Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

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Title:	**Learning From Deaths Report – Quarter 1 2026/27**

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Confidential:	**No**
Strategic Pillar:	**Patients**

Executive Summary

1. There were 571 inpatient deaths during Quarter 1 of 2026/27.
2. Mortality review compliance remained high, and actions have been taken in response to identified concerns.
3. No avoidable deaths were identified in Quarter 1 of 2026/27.
4. Two investigations relating to deaths remain ongoing and their findings will be reported when concluded.
5. The latest mortality indicators remain favourable. SHMI was 0.91, “as expected”, for April 2025 to March 2026, with no published diagnosis groups statistically higher than expected. HSMR+ was 94.8 for July 2025 to June 2026 and was rated “lower than expected”.
6. The absence of avoidable deaths and the stable or favourable SHMI and HSMR+ positions provide assurance that there is no evidence of an emerging Trust-wide mortality concern.
7. Actions arising from mortality reviews continue to be monitored through the established mortality governance process.

Recommendation

8. The Trust Board is asked to note the Learning from Deaths update for Quarter 1 2026/27.

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Learning From Deaths Report – Quarter 1 2026/27

1. Purpose

1.1. This paper summarises the key learning identified in the mortality reviews completed for Quarter 1 of 2026/27: April 2026 to June 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.

3. Mortality reviews during Quarter 1 of 2026/27

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

3.2. During Quarter 1 of 2026/27 there were 571 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 (Q1-4)	2670	2080 (78%)	1191 (45%)	2646 (99%)	2670 (100%)
2026/27 (Q1)	571	513 (90%)	253 (44%)	559 (98%)	571 (100%)

*Including reviews completed after 8 weeks.

3.3. 16 structured judgement reviews (SJR) were completed and presented to MRG in Q1. The reasons for the SJRs presented to MRG included:

- Death of individuals with a learning disability (6 reviews).
- Concerns raised by staff or families (7 reviews).
- A Coroner's Inquest into a death (3 reviews).

4. The Medical Examiner (ME) system

Background

4.1. 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.

4.2. 100% of Trust deaths were reviewed by the ME in Q1.

4.3. 100% of adult Hospice deaths were reviewed by the ME in Q1.

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

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

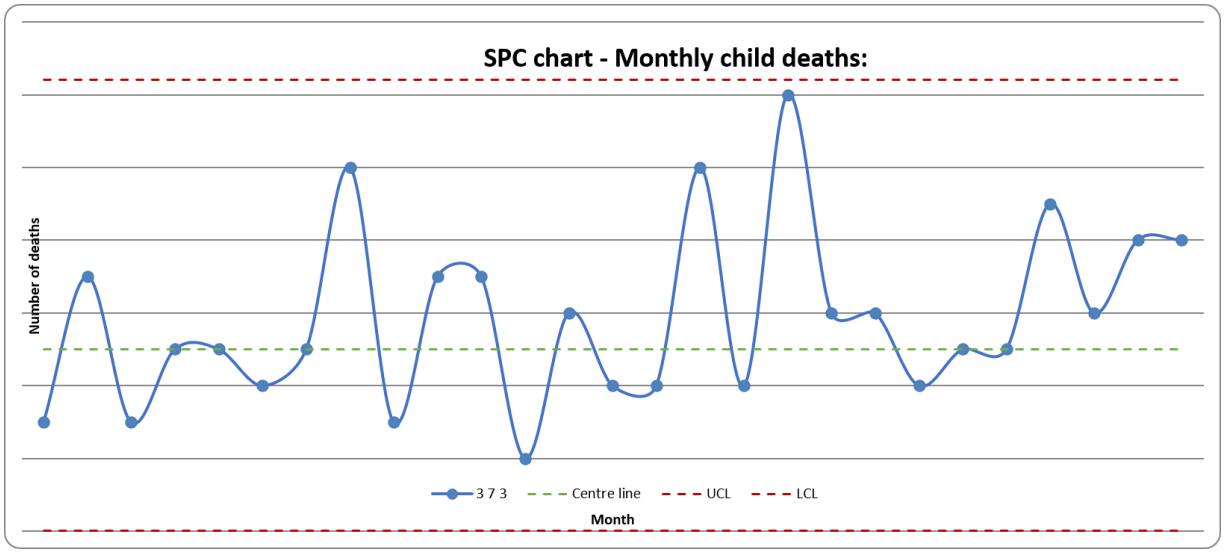
Quarter 1 update:

4.6. Work is now underway to explore the use of an online method of reporting of Medical Examiner concerns rather than via emailed forms. This will ensure timely reporting and consistent feedback of the outcome to the ME office and provide an opportunity to effectively audit feedback and report themes to MRG accordingly.

