Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 27 May 2026

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Title:	**Learning From Deaths Report – Quarter 3 2025/26**

Status:	**For Information**
History:	**Quarterly reporting**

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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This paper summarises key learning identified in mortality reviews completed for Quarter 3 of 2025/26; the latest available Dr Foster Intelligence mortality data; and provides assurance on the actions taken in relation to any highlighted concerns.
2. During Quarter 3 of 2025/26 there were 701 inpatient deaths of which 694 (99%) were reviewed within the target of 8 weeks, including 333 level 2 and 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 3.
4. The Summary Hospital-level Mortality Indicator (SHMI) for October 2024 to September 2025 is 0.89 ‘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 January 2025 to December 2025 was 92 (87.7-96.5), ‘lower than expected’.

Recommendation

6. The Trust Board is asked to note the Learning from Deaths update for Quarter 3 (2025/26).

Contents

Learning From Deaths Report – Quarter 3 2025/26

1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 3 of 2025/26: October 2025 to December 2025.

1.2. This report provides a quarterly overview of Trust-level mortality data; the latest available Dr Foster Intelligence (Telstra) 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 3 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 3 of 2025/26 there were 701 inpatient deaths (source: - Divisional MRG reports). See Table 1.

Table 1: Mortality reviews completed *(source - Quarterly Divisional Mortality Reports)*

Reporting period	Total deaths	Reviews completed within 8 weeks			Total reviews completed*
		Level 1	Level 2 & SJRs	Total	
2023/24 (Q1-4)	2762	2731 (99%)	1294 (47%)	2731 (99%)	2762 (100%)
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%)**

*Including reviews completed after 8 weeks.

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

3.3. The seven remaining mortality reviews have since been completed outside the expected 8-week window.

3.4. Eight structured judgement reviews (SJR) were presented at MRG in Q3. The reasons for completing an SJR 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. At OUH MEs have been scrutinising deaths since June 2020. 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.

4.2. Statutory scrutiny of all deaths including those in Primary Care started on 9 September 2024.

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.

Quarter 3 update and progress

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

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

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. Staffing and vacancies in the ME team have been highlighted at the MRG meeting in Quarter 3. The team will continue to follow the vacancy control process. Issues around this have been escalated work remains ongoing.

4.9. The Lead ME will work with the palliative care and child mortality leads to improve rapid release of bodies and adhere to family wishes based upon faith.

5. Child death overview process (CDOP) Quarter 3 update

5.1. There was a total of 16 child deaths in OUH in Q3. A spike in the number of deaths for Q2 had been identified (see table 2). Notably this increase did not persist into Q3.

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

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

5.2.1. Excellent palliative care and post-death bereavement support supported by Charities.

5.2.2. Upholding family wishes where possible.

5.2.3. Where applicable, positive efforts made to offer survival focused care on very preterm infants.

5.2.4. Good communication with regional and national specialities to identify a metabolic disorder and in the management of children with haematological malignancy.

5.3. Key learning points include:

5.3.1. Chaplaincy should be offered for support in all cases (both emergency and ward settings). The Family Liaison Nurse role, established early in 2025, is critical for supporting long term Paediatric critical care patients.

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

5.5. Standard operating procedure required for removal of indwelling central venous catheters prior to children transferred to hospice after death. This is in progress, with an update expected at the May Mortality Review group meeting.

6. Example learning and actions from mortality reviews (adults and children) completed in Quarter 3

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 – Emergency Department (ED)	A mortality review completed by the Emergency Department suggested a trauma assessment may have been beneficial given the patient's frailty, dementia, and mechanism of injury.	Review of over 65-year-old trauma pathway underway. Case used at the 4 pm handover teaching.
MRC – Emergency Department (ED)	There were delays in initial triage and antibiotic administration in the ED.	An action plan is in place for managing sepsis in EAU and will be reviewed again. Sepsis awareness month was delivered in April 2026 in the Emergency Assessment Unit. Sepsis related data will continue to be reported monthly to the Clinical Governance Committee
MRC - Respiratory	Delayed recognition of clinical deterioration, escalation of care following confirmation of pulmonary embolism, and failures in communication and escalation processes, including radiology reporting and NEWS-based escalation.	Reinforcement of NEWS (early warning) escalation processes on the respiratory ward via teaching sessions with resus Practitioner, feedback to radiology regarding out-of-hours communication of critical results, engagement with the acute general medicine team, and targeted training for resident doctors on the management of sub-massive and massive pulmonary embolism.
SUWON Palliative Care	Use of the 'Care of the Dying Prompt' within the hospices was discussed.	Use within Katharine House to be audited and results presented at local Clinical Governance meeting.
SUWON General Surgery	Notable practice included early palliation, involvement of other teams and involvement of family regarding DNACPR and overall pathway/care. Additionally, excellent care was provided by the SEU team in relation to accommodating religious and patient specific requests.	Not applicable/good practice. Feedback has been provided to the team via local safety huddles.
NOTSSCAN Trauma	A Structured Review highlighted a delay in the administration of pain relief for a patient	Review of controlled drug stock lists with ward Pharmacist. Medicines Safety representative to be invited to monthly Mortality Review Group meetings, this

