Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

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Title:	**Learning From Deaths Report – Quarter 4 2025/26**

Status:	**For Information**
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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This paper summarises key learning identified in mortality reviews completed for Quarter 4 of 2025/26, which is the latest available Dr Foster Intelligence mortality data. It also provides assurance on the actions taken in relation to any highlighted concerns.
2. During Quarter 4 of 2025/26 there were 717 inpatient deaths of which 707 (99%) were reviewed within the target of 8 weeks, including 313 level 2 and 13 structured judgement reviews (Table 1). The remaining outstanding mortality reviews have since been completed outside the expected 8-week window.
3. There were no avoidable deaths reported in Quarter 4.
4. The Summary Hospital-level Mortality Indicator (SHMI) for January 2025 to December 2025 is 0.88 ‘as expected’ which remains consistent with previous quarters. Of the 10 groups that NHSE publish SHMI values for, none of these are statistically higher than expected.
5. The Trust’s HSMR+ for April 2025 to March 2026 was 92 (87.7-96.5) and banded ‘lower than expected’.

Recommendation

6. The Trust Board is asked to note the Learning from Deaths update for Quarter 4 2025/26.

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Learning From Deaths Report – Quarter 4 2025/26

1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 4 of 2025/26: January 2026 to March 2026.

1.2. This report provides a quarterly overview of Trust-level mortality data; the latest available Dr Foster Intelligence mortality data; and assurance on the actions taken in relation to any highlighted concerns.

2. Background and Policy

2.1. Oxford University Hospitals NHS Foundation Trust (OUH) is committed to accurately monitoring and understanding its mortality outcomes; and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains in the NHS Outcomes Framework.[1]

3. Mortality reviews during Quarter 4 of 2025/26.

3.1. A summary of the Trust's learning from deaths processes including mortality reviews, is provided in Appendix 2.

3.2. During Quarter 4 of 2025/26 there were 717 inpatient deaths (Table 1).

Table 1: Mortality reviews completed

Reporting period	Total deaths	Reviews completed within 8 weeks			Total reviews completed*
		Level 1	Level 2 & SJRs	Total	
2024/25 (Q1-4)	2761	2719 (98%)	1199 (43%)	2719 (98%)	2761 (100%)
2025/26 (Q1)	634	443 (70%)	266 (42%)	630 (99%)	634 (100%)
2025/26 (Q2)	618	421 (65%)	279 (43%)	615 (99.5%)	618 (100%)
2025/26 (Q3)	701	509 (73%)	333 (48%)	694 (99%)	701 (100%)
2025/26 (Q4)	717	707 (99%)	313 (44%)	707 (99%)	717 (100%)

*Including reviews completed after 8 weeks.

[1] About the NHS Outcomes Framework (NHS OF) - NHS Digital

3.3. The ten remaining mortality reviews have been completed outside the expected 8-week window and assurance provided by the responsible Divisions.

3.4. Thirteen structured judgement reviews (SJR) were completed and presented at MRG in Q4. The reasons for the SJRs presented to MRG included:

- Death of individuals with a learning disability
- Concerns raised by staff or families
- A Coroner's Inquest into a death

4. The Medical Examiner (ME) system

Background

4.1. Since June 2020, Medical Examiners have scrutinised deaths at OUH. Statutory scrutiny of all deaths including those in Primary Care started on 9 September 2024.

4.2. The purpose of the ME system is to provide greater safeguards for the public by:

- Ensuring proper scrutiny of all non-Coronial deaths.
- Ensuring appropriate referral of deaths to a Coroner.
- A better service for the bereaved, including an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased.
- Improved quality of death certification and mortality data.

4.3. Any concerns raised by the ME or the bereaved families/carers and other feedback including in relation to excellent practice are fed back to the Clinical Governance Team and shared with the Divisions to inform mortality reviews and any learning.

4.4. 100% of Trust deaths were reviewed by the ME in Q4.

4.5. 100% of adult Hospice deaths were also reviewed by the ME in Q4.

4.6. All child/neonatal deaths within the Trust are also scrutinised by the ME Service (excluding Stillbirths and termination of pregnancies).

