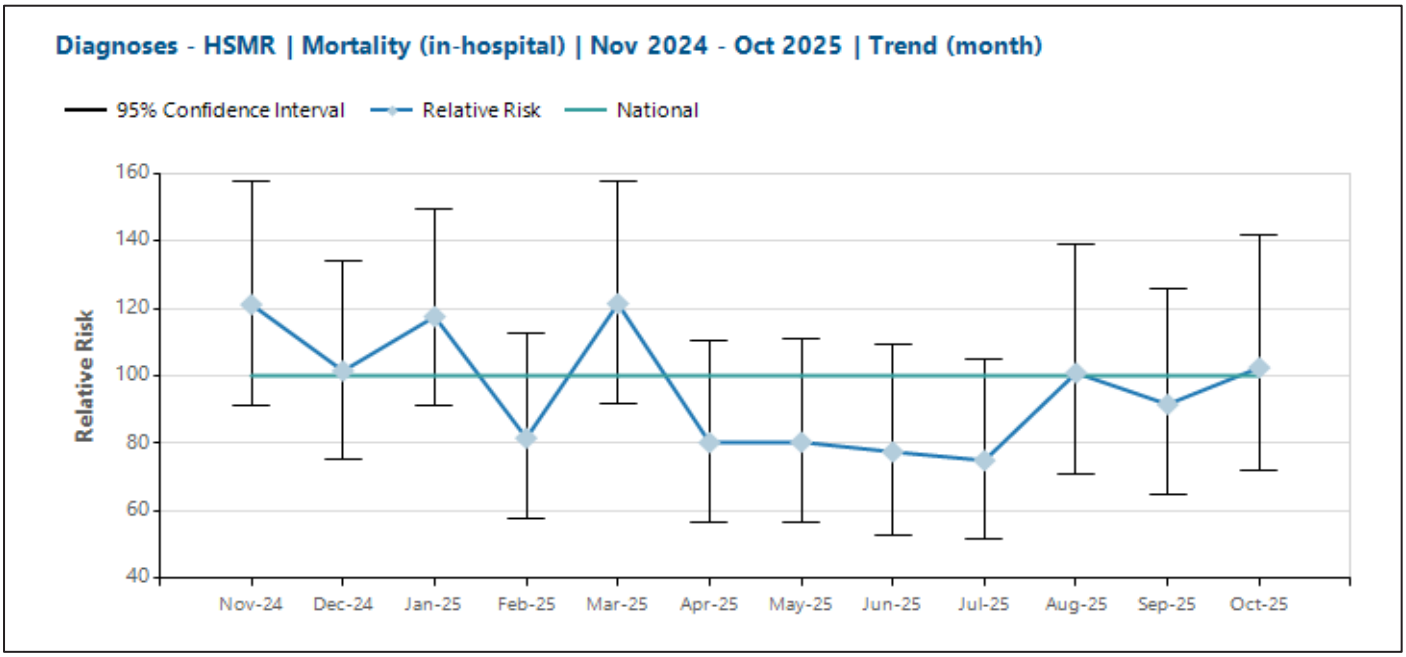
2.2. Hospital Standardised Mortality Ratio (HSMR)

The Trust's HSMR for the period January 2025 – December 2025 is 89.85 (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	53,600	1,359	1,577	86.2	81.6	90.9
ICHT	49,445	1,200	1,604	74.8	70.6	79.1
CWFT	35,135	970	1,252	77.44	72.6	82.5
THH	18,300	460	511	89.85	81.8	98.4

HSMR (41 diagnostic groups) by Trust, January 2025–December 2025, Source: Telstra, exported 20th April 2026



HSMR (41 diagnostic groups) by month, November 2024–October 2025, Source: Telstra, exported 24th February 2026

The information in the graph above is not aligned with the rest of the Acute Collaborative indicators as the trust has moved to an alternate provider for the data. This will be provided for the next quarter.

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 (Q4).

Diagnostic group alerts

Group	Vol	Observed deaths	Expected deaths	HSMR
Biliary tract disease	715	10	5.7	173.9
Learning: Biliary tract disease alerts as a CUSUM alert at 99% detection level in February 2025. There were 10 deaths that occurred and a review of coding and care that the patients received is underway.				
Other infections, including parasitic	59	3	2.1	145.4
Learning: Other infections, including parasitic alerts as a CUSUM alert at 99% detection level in January 2025 and alerted in the last reporting data period October 2024 to September 2025. A review of the 3 cases was carried out. See 2.3 for further details.				

Sickle cell anaemia	45	1	0	3569.4
Learning: Learning: Sickle cell anaemia alerts as a CUSUM alert at 99% detection level in March 2025 and also alerted in the last reporting data period October 2024 to September 2025. A previous review of the case had been completed, coding was correct and the patient had received no sub-optimal care. A local audit on Sickle cell has also 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 'Other infections including parasitic' was received in the last reporting data period October 2024 to September 2025, which alerted in January 2025. A review of the three cases was completed during Q4 which confirmed that all three cases were coded correctly at the time, based on the first FCE (Finished Consultant Episode) however only one genuinely fitted these diagnostic criteria. This is because one patient died of severe Falciparum Malaria after being transferred to LNWH where they were treated on ITU. The other 2 patients in this group in fact died of respiratory infections, one had aspiration pneumonia, the other had RSV, so do not strictly fit into this category, but the coding performed at the time of the FCE is reported as being correct.

