NHS
East Suffolk and North Essex
NHS Foundation Trust

Board of Directors

Report Summary

Date of meeting: 7 May 2026	
Title of Document: Learning from Deaths, Quarterly Report	
To be presented by **Dr A Tillett, Chief Medical Officer**	**Author:** Julie Sage (QI Officer & Data Analyst)
1. Status: For Assurance	
2. Purpose: To provide data around national and Trust mortality trends, benchmarked mortality data, and examples of projects and initiatives which positively impact patient care.	
Relates to:	
Strategic Objective	Include the relevant objective/all – • **Improving health:** not just treating illness, moving from treatment to prevention. • **Joined up care:** integration and community-based delivery. • **Excellent care:** improved outcomes, increasing personalisation and co-production. • **Developing staff:** supporting our teams and building for the future. • **Using technology to improve care:** digital, technology and innovation – shifting from analogue to digital care.
Operational performance	NA
Quality and equality impact	Although deaths account for less than 1.3% of admitted and day-case activity, the learning that arises from reflective practice supports some of the work around safe and effective care delivery for the remaining 98.7%.
Legal, Regulatory, Audit	Child Death Overview Panel, The Health Services Safety Investigations Body and the National Medical Examiner System.
Finance	Failure to learn from deaths and patient care will increase the risk of litigation.
Governance	Learning from deaths occurs at multiple levels across the trust through governance structures. These include team huddles at ward level, service mortality and morbidity meetings and further triangulation and escalation in patient safety forums.
NHS policy/public consultation	The Trust complies with the National Quality Board Learning from Deaths Guidance, LeDeR, MBRRACE, the Child Death Overview Panel, The Health Services Safety Investigations Body and the National Medical Examiner System.
Accreditation/Inspection	NA
Anchor institutions	NA

ICS/ICB/Alliance	
Board Assurance Framework (BAF) Risk	
Other	

Summary

The MBRRACE UK perinatal mortality report, 2024 births, identified mortality rates that were more than 5% higher than the average for similar Trusts & Health Boards, in five of the six reported categories. All cases had been reviewed in detail including external reviewers in the process and the perinatal mortality position reflects population risk and case complexity rather than systemic failure, with no consistent themes identified to suggest underlying safety concerns.

Stillbirths

The Trust was rated “average for similar Trusts & Health Boards”, and marginally above average where deaths associated with congenital abnormalities were removed. Trend data demonstrated a stable position for both stillbirth numbers and rates.

- Key themes identified include:
- Maternal risk factors: Higher rates associated with BMI >35, maternal age 36–40, deprivation and Asian ethnicity
- Only a small proportion of cases identified care issues that may have contributed to the outcome, and none were considered likely to have changed the outcome. There were no consistent clinical themes indicating systemic failure.

Next steps

- Improvement in term outcomes - stillbirths ≥37 weeks have reduced to the lowest level in five years, likely reflecting improved clinical pathways such as earlier induction, focus on foetal movements and growth. Focused areas of work on encouraging early booking, healthy weight advice for subsequent pregnancies,

Neonatal Deaths

There was an increase in the number of neonatal deaths from 5 in 2023 to 11 in 2024. This resulted in a stabilised adjusted rate of 1.29 per 1,000 live births, compared to a peer group average of 1.04. The Trust’s overall position was reported as “outside the expected range.”

- A significant proportion of deaths occurred in very high-risk groups, particularly extreme preterm infants (<27 weeks gestation), which accounted for over half of preterm-related deaths. 27% were related to congenital anomalies,
- Key learning themes included:
- Recognition and optimisation of preterm labour
- Use of appropriate translation services
- Improved documentation and delivery of neonatal resuscitation
- Importance of face-to-face postnatal review for early identification of deterioration

Next steps

The key areas identified for further focus in 2026 are improving ‘Right Place of Birth’ for extremely preterm infants and strengthening optimisation of preterm care pathways. These are recognised national priorities and are likely to have the greatest impact on reducing neonatal mortality going forward.

Trust Mortality data

National and peer benchmarking of mortality rates remain unreliable due to data upload issues arising following Epic implementation. The volumes involved mean that mortality rates from tertiary providers would not be wholly accurate. This is being urgently addressed by the Business Informatics teams. Oversight of mortality rates within the trust is maintained through weekly monitoring of deaths, close working with the Medical Examiner teams and triangulation with patient safety incident reporting. The Trust mortality rates in March are below seasonal norms compared to the past 5 years.

The National Learning from deaths dashboard continues to be used at present but may well be reviewed with the changes in National Oversight Framework.

Key learning from the Learning from deaths group includes:

- Prevention of Future Deaths notice issued following withdrawal of treatment where reassessment and communication with patient and family was insufficient.
- Learning identified and actions taken.
- Guidance updated to stipulate that discussion must be had with a Consultant or senior resident of suitable experience and recommendation of wider MDT discussion. Potentially reversible deterioration causes must be considered and documented.
- Individual Care Plan of Last Days of Life (ICPLDL) on Epic updated to reflect wording and to make it easier to record who has been involved in the discussion
- End Of Life policy updated to include recognising dying and ICPLDL
- Update e-learning in near future
- New guidance to be developed for Care in the Last Days of Life
- Training delivered regarding Mental Capacity Act and Lasting Power of Attorney

4. Recommendations / Actions

The Board is invited to note the key mortality indicators and learning from MBRACE report and Trust wide Learning From Deaths Group.