4.7. A monthly update is provided to the Mortality Review Group (MRG) by the Lead Medical Examiner.

4.8. Quarter 4 learning: An opportunity to improve rapid release processes for children and adults was reported to the Mortality Review Group, with a

group convened to implement changes with the aim of reducing distress for families and ensure statutory requirements are met.

5. Child death overview process (CDOP) Quarter 4 update

5.1. There were 18 child deaths in OUH in Q4; this is similar to the trend over previous quarters with the exception of a spike in Q2 (see Table 2).

Table 2: Number of child deaths by Quarter from 2024

2024-2025	**Number of child deaths**
Q1	13
Q2	15
Q3	18
Q4	16
2025-2026	**Number of child deaths**
Q1	13
Q2	27
Q3	16
Q4	18

5.2. Key themes of good practice arising from the Q4 completed reviews include:

5.2.1. Excellent multidisciplinary team (MDT) working, supported by high-quality palliative care and comprehensive bereavement support for families following a child's death, with valuable contributions from charitable partners**.**

5.2.2. Upholding family wishes where possible including choice of care locations.

5.2.3. Robust responses to cardiac arrests.

5.2.4. Good early airway management and prompt intubation to stabilise a child's airway

5.3. Key learning points include:

5.3.1. Bereavement key worker support for families outside of Paediatric Critical Care remains inconsistent (recruitment and appointment is pending).

5.3.2. Whenever possible all investigations for genetic or metabolic disease should be performed prior to death.

5.3.3. Accuracy when recording Medical Certificate of Cause of Death (MCCD) documentation.

5.3.4. Consideration of locations for sensitive family discussions – ward-based discussions may not be appropriate.

6. Example learning and actions from mortality reviews (adults and children) completed in Quarter 4 and action impact

6.1. Examples of learning during this quarter are summarised in Table 3.

Table 3: Learning and Actions from mortality reviews

Division (Service)	Learning	Action
MRC Division wide (L2 reviews)	Earlier involvement of palliative care was identified as a recurring learning theme across completed mortality reviews.	The Division will reinforce the referral triggers for palliative care, particularly for patients with frailty, deterioration, complex symptoms, or uncertain ceilings of care. Impact: earlier involvement of palliative teams and improved care at end of life.
MRC Emergency Department (ED)	Delays in initial triage and antibiotic administration in the ED.	An action plan was developed for managing sepsis. Sepsis awareness month was delivered in April 2026 in ED/EAU across both sites. Impact: An increase in performance has been observed in management of moderate-risk sepsis, with 100% of patients being treated on time. Monthly monitoring continues.
MRC Acute General Medicine (SJR)	Process for medication changes (trust wide change over to Enoxaparin)	MRC and Pharmacy teams have identified the risk during Trust-wide medication changes and ,learning actions related to how trust wide medications changes are made. Actions focus on: • strengthening communication & early training for important changes • The need to highlight high risk drugs to ensure review by clinical pharmacists • Timely updates to associated Powerlans and EPR prompts to ensure safety • Ensuring appropriate stock is held on wards
SUWON Oncology (L2 review)	System failure leading to loss of follow-up in a high-risk Oncology patient.	Governance & Education: Letter Workflow Risk: Use of "sign and submit" bypasses administrative safety nets and can result in missed follow-up. Division wide messaging has been shared. Risk Register: Inability to report on "signed and submitted" letters to the Oncology and Haematology added to Risk Register. Administrative Processes: Refresh training for administrative staff on follow-up checks.