The trust does not have regular clinical review or auditing of coding to address such inconsistencies, which have been noted in previous deep dives.

3. Adult and Child Mortality Review

All in-hospital adult and child deaths are screened to identify cases requiring more in-depth structured judgement review. Mortality review provides clinical teams with the opportunity to review outcomes and learning 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, rather than the SJR process. During quarter four there was one child death and one neonatal death that were reported to CDOP for review.

3.1. Medical Examiner Scrutiny

- **Number of cases scrutinised;** 187 hospital and 276 community deaths were scrutinised, total 463. This includes 100% of hospital (40.3%) and community (59.7%) where the coroner's duty to investigate (S1:CJA2009) was not engaged.
- **Number of cases referred to Coroner;** 28 hospital and 29 community deaths were referred to the Coroner.
- **Number of cases referred to Coroner confirmed for Inquest / Pre Inquest review;** 18 hospital, 7 community.

3.2. Adult Mortality Review Structured judgement review

Over the last four financial quarters, 637 in-hospital adult deaths were recorded within the Trust's mortality review system, of these 100% have been screened under the SJR process. 79% of those requiring in depth review have been completed. The drop in performance was predominantly in Planned Care and due to leave and competing priorities. This has now improved as will be demonstrated in the next quarters data.

	No. of deaths	No. of cases screened	No. of cases flagged for level SJR review	No. case with completed SJR review	% cases Screened	% of SJR reviews completed
Q1 25/26	144	144	11	11	**100%**	**100%**
Q2 25/26	136	136	18	18	**100%**	**100%**
Q3 25/26	172	172	13	11	**100%**	**85%**
Q4 25/26	185	185	14	4	**100%**	**29%**
Totals	**637**	**637**	**56**	**44**	**100%**	**79%**

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.

3.3. 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, 44 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
Q1 25/26	8	3	0	0
Q2 25/26	12	5	1	0
Q3 25/26	7	3	1	0
Q4 25/26	4	0	0	0
Total	**31**	**11**	**2**	**0**

Closed mortality cases by CESDI grade, April 2025 to March 2026

The Patient Safety Incident Response Framework (PSIRF) requires that deaths assessed to have been more likely than not due to problems in care 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.

3.4. 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:** Opportunities to improve the timeliness of discussion and completion of Treatment Escalation Plans (TEPs). To raise awareness of early TEP discussions through departmental clinical governance meetings and via newsletter.

- **Transfers of care:** Transfer of care should provide teams with the opportunity to review the treatment escalation plan and patient's summary of admission on first ward round after transfer of care as well as the post take ward round. This maximises opportunities to review cases that could otherwise post a risk due to loss of continuity.
- **Recognition of the deteriorating patient:** There was learning regarding the recognition of signs of deterioration outside of NEWS (ie reduced alertness, hypoglycaemia, reduced oral intake) and learning is being shared Trust wide around this.

- **Awareness of the Learning Disability Specialist Nurse role;** To have considered referral to the Learning Disability Specialist Nurse, or the mental health team, especially as agitation, aggression and non-compliance documented, and this could have helped with compliance and behaviour. To raise the awareness of the Learning Disability Specialist Nurse role through departmental clinical governance meetings and via newsletter.

- In several CDOP cases it was noted that there was a delay in calling 999, often if families where English is not their primary language. This has now been escalated again to the ICB for wider learning and consideration of improved strategies to educate parents on accessing healthcare in an emergency.

- Learning from child mortality review also highlighted the importance of use of interpreters: Use of RITA is available in Maternity/ED but not on ward. Currently NWL Child Death Team has staffing challenges - only 1 nurse as recruitment frozen while service is reconfigured and there was a missed notification to SPEN (Submit a Perinatal Event) for the Sudden Death in Infancy (SUDI) neonatal death – a pathway for this is now in place.

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' learning 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 December 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	5	4	4	4	**Case 1 – C and B Case 2 – B and B Case 3 – A and B Case 4 – A and B**
Late fetal losses	0	0	0	0	**0**
Neonatal and post-natal deaths	1	1	1	1	**B and A and B**

PMRT review status by case category (Q3 2025/26), October 25 – December 25

*For stillbirth 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. See appendix 3 for guide to care gradings.

*For neonatal death PMRTs, three gradings are given to each case. The first grading is for the care provided to the mother and the baby up to the point of the birth of the baby. The second grading is for the care provided to the baby from birth up to the death of the baby and the third grading is the care provided to the mother following the death of her baby. See appendix 3 for guide to care gradings.