Division (Service)	Learning	Action
	admitted to the Trauma Ward (alfentanil).	will support reviews where medication has impacted patient care.
Clinical Support Services (CSS) Palliative & End-of-Life Care (EOLC)	Discussion around a case where there were differing clinical opinions on whether EOLC care was appropriate and immediate family were not available to input.	In such cases, the named consultant for the patient will make and document the final decision.
CSS Adult ICU service referrals	Three cases had concerns about the appropriateness of admission to Critical Care.	Feedback to the referring teams will be provided.

7. Impact of completed actions in Quarters 1 and 2

7.1. In MRC Division: Telemetry equipment failures meant staff could not reliably detect and document arrhythmias (consequently, ventricular tachycardia episodes were not clearly escalated). As a result, the High Care Unit telemetry upgrade has been expedited. Quarter 3 update: The upgrade of telemetry equipment has been approved, with works to commence on the 15th June and be completed by 19th June 2026. A group of Resident Doctors have presented a quality improvement project related to requiring medical sign off of all ECGs within 15 minutes to capture any abnormality noted on cardiac monitors. This has been audited after 3 months across Horton Medicine with a 70% success rate a with plans to roll out across acute general medicine at the John Radcliffe sites due to its success.

7.2. In NOTSSCaN Division: An avoidable death was reported in quarter 2 involving a knee bursitis. Two missed doses of Dalteparin were identified during the investigation process. This has prompted specific actions relating to VTE compliance across the Division. NOTSSCaN has now consistently reached 90% but not yet above target VTE compliance of 95%. Directorate level compliance is monitored at the monthly Divisional governance meetings. VTE risk assessment is a Quality Priority for 2026/27. Actions include targeted educational videos and adding a thromboprophylaxis reminder to the electronic ward white boards.

7.3. In SUWON Division: Families are sometimes unaware of the reasons behind repositioning family members during end-of-life care. To improve understanding and alleviate concerns, a patient information leaflet has been updated to address this topic.

7.4. In CSS Division: A LMDTR was conducted to review a case in which a patient died due to complications of necessary emergency surgery. The patient had a rare undiagnosed cardiac condition, and the death was deemed not avoidable. Incidental to these events, it was noted that the central venous line was 20cm long - this meant it needed to be partially inserted and then sutured at two locations to remain in the correct location. The second suture was not completed in the emergency and resulted in the line being dislodged. Availability of a shorter line would have allowed a single suture point to have been used. As a result of this, the JR now has a stock of 10cm MAC (millilumen access catheters) central lines within JR theatre 18.

8. Patient Safety Incident Investigations (PSII) of incidents resulting in death during Quarter 3

8.1. There were no new incidents with an impact of death declared as a PSII during Quarter 3 2025/26.

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

8.3. One PSII report was presented to the group in October 2025, details of this case have been previously reported in the Quarter 1 learning from deaths report - Trust Board papers for 12 November 2025 - Oxford University Hospitals.

9. National mortality benchmark data

9.1. There have been no mortality outliers reported for OUH from the Care Quality Commission (CQC) or NHS Digital during Quarter 3 2025/26.

9.2. The Summary Hospital-level Mortality Indicator (SHMI) for October 2024 to September 2025 is 0.89 ‘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.