Division (Service)	Learning	Action
		Agree and document a minimum mandatory review interval for patient-missing-follow-up worklists.
SUWON Oncology	Safe and robust follow up process.	Governance and patient safety have been strengthened through safer Oncology follow-up processes, including improved letter workflows, mandatory worklist reviews, enhanced administrative training, and escalation of reporting risks via the risk register. Clinical practice has been enhanced by reinforcing senior-led escalation pathways for junior clinicians, increasing overnight medical cover, and promoting timely recognition of dying, compassionate palliative care, and appropriate ICU decision-making for high-frailty patients.
SUWON Gynaecology (L2 review)	Importance of documenting MDT discussions, especially regarding differential diagnoses, treatment options (including medical therapy), and the rationale for surgical decisions. Gaps identified in the EPR record, particularly around verbal MDT discussions and alternative treatments considered.	SUWON will develop a proposal to adapt the sarcoma pathway checklist for complex benign gynaecology cases. Intended impact: Ensure comprehensive MDT input and improved documentation.
NOTSSCAN Trauma	More focused and tailored care for medical outliers.	The Division is currently drafting and approving a standard operating procedure (SOP) for the care of medical outlier patients following incidents and Inquests involving medical outliers. Intended impact: Improved care and outcomes for medical outliers, reduction in harm incidents and Coroner Inquest referrals.
Clinical Support Services (CSS) Critical Care L2 review	A case was reviewed and discussed where a patient presented at Milton Keynes with severe sepsis from Ludwig's angina and was transferred to OUH.	The management of severe septic shock was reviewed and presented the following month to further explore current approaches to the treatment of severe sepsis, including the use of Milrinone. There were no care concerns and the death was deemed unavoidable.

7. Patient Safety Incident Investigations (PSII) of incidents resulting in death during Quarter 4

7.1. The findings of all PSIIs with an impact of death are presented to MRG (as well as other clinical governance forums).

7.2. There were no new incidents with an impact of death declared as a PSII during Quarter 4 2025/26.

8. National mortality benchmark data

8.1. There have been no mortality outliers reported for OUH from the Care Quality Commission (CQC) or NHS Digital during Quarter 4 2025/26.

8.2. The Summary Hospital-level Mortality Indicator (SHMI) for January 2025 to December 2025 is 0.88 ‘as expected’ which remains consistent with previous quarters. Of the 10 groups that NHSE publish SHMI values for, none of these are statistically higher than expected.

8.3. The Trust’s HSMR+ for April 2025 to March 2026 was 92 (87.7-96.5) and banded ‘lower than expected’.

Chart 1: Rolling 12-month HSMR+

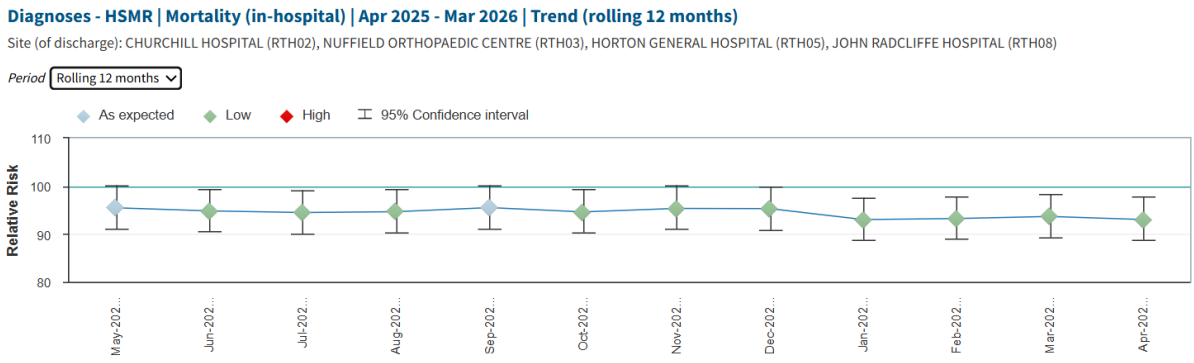
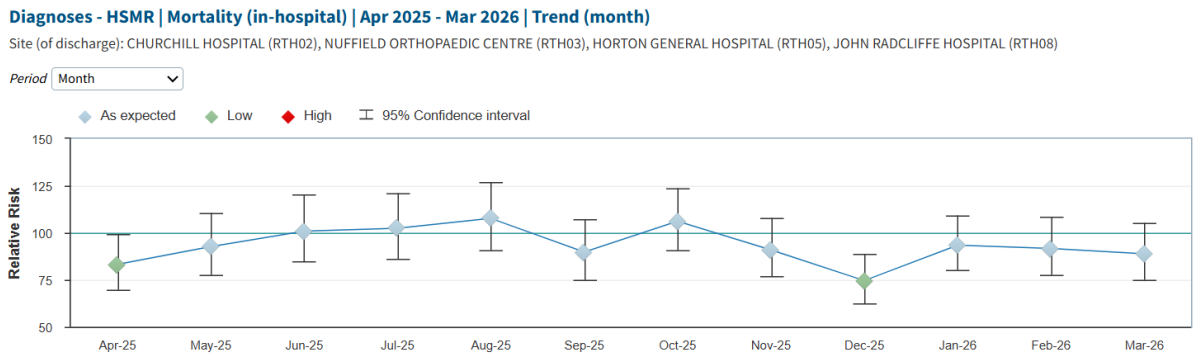