5. Child death overview process (CDOP) Quarter 1 update

Table 2 and Chart 1: Number of child deaths by Quarter from 2025 to-date and Statistical Process Control (SPC) chart:

2025-2026	**Number of child deaths**
Q1	13
Q2	27
Q3	16
Q4	18
2026-2027	**Number of child deaths**
Q1	22



5.1. There were 22 child deaths in OUH in Q1; this is similar to previous quarters apart from a spike in Q2 2025/26 (Table 2). The SPC chart demonstrates common cause variation.

5.2. This quarter included neonatal unit, delivery suite, Emergency Department (ED), paediatric critical care, Horton and JR deaths, including some unexpected infant deaths over a short period of time. The reviews into deaths this quarter did not identify any significant care concerns.

5.3. Key themes of good practice arising from the Q1 completed reviews include:

5.3.1. 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.

5.3.2. Good use of interpreters, phone transcription and online sign language interpretation were highlighted across case reviews.

5.4. Key learning points include:

5.4.1. Cases involving very premature babies required ongoing family discussions about survival-focused treatment versus comfort care. Learning included efficient drug prescribing, screening and administration, timely infectious-disease review and ensuring teams know that paediatric radiologists are available all hours.

5.4.2. Co-sleeping factors in unexpected infant deaths was noted despite documented teaching by midwives and health visitors.

5.4.3. OUH has evidence-based safer-sleep guidance and provides repeated, individualised advice to families, including specific information regarding hazardous co-sleeping circumstances.

5.4.4. This learning should therefore prompt strengthened assurance around the consistency, quality and documented understanding of safer-sleep discussions, with themes from child-death reviews monitored at MRG.

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

6. Example learning and actions from mortality reviews (adults and children) completed in Quarter 1 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 & Impact**
MRC Emergency Medicine (L2 reviews)	Action plan put in place for managing sepsis. Sepsis awareness month took place in April 2026 for all MDT members in EAU/ED. Included teaching, games, huddles, quizzes, and prizes.	Emergency care performance in prompt management of sepsis in August 2026 was excellent. All seven of seven high-risk patients (100%) received antibiotics within one hour. The moderate-risk cohort also achieved 100% compliance, with no delays recorded. **Impact**: An increase in performance has been observed in management of moderate-risk sepsis, with 100% of patients being treated on time. Monthly Divisional; monitoring continues. A further awareness month is planned in December 2026.
SUWON Oncology (L2 reviews)	Three Level 2 mortality reviews highlighted cases involving escalation in response to Track and Trigger scores, complex family dynamics and recurrent complications associated with Naso jejunal (NJ) tube management.	Action: Learning and actions include the appropriate escalation of care in relation to physiological deterioration; improved approach to complex family dynamics; the need for robust management pathways for recurrent NJ tube complications and earlier palliative care referral where appropriate. **Implemented** the Division continues to promote the Track and Trigger process review and NJ insertion pathways with Interventional Radiology, improving quality of care and outcomes.
SUWON SJR	Transfusion-Associated Circulatory Overload (TACO) Case: The case of a 79-year-old	The reviewer described educational interventions, updates to induction materials, and compliance audits to improve transfusion practice.

Division (Service)	Learning	Action & Impact
	man who died from TACO following a transfusion.	**Impact:** The transfusion team has reviewed the EPR alert thresholds to prevent inappropriate bypassing of TACO risk assessments greatly reducing the risk.
NOTSSCAN Division wide	More focused and tailored care for medical outliers.	The Division is developing a standard operating procedure to strengthen the care of medical outlier patients following incidents involving medical outliers. **Proposed impact**: Improved care and outcomes for medical outliers, reduction in harm incidents.
Clinical Support Services (CSS) Psychological medicine L2 review	A case was reviewed and discussed where a 19-year-old patient with a history of self-harm was discharged with referral to local mental health services, but this was rejected without a different provision in place. The patient later died by suicide.	**Implemented:** All psychological medicine assessments now include a mental state examination of a range and depth proportionate to the risks. A further learning point agreed was that where self-harm is present and is particularly severe, consideration must be given to obtaining collateral information from a patient's family/next of kin. Evaluation of impact of these measures awaited.

