Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 23 November 2025

Learning from Deaths/Mortality report

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each trust to collect and publish specified information on a quarterly basis. This report covers the period 1 April 2025 to 30 June 2025. The Board of Directors is requested to accept this Mortality Report as assurance of the Trust's approach and agree for the report to be published on the Trust's website as per national guidance.

Executive Summary

The Trust received 498 death notifications of patients who had been in contact with our services in the last year. There is very little variation between male and female deaths; 264 male deaths were reported, compared to 234 females.

There have been seven Learning Disability deaths in the reporting timeframe, one of which relate to patient with a diagnosis of autism.

There has been one inpatient Suspected Suicide of a patient reported as missing from the ward.

The Trust commissioned seven Learning Responses surrounding deaths through Case Record Review. There were four Patient Safety Incident Investigations commissioned, all of which are ongoing. Learning emerging from Case Record Reviews and Patient Safety Incident Investigations (PSII) raises themes in relation to:

Risk Management, comprehensive risk assessments being completed/reviewed to reflect needs, are individualised and holistic

Communication and Teamwork, need to enhance communication between multi-disciplinary teams (MDTs) and the importance of open and transparent communication with patients and families

Supporting staff with complex case management particularly around safeguarding, risk management and clinical decision-making in complex cases

Patient Safety and Incident Reporting, developing a culture of openness, where incidents, near misses and concerns are reported, managed and responded to, to support the dissemination of learning.

The newly-established Learning the Lessons Oversight Committee will hold oversight for actions resulting from Learning Responses, quality improvement plans, early learning and thematic analysis of incidents including deaths supported by subgroups within each service to improve ownership, accountability, joined up working.

Medical Examiner Officers have been established in all Acute trusts in England with their role extended to community deaths not referred to the coroners, to provide independent scrutiny. There is an agreement in place for cause of death information to be released to the Trust Patient Safety team for patients open to our service (six months prior to death) with the University Hospitals of Derby and Burton and Chesterfield Royal Hospital. This has been impacted by technical issues and a shortage of medical examiners. The Trust will continue to meet with Medical Examiners to improve this access and put into place a formal agreement.

Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.

A process has been implemented within the Electronic Patient Record, which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths Guidance in that all deaths are considered for red flags.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

This report provides limited assurance to the Quality and Safeguarding Committee that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths.

Consultation

This report has been reviewed by the Medical Director, the Executive Incident Review Group membership and the Quality and Safeguarding Committee.

Governance or Legal Issues

There are no legal issues arising from this report.

The Care Quality Commission Regulations - this report provides assurance as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Duty of Candour (Regulation 20).

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

- Between 1 April 2025 to 30 June 2025, there was very little variation between male and female deaths; 264 male deaths were reported, compared to 234 female deaths
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

The Board of Directors is requested to accept this report with limited assurance of the Trust's approach and agree for the report to be published on the Trust's website as per national guidance.

Report presented by: **Lynn Andrews**
Chair, Quality and Safeguarding Committee

Report prepared by: **Rachel Williams**
Lead Professional for Patient Safety

Louise Hamilton
Safer Care Co-ordinator

Davinia Connelly
Operational Patient Safety Manager

Learning from Deaths/Mortality report (quarterly)

1. Background

In line with the Care Quality Commission's (CQC) recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a framework for NHS Trusts - 'National Guidance on Learning from Deaths'. The purpose of the framework is to introduce a more standardised approach to the way NHS trusts report, investigate, and learn from patient deaths, which should lead to better quality investigations and improved embedded learning. To date, the Trust has met all the required guidelines.

The report presents the data for 1 April 2025 to 30 June 2025.