9.3. The Trust’s HSMR+ for January 2025 to December 2025 was 92 (87.7-96.5) and banded ‘lower than expected’.

Chart 1: Rolling 12-month HSMR+

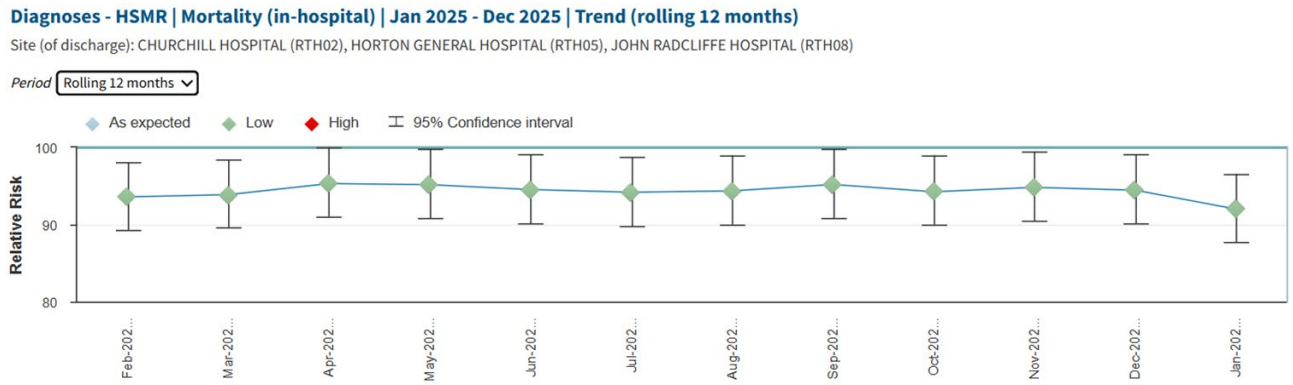
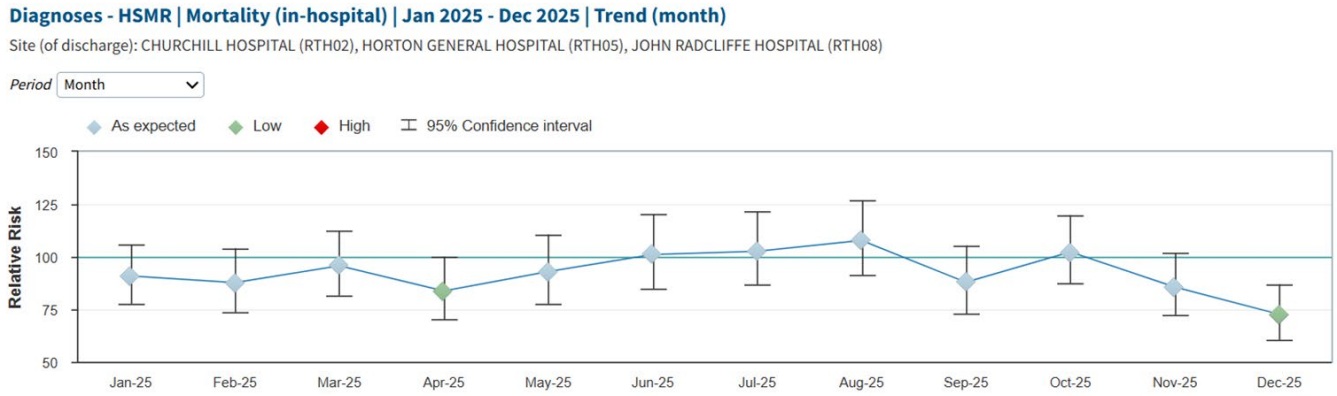


Chart 2: Non-rolling HSMR+ by month



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

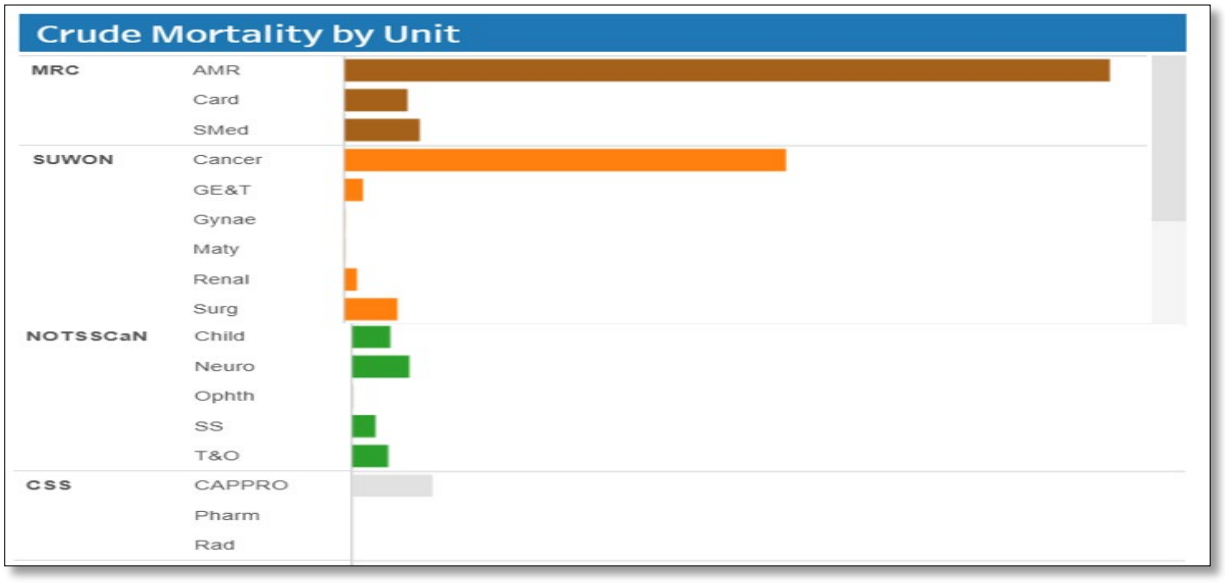
10. Detailed analysis of deaths during reporting period