7. Broader learning themes, actions and impact in Quarter 1

Theme / domains	Learning Identified	Actions Agreed / Implemented / Impact
Documentation and handover	Documentation clarity and handover between teams could be improved. Reliance on addendums should be reduced and issue lists kept up to date. Consideration should be given to reviewing anticoagulation more systematically.	Action: Explore digital options (e.g. smart alerts) for anticoagulation review; share learning through Acute General Medicine and Geriatric governance forums.
Paediatric Haematology & Oncology - Varicella Infection	A significant infection reinforced the importance of sibling vaccination for vulnerable patients.	Action: Support and promote vaccination processes in line with national immunisation rollout.

Paediatric Haematology & Oncology - Genetic Testing Delays	Missing genetic testing led to excessive treatment toxicity.	Action: Mandatory testing embedded within EPR care sets. Impact: External laboratory turnaround reduced to 10 days; Implemented: Prescribing system amended to prevent chemotherapy dosing without results.
Paediatric Haematology & Oncology - Resistant Infections	Multi-resistant Pseudomonas infections were associated with rapid deterioration.	Action: Higher dose meropenem adopted when escalation required; earlier aminoglycoside use supported by genetic testing; regular MDT reviews established with Infectious Diseases and PICU teams.
Medical Rehabilitation & Community (MRC) Quarterly Review	Learning themes centred on communication quality and recognition of patient deterioration.	Action: Continued focus on improving communication and escalation practices within mortality reviews.
CSS Division Quarterly Review	Key learning related to end-of-life decision making, appropriateness of tertiary transfers, maintaining objectivity when caring for colleagues, and challenges obtaining coronial/post-mortem information.	Action: Highlighted need for improved access to coronial and post-mortem information. Implemented: Key Divisional team members now included in Bereavement team reports. Division can request PM reports directly via the coroner's office. Impact: Key mortality related information available earlier in the process has supported more efficient reviews.
SUWON Quarterly Review	Learning themes included communication, coordination between oncology and palliative care pathways, and handover clarity.	Action: Ongoing focus on pathway coordination and handover improvement.
Coroner Communication Process	Difficulties obtaining post-mortem reports were affecting	Acton: Clinical Outcomes Manager to explore improved

	learning from deaths processes.	processes for obtaining coronial information. Implemented: Process now in place to request postmortem reports directly from the Coroner when required.

8. Patient Safety Incident Investigations (PSII) of incidents resulting in death during Quarter 1

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

8.2. There were two new incidents with an impact of death declared as a PSII during Quarter 1 2026/27.

8.3. The first relates to a baby born in poor condition who died after admission to intensive care.

8.4. The second relates to a child who died in theatre from an upper gastrointestinal bleed.

8.5. Learning from these investigations will be included in future reports when concluded.

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 1 2026/27.

9.2. The Summary Hospital-level Mortality Indicator (SHMI) for April 2025 to March 2026 is 0.91 ‘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 July 2025 to June 2026 was 94.8 (90.2-99.5) and banded ‘lower than expected’.