2. Current Position and Progress

- Cause of death information is currently being sought through the Coroner offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available
- Medical Examiner Officers at acute trusts provide independent scrutiny of non-coronial deaths, including those in the community. Medical Examiners are senior doctors from a range of specialties, including general practice, who provide independent scrutiny of deaths not taken at the outset for coroner investigation. They carry out a proportionate review of medical records and liaise with doctors completing the Medical Certificate of Cause of Death (MCCD). They give families and next of kin an opportunity to ask questions and raise concerns. There is an agreement in place for cause of death information to be released to the Trust's Patient Safety team for patients open to our service in the six months prior to their death. This agreement is in place with the University Hospitals of Derby and Burton and Chesterfield Royal Hospital, via working relationships between the corresponding Patient Safety teams. This has been slow to come into force due to numerous technical issues with the various EPR systems and a shortage of Medical Examiners. The Trust will continue to meet with Medical Examiners to improve this access and put into place a formal agreement
- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary amendments made. This has included auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed 7 August 2025
- A process has been implemented within the Electronic Patient Record, which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for red flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release capacity within the service to re-deploy into other priorities, such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services ensuring better sharing of information and identification of priorities for both services
- In line with changes being made to the assurance and oversight of learning post-incident, the Trust Mortality Committee was replaced with the Learning the Lessons Oversight Committee. This Committee will have oversight and governance responsibility for incidents which include Mortality red flags and be responsible for overseeing the dissemination of learning post-incident. The Committee will work with service line Learning the Lessons groups to develop and drive forward quality improvement programmes across the Trust. Further resource and prioritisation is required to support implementation
- We are in the process of re-establishing the Regional Mortality Review Networking Group at DHcFT. Prior to the COVID-19 pandemic, we were active members of this group, which provided a valuable forum for shared learning and collaboration across organisations. As the group has not met for some time, we are taking steps to restart it and will be inviting colleagues from Leicester Partnership Trust (LPT), Coventry, Nottinghamshire, and other Midlands-based mental health trusts. The aim is to strengthen regional links, share learning from mortality reviews, and support continuous improvement in patient safety
- We are developing an Incident Review Tool (IRT) Audit Group to strengthen our approach to incident learning under the Patient Safety Incident Response Framework (PSIRF). The purpose of the group will be to ensure that outcomes from incident reviews are being shared appropriately, learning is effectively disseminated across services, and that there is alignment between the IRT process and the broader PSIRF requirements. This will support improved consistency, transparency, and assurance that learning from incidents is fully embedded into practice

- Following release of the Annual Learning from Deaths report 2024/25, an error was identified in the reported number of Talking Mental Health Derbyshire (TMHD) deaths. The report initially showed **27 cases**, however, this was incorrect due to a system issue which was not correctly filtering deaths by the team the individual was under at the time of death. A review was undertaken by the Patient Safety team, with support from IT and the database lead, to re-check each case. This confirmed that the actual figure was **18 cases**, not 27. Of these, **one case** met the Trust's red flag criteria and was reported via Datix. The system error that caused the incorrect figure has since been fixed, ensuring that future data pulls will display the correct information. Work is ongoing with the Records Team to confirm further details where possible (eg cause of death), but assurance has been given that the overall figure and reporting process are now accurate.

  As it stands, there have been **19 Improving Access to Physical Therapies (IAPT) deaths** (including one newly reported case during the previous reporting period).

  Two cases have been referred to the coroner, one case has been to inquest with a confirmed Narrative Conclusion - death was due to a combination of traumatic injury secondary to recurrent falls and alcoholic ketoacidosis secondary to significant and excessive alcohol consumption, the second case is awaiting on an inquest hearing to be listed.

  We have received **cause of death (CoD)** information for **13 deaths**, all of which were confirmed as natural causes.

  CoD is still awaited for **three deaths**.

3. Data Summary of all Deaths

Note that Inpatient and Learning Disability (LD) data is based upon whether the patient has an open Inpatient or LD referral at time of death.

The following table outlines information from 1 April 2025 to 30 June 2025:

	Apr	May	Jun
Total Deaths Per Month	167	177	154
LD Referral Deaths	3	1	3

Correct as at 6 August 2025.

Between 1 April 2025 and 30 June 2025, the Trust received 498 death notifications of patients who had been in contact with our services. Of these deaths, 264 patients were male, 234 female, 395 were white British and nine Asian British. The youngest age was zero years, the oldest age recorded was 102. The Trust has reported seven Learning Disability deaths in the reporting timeframe and one death of a patient with a diagnosis of autism.