10.1. 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 3 of 2025/26

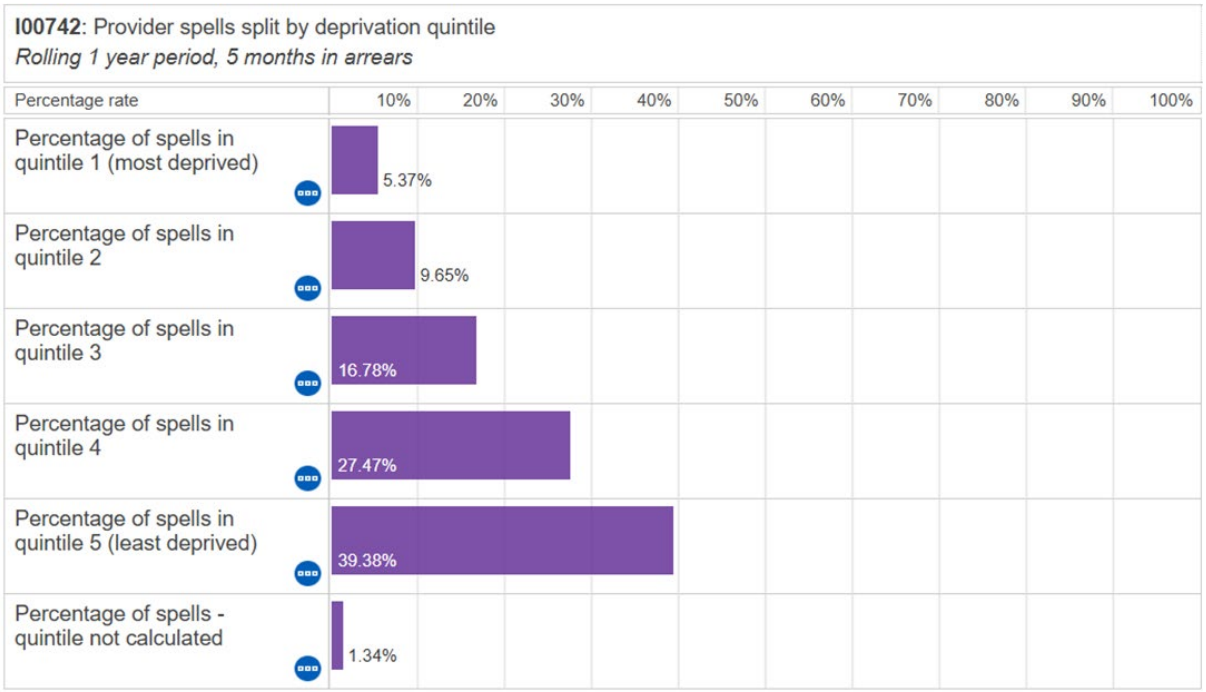
Division	Total Discharges (From Orbit)	Number of deaths (Reported to MRG)
NOTSSCAN	16,090	53
MRC	22,640	392
SUWON	19,930	215
CSS	812	41
Total	59,472	**701**

Chart 3: Deaths by Directorate (annual data)



10.2. Mortality by Index of Multiple Deprivation: Chart 5 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 5: % SHMI spells in each deprivation quintile October 2024-September 2025



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

11.1. 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

12. Recommendation

12.1. The Trust Board is asked to note the Learning from Deaths update for Quarter 3 (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
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: 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.