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. SMART actions are identified and monitored by the PMRT Lead Midwife and the Maternity Governance Group. The trust has introduced a yearly thematic review of all Stillbirths using the PMRTS to support the review to identify themes and trends and any further actions to strengthen learning and improving care and experience. This review was completed in March 2026 and outcome from this will be presented in the next report.

5. Child death overview panel

During quarter four there was one child death and two neonatal deaths. One child death (age 13) and one neonatal death (3 weeks) – Sudden Unexpected Death in Infancy (SUDI) were reported to CDOP for review. One neonatal death (20+6) was born with signs of life but below age of viability and reporting to CDOP.

Learning from child mortality review;

a) Delay in calling 999: this has been noted in several cases, often in families where English is not their primary language. This has now been escalated again to the ICB for wider learning and consideration of improved strategies to educate parents on accessing healthcare in an emergency.
b) Importance of use of interpreters: Use of RITA is available in Maternity/ED but not on other wards.
c) Currently NWL Child Death Team has staffing challenges - only 1 nurse as recruitment frozen while service is reconfigured.
d) Missed notification to SPEN (Submit a Perinatal Event) for the Sudden Unexpected Death in Infancy (SUDI) case - pathway for this now in place.

6. 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 Q4 2025/26:

Ref	Month of Death	Process stage	Specialty	CESDI grade
SJR 54	January	Completed	Care of the Elderly	CESDI 0

Learning from Life and Death Review cases, January 2026 March 2026

7. Prevention of future deaths (PFD)

The Trust has not been issued with a Prevention of Future Deaths (PFD) notice during Q4 2025/26.

8. 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

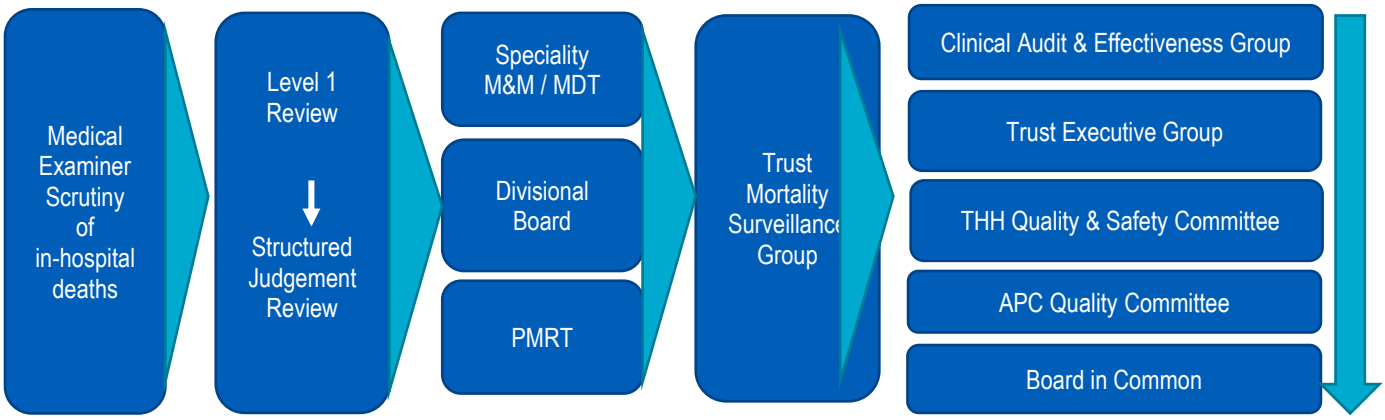
Appendix 1: Mortality review process

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:

APC 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
51	2	W153060	THH	Care of the Elderly	Lack of recognition of deteriorating patient	SJR Completed Robust action plan in place

CESDI grade 2 and 3 cases linked to an incident learning response in last 12 months, 1st April 2025 – 31st March 2026

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. 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.

Mortality Ref 51 – Discussed at IRG on 10th February 2026. Whilst the patient was independent on admission, he deteriorated during the course of the admission. Delays in care were identified through the review and although it is possible that prompt escalation and treatment may have impacted the outcome. It is more than likely he would have continued to deteriorate and the case has been downgraded to moderate harm on the datix. Immediate safety actions have been identified and a robust action plan is in place.

Appendix 3: Guide to care grading for PMRT.

Stillbirth PMRTs:

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.

Neonatal death PMRTs:

Grading of care provided to the mother and the baby up to the point of the birth of the baby.
A – The review group concluded that there were no issues with care identified up to the point of the birth of the baby
B – The review group identified 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 for the baby
D – The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care provided to the baby from birth up to the death of the baby.
A – The review group concluded that there were no issues with care identified from birth up to the point the baby had died
B – the review group identified care issues which they considered would have made no difference to the outcome of the baby
C – The review group identified care issues which they considered may have made a difference to the outcome for the baby
D – The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care provided to the mother following the death of her baby.
A – The review group concluded that there were no issues with care identified for the mother following confirmation of the death of the baby
B – The review group identified care issues which they considered 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 for 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