4. Review of Deaths

Total number of deaths between 1 April 2025 and 30 June 2025 reported on Datix.	50 "Unexpected deaths" 11 "Suspected Suicide deaths" 7 "Expected - end of life pathway" NB some expected deaths have been rejected so these incidents are not included in the above figure. One patient died off the ward whilst an inpatient due to a suspected suicide. *W108844*
Incidents assigned for a review.	57 incidents assigned to the Operational Incident Group. One incident to be confirmed.

Only deaths which meet the criteria below should be reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Incident Reporting and Investigation Policy and Procedure.*

Any patient, open to services within the last six months, who has died and meets the following:

- Homicide – perpetrator or victim
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHcFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLS) authorisation
- Death of patient following absconsion from an Inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family/carer the Ombudsman or where staff have raised a significant concern about the quality-of-care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroner's Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient, whether they were open to the Trust at time of death or not
- Death of a patient with autism
- Death of a patient who had a diagnosis of psychosis within the last episode of care
- Death of a patient who had a diagnosis of an eating disorder within the last episode of care or within six months of discharge
- Death of a patient open to Crisis Home Resolution team or equivalent at the time of death.

5. Inpatient Deaths

There has been one Inpatient death for the period, which relates to a male patient who had left the ward and was reported missing. This death is categorised as a 'Suspected Suicide' and is subject to full Patient Safety Incident Investigation, which is being undertaken by an external company commissioned by the Trust.

6. Learning Responses for 2023/24, 2024/25 and 2025/26

The table below outlines the number of deaths that have been recorded through the Trust incident reporting system Datix and the learning response that has been commissioned. All deaths reported through the Datix system meeting the Trust 'red flag' will have an Incident Review Tool completed. This is then reviewed and a decision made as to whether a further Learning Response is required.

Financial Year	Datix	Case Record Review	Patient Safety Incident Investigation
2023/24	119 deaths	39	16
2024/25	141 deaths	23	3
2025/26	68 deaths	7	4

Please note: 57 deaths are currently awaiting a decision.

7. Duty of Candour (DoC) for 1 April 2025 to 30 June 2025

Between 1 April 2025 and 30 June 2025, there were zero deaths which met the criteria for DoC. There have been no deaths determined to be DoC for 2025/26. However, it should be noted there are Learning Responses for this period which remain active.

7. Learning from Deaths Procedure

The Trust has now completed a move in terms of its mortality process; a process has been implemented within the Electronic Patient Record which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for red flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release some capacity within the service to re-deploy into other priorities such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services, ensuring better sharing of information and identification of priorities for both services.

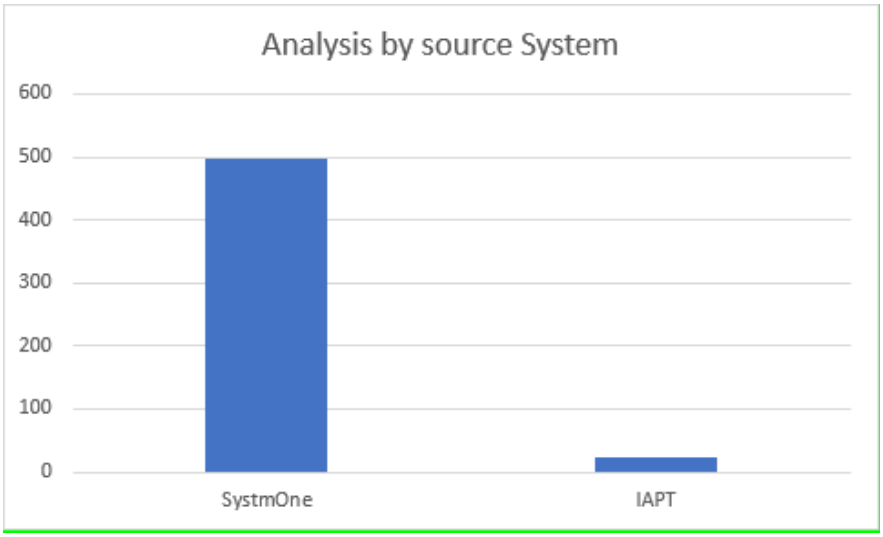
There is a process for weekly random audits of deaths against the red flags to provide assurance that the new process is working as intended.