Chart 2: Non-rolling HSMR+ by month



8.4. A summary and comparison of the methods used to calculate the SHMI and HSMR+ is included in Appendix 1.

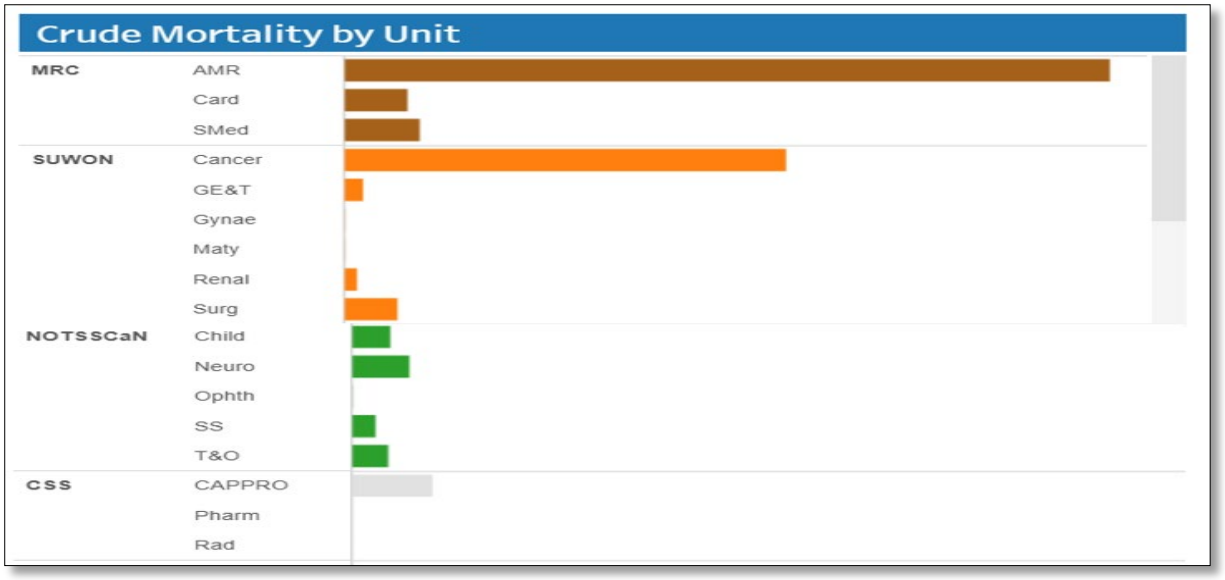
9. Detailed analysis of deaths during reporting period

9.1. The highest number of deaths occur in the Acute Medicine and Rehabilitation (AMR) Directorate under the Medicine Rehabilitation and Cardiac (MRC) Division (Table 4 and Chart 3). This is consistent with previous reports.