Chart 2: Rolling 12-month HSMR+

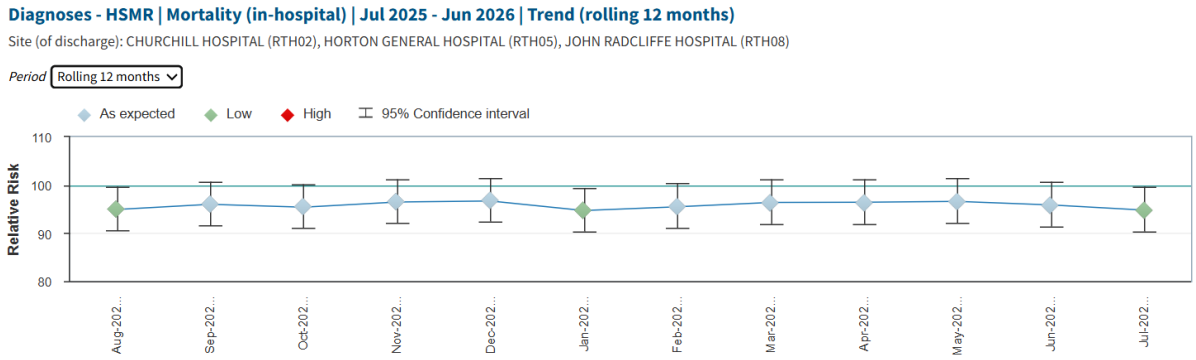
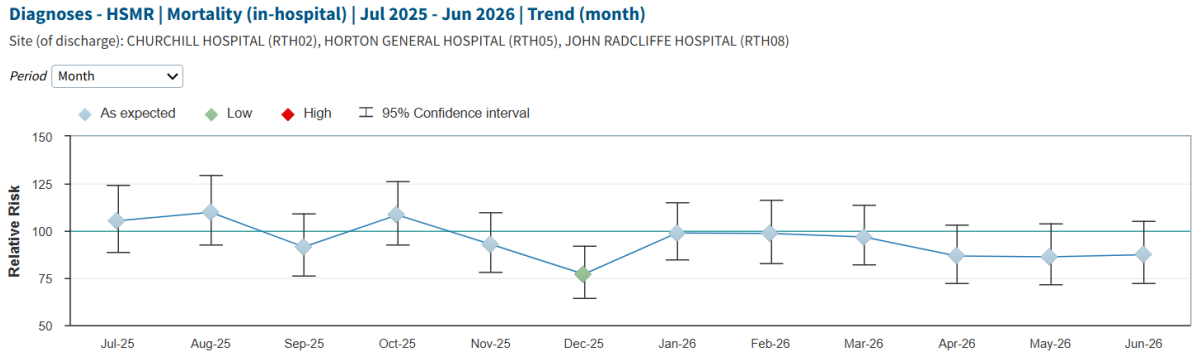


Chart 3: Non-rolling HSMR+ by month



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

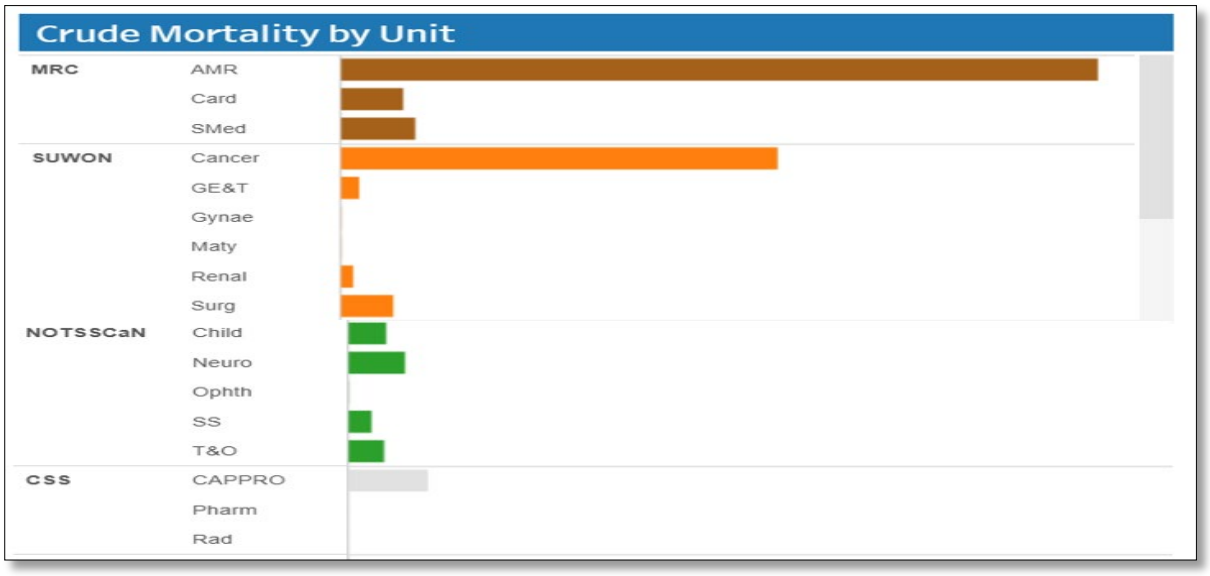
10. Detailed analysis of deaths during reporting period

10.1. The highest number of deaths occurred 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. Acute General Medicine and Geratology sit within this Directorate and care for sick and elderly patients.