As mentioned previously, the Patient Safety team is revising the function of its Mortality case record review process and developing an Incident Review Tool (IRT) Audit Group. All national mortality red flags now sit within the Trust's overarching red flags for the reporting of deaths as an incident. A plan has been agreed to re-appropriate the resource to strengthen our approach to incident learning under the Patient Safety Incident Response Framework (PSIRF).

The process will work to ensure that outcomes from incident reviews are being shared appropriately, learning is effectively disseminated across services, and that there is alignment between the IRT process and the broader PSIRF requirements.

8. Analysis of Data

8.1. Analysis per notification system since 1 April 2025 to 30 June 2025

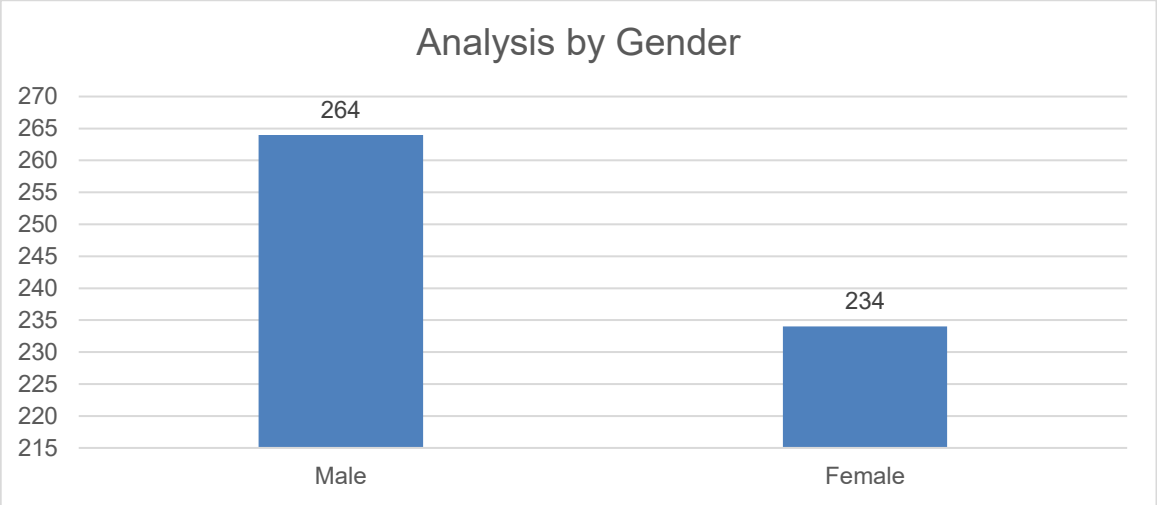


System	Number of Deaths
SystmOne	496
IAPT	22
Grand Total	**498**

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from SystmOne. This clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care.

8.2. Analysis by Gender

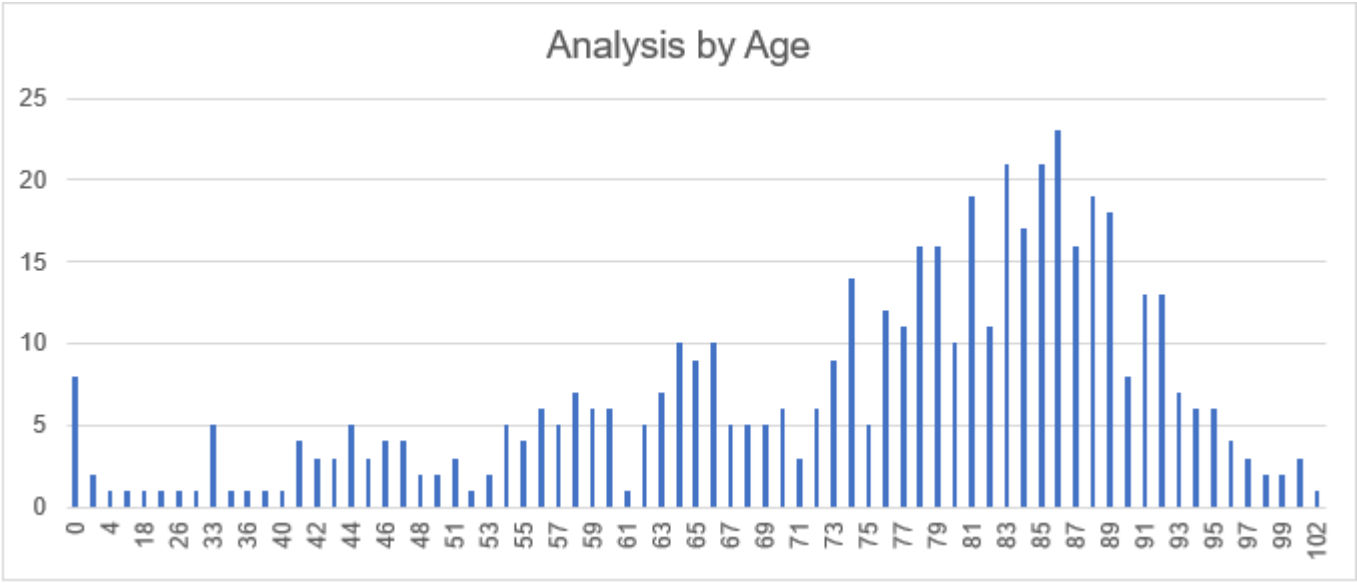
The data below shows the total number of deaths by gender 1 April 2025 to 30 June 2025. There is very little variation between male and female deaths; 234 female deaths were reported. compared to 264 males.