Table 4: Crude mortality by Clinical Division, Quarter 4 of 2025/26

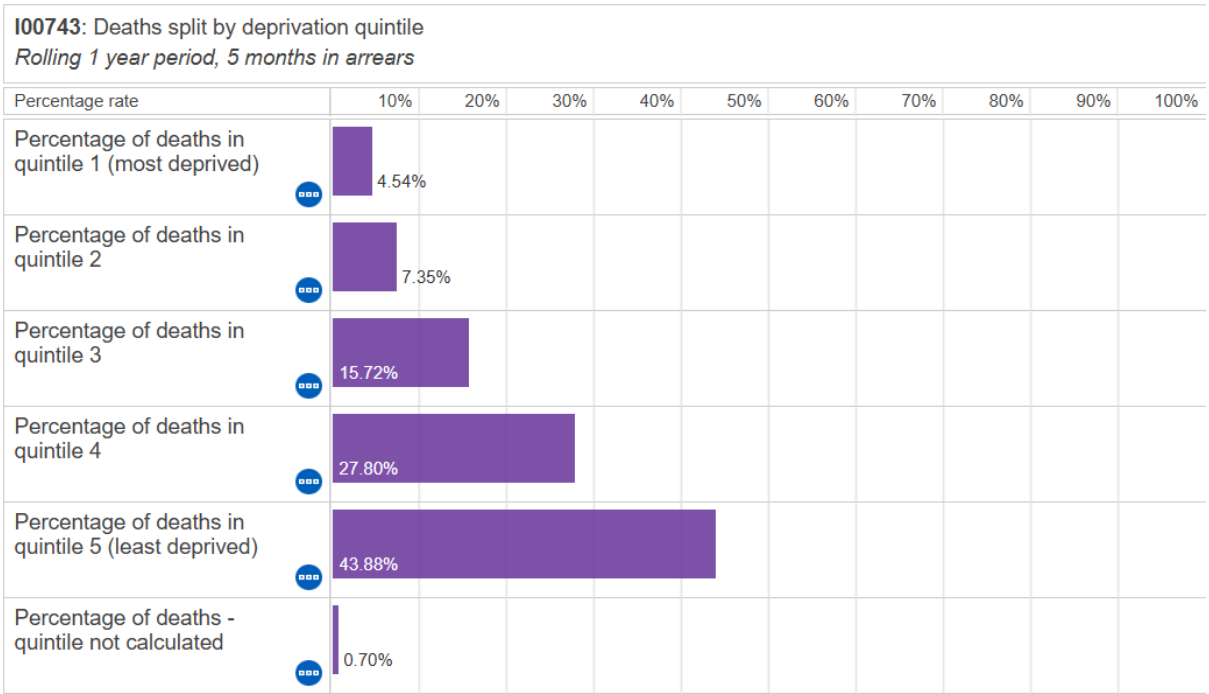
Division	Total Discharges	Number of deaths (Reported to MRG)
NOTSSCAN	16,094	66
MRC	22,621	386
SUWON	19,930	230
CSS	802	35
Total	59,447	**717**

Chart 3: Deaths by Directorate (annual data) - This chart demonstrates most deaths are in either MRC Division /Acute Medicine and Rehabilitation Directorate (AMR) or SUWON Division/Cancer Directorate:



9.2. Mortality by Index of Multiple Deprivation: Chart 4 displays the percentage breakdown of spells by Index of Multiple Deprivation quintile. This pattern is in line with previous LFD reports. This chart demonstrates that many patients admitted to OUH are in the least deprived areas of the region. Detailed interpretation of this data is difficult without adjusting for confounders such as age which may explain much of the observed variation.

Chart 4: % SHMI spells in each deprivation quintile January 2025- December 2025



10. Mortality-related risks on the Corporate (Trust level) Risk Register

10.1. Relevant mortality-related risks from the Corporate (Trust) Risk Register are listed below in Table 5:

Table 5- Mortality related risk on the Corporate (Trust) Risk Register)

Risk Title	Risk Rate	Risk Number
Patients may not be directed to the right care pathway impacting on patient outcome, experience and staff morale	Moderate	1111
Ability to meet delivery plan trajectories for the achievement of 62-day cancer target that might impact on patient outcomes.	Moderate	2445
Diagnostic capacity and impact on cancer and elective care targets	High	1136

11. Recommendation

11.1. The Trust Board is asked to note the Learning from Deaths update for Quarter 4 2025/26.

Appendix 1: Key differences between the SHMI and HSMR+

The Trust references two mortality indicators: the SHMI, which is produced by NHS Digital, and the HSMR+ produced by Dr Foster Intelligence.

Both are standardised mortality indicators, expressed as a ratio of the observed number of deaths compared to the expected number of deaths adjusted for the characteristics of patients treated at a Trust.

While both mortality indicators use slightly different methodology to arrive at the indicator value; both aim to provide a risk adjusted comparison to a national benchmark (1 for SHMI or 100 for HSMR+) to ascertain whether a Trust's mortality is 'as expected', 'lower than expected' or 'higher than expected'.