Table 4: Crude mortality by Clinical Division, Quarter 1 of 2026/27

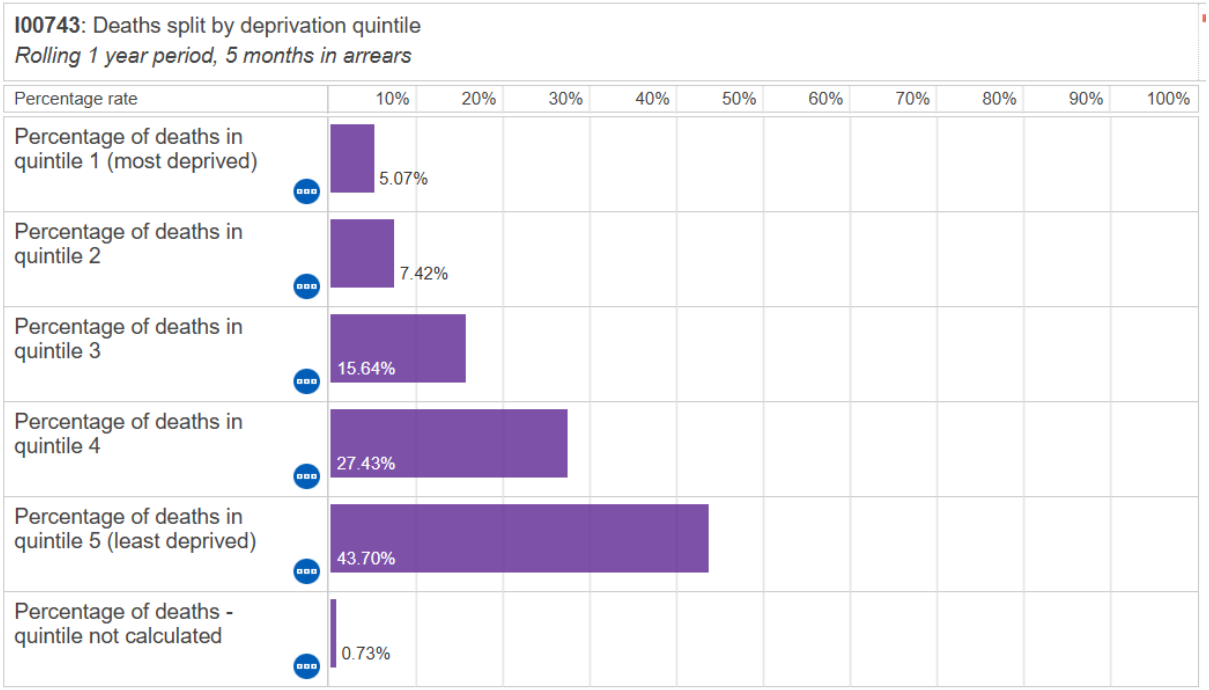
Division	Number of deaths (Reported to MRG)
NOTSSCAN	48
MRC	318
SUWON	178
CSS	27
Total	**571**

Chart 4: 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:



10.2. Mortality by Index of Multiple Deprivation: Chart 4 displays the percentage breakdown of deaths by Index of Multiple Deprivation quintile. This pattern is in line with previous LFD reports. This chart demonstrates a greater proportion of deaths occurred in patient's resident in the less deprived quintiles. Detailed interpretation of this data is difficult without adjusting for confounders such as age, case mix, admission volume or other cofounders and should not be interpreted as a comparison of mortality risk between deprivation groups.

Chart 5: % SHMI deaths in each deprivation quintile April 2025- March 2026



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 1 2026/27.

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: 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[1] 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.

9. 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.
10. The Trust Mortality Review policy requires that all inpatient deaths are reviewed within 8 weeks of the death occurring.
11. 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.
12. 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.
13. 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).
14. 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).

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

15. 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

16. 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*).
17. 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).
18. 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.