East Suffolk and North Essex NHS Foundation Trust

Board

Report Summary

Date of meeting: Thursday 3rd September 2026	
Title of Document: **2.9 Annual Mortality Report 2025/6 and Learning from Deaths Update**	
To be presented by: Dr Angela Tillett, CMO	**Author:** Julie Sage (QI Officer & Data Analyst) and Dr Dan Coates, AMD Patient Safety
1. Status: Discussion/Information	
2. Purpose: To provide data around national and Trust mortality trends, benchmarked mortality data (SHMI), issues contributing to differing health outcomes 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	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%.
Quality and equality impact	Examples of projects and staff training in the report support the Trust's commitment to improve the quality of care for our patients (Quality Strategy) and deliver the Trust's ambition to offer the best care and experience and to increase equity in health outcomes.
Legal, Regulatory, Audit	N/A
Finance	N/A
Governance	Trust policy is clearly defined, but executed with varying success.
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	Compliance with the mortality review process is reported in the accountability framework. Poorly completed reviews are escalated to clinical leads.
Anchor institutions	N/A
ICS/ICB/Alliance	Information is shared at the ICB Learning from Deaths Fora for

	NHS Essex and NHS Norfolk and Suffolk.
Board Assurance Framework (BAF) Risk	BAF1 - Partnership working. BAF4 - Quality assurance mechanisms regarding the quality and safety of patient services.
Other	

3. Summary:

Annual Mortality Report

Deprivation and health literacy remain key drivers in patient mortality. Comparing deprivation rates by postcode with admission outcome, the range for people using ESNEFT services is from 0.2 to 5.4/1000 population, depending on where the patient lives. Supporting patients in taking responsibility for their health will reduce mortality in the long term by ensuring that signs and symptoms are acted on before disease progression occurs and becomes untreatable. It is reassuring to see that recent data released by the Department of Health & Social Care indicates improvements in all-cause mortality in both East Suffolk and Tendring, based on the last 5 points; suggesting that improvement work across the health economy is having a positive impact.

The work being done by ESNEFT as part of the Clinical Strategy to support people in managing their own health and wellbeing is also a key driver in making the best use of health resources.

The number of deaths reduced on both acute sites in 2025/6 but the crude mortality rate increased slightly owing to a loss of discharge volume.

It was not possible to include detailed validated Dr Foster data for 2025/6 owing to data submission issues following the migration to Epic.

Learning from Deaths Update

What

Change of mortality benchmarking service from Dr Foster to CHKS.

So What

Data have been submitted, starting with training environment data and then live and legacy data (A&E, ECDS, Admitted Patient Care and Outpatient). Patient identifiers (RGQ/D) have been merged with MRN to facilitate continuity of encounter reporting. The ESNEFT Head of Data Engineering & Core Reporting (Business Informatics), commented on the excellent customer service provided by CHKS - timely data validation checks with reports that quickly identify data anomalies. This was never provided by Dr Foster. This will significantly aid the timely and accurate submission of data to HES.

What next

The Trust should be able to see benchmarked data in a short while. As well as HSMR/SMR and SHMI, CHKS provides its own nationally benchmarked algorithm which includes the impact of LoS (hospital deconditioning/iatrogenic harm) as a mortality risk.

What

Recent increases in perinatal mortality have now returned to rates below national benchmarks. There are ongoing issues with the way that infant deaths are recorded in Epic. Governance managers are having to compare mortuary reports with Epic records in order to provide assurance around the number of deaths and gestation of the baby. It is not currently possible to correct the mis-recording on Epic.

So what

All infant deaths are scrutinised by an MDT in collaboration with the baby's parents. Immediate learning is shared with the team. Detailed perinatal mortality spreadsheets are being maintained until there is an Epic resolution.

What next

Eventually, it will be possible to provide Epic infant mortality reports. Until then, the team will continue to manually cross check and validate data for reporting.

What

Data published 13/8/2026 for SHMI data to March 2026 identifies Colchester Hospital as having a 'higher than expected' SHMI. This is, in part, due to data losses.

So what

Colchester's SHMI has been 'as expected' since April 2019.

What next

It is not possible to determine at this stage how accurate this figure is, i.e. to what extent the inclusion of same day emergency care was masking a 'mortality issue', against the loss of data submitted to HES owing to gender mapping issues and volume lost for patients admitted to a deep ward from SDEC.

4. Recommendations / Actions