Key differences between the SHMI and HSMR+

Indicator	Summary Hospital-level Mortality Indicator (SHMI)	Hospital Standardised Mortality Ratio (HSMR)
Published by	NHS Digital	Dr Foster Intelligence
Publication frequency	Monthly	Monthly
Data period to calculate indicator value	Rolling 12-month period for each release, approximately five months in arrears.	Provider-selected period, up to three months in arrears

Indicator	Summary Hospital-level Mortality Indicator (SHMI)	Hospital Standardised Mortality Ratio (HSMR)
Coverage	Deaths occurring in hospital or within 30 days of discharge. All diagnosis groups excluding stillbirths. Day cases and regular attenders are excluded.	In-hospital deaths for 41 selected diagnosis groups that accounts for 80% of in-hospital mortality. Regular attenders are excluded.
Assignment of deaths	Deaths that happen post transfer count against the transfer hospital (acute non-specialist trusts only).	Includes deaths that occur post transfer to another hospital (superspell effect).
Palliative Care	Not adjusted for in the model.	Not adjusted for in the model.
Casemix adjustment	8 factors: diagnosis, age, sex, method of admission, Charlson comorbidity score, month of admission, year, birth weight (for individuals aged <1 year in perinatal diagnosis group).	Admission type, age, year of discharge, deprivation, diagnosis subgroup, sex, Elix Hauser comorbidity score, emergency admissions in last comorbidity score, emergency admissions in last 12 months, month of admission, source of admission, interaction between age on admission group and comorbidity admission group.

Appendix 2: Process, Background, Policy and monitoring of mortality related actions

1. Oxford University Hospitals NHS Foundation Trust (OUH) is committed to accurately monitoring and understanding its mortality outcomes; and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains[2] set out in the NHS Outcomes Framework:
    - Preventing people from dying prematurely.
    - Treating and caring for people in a safe environment and protecting them from avoidable harm.
2. OUH uses the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare mortality data nationally. Although these are not direct measures of the quality of care, benchmark outcome data help identify areas for investigation and potential improvement.
3. The Trust Mortality Review policy requires that all inpatient deaths are reviewed within 8 weeks of the death occurring.
4. All patients undergo a level 1 review. The level 1 review is allocated to the responsible Consultant via the electronic patient record (EPR). A minimum of 25% of level 1 reviews are then selected at random for a more comprehensive level 2 review (in many departments all deaths undergo a level 2 review) and all (100%) of deaths undergo independent scrutiny from the Medical Examiner's office.
5. A comprehensive level 2 review is also completed for all cases in which concerns are identified at the level 1 review. The level 2 review involves one or more consultants not directly involved in the patient's care. A structured judgement review (SJR) is required if the case complies with one of the mandated national criteria - NHS England » Learning from deaths in the NHS. This is completed by a trained reviewer not directly involved in the patient's care. More recently an SJR is requested if there is a Coroner's Inquest.
6. Each Division maintains a log of actions from mortality reviews (of any type) and monitors progress against these action plans. The clinical units are responsible for disseminating learning and implementing the actions identified. Actions are recording using the trust incident reporting system (Ulysses).
7. Mortality related actions are reported quarterly to the Mortality Review Group (MRG) and via the Divisional Quality Reports presented to the Clinical Governance Committee (CGC).

[2] About the NHS Outcomes Framework (NHS OF) - NHS Digital

8. The Divisions also provide updates to MRG on the previous quarter's actions as part of the next quarter's mortality report. MRG reports to the Clinical Improvement Committee (CIC).

CDOP background

9. There is a statutory requirement for local panels to review every child death (section 14 of the *Children Act 2004* and *Working Together to Safeguard Children 2018*).
10. Panels are required to review deaths of all children up to the age of 18 years and neonates less than 28 days old. (including babies born before viability, but not those who are stillborn or are terminated pregnancies within the law).
11. The administration of the Oxfordshire CDOP is hosted by the BOB ICB and is chaired by the Director of Quality and Lead Nurse from the ICB. The Designated Doctor for Child Death is a Consultant Paediatrician at OUH and is commissioned by the ICB to undertake this role. The CDOP is committed to ensuring the review process is grounded in respect for the rights of children and their families and focuses, where possible, on preventing future child deaths.