Gender	Number of Deaths
Male	264
Female	234
Grand Total	**498**

8.3. Analysis by Age Group

The youngest age was classed as zero, and the oldest age was 102 years. Most deaths occurred within the 78 to 89 age groups:



8.4. Learning Disability Deaths (LD)

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the LeDeR programme. Scoping is planned with operational services through their Learning the Lessons subgroups to consider the most appropriate management process for Learning Disability deaths moving forward.

	Apr	May	Jun
LD Deaths	3	1	3
Autism	0	0	1

Since 1 January 2022, the Trust has been required to report any death of a patient with autism. To date, fifteen patients have been referred.

During 1 April 2025 to 30 June 2025, the Trust has recorded seven Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this is shared in the Mortality monthly meeting.

8.5. Analysis by Ethnicity

White British is the highest recorded ethnicity group with 395 recorded deaths; 28 deaths had no recorded ethnicity assigned. The following chart outlines all ethnicity groups:

Ethnicity	Number of Deaths
White - British	395
Other Ethnic Groups - Any other ethnic group	58
Not Known	24
Asian or Asian British - Indian	7
Not stated	4
White - Any other White background	3
Black or Black British - Any other Black background	2
Mixed - White and Black Caribbean	1
Asian or Asian British - Pakistani	1
Black or Black British - Caribbean	1
Asian or Asian British - Any other Asian background	1
Mixed - Any other mixed background	1
Grand Total	**498**

8.6. Analysis by Religion

Christianity is the highest recorded religion group with 192 recorded deaths, 122 deaths had no recorded religion assigned. The chart below outlines all religion groups:

Religion	Number of Deaths
Christian	183
Not religious	140
(blank)	83
Patient religion unknown	39
Church of England, follower of	15
Christian religion	9
Church of England	7
Roman Catholic	4
Sikh	3
Catholic: non Roman Catholic	2
Atheist movement	2
Methodist	2
Pagan	2
Anglican	1
Agnostic movement	1
Atheist	1
Catholic religion	1
Buddhist	1
Protestant	1
Rastafarian movement	1
Grand Total	**498**

8.7. Analysis by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 341 recorded deaths, 153 have no recorded information available. The chart below outlines all sexual orientation groups:

Sexual Orientation	Number of Deaths
Heterosexual	341
(blank)	130
Sexual orientation not given - patient refused	12
Sexual orientation unknown	7
Not stated (person asked but declined to provide a response about their sexual orientation)	3
Homosexual	1
Unknown	1
Homosexuality NOS	1
Bisexual	1
Male homosexual	1
Grand Total	**498**

8.8. Analysis by Disability

The table below details the top eight categories by disability. Gross motor disability was the highest recorded disability group with 97 recorded deaths:

Disability	Number of Deaths
Gross motor disability	97
Disability	46
Patient reports no current disability	41
Intellectual functioning disability	19
Emotional behaviour disability	17
Hearing disability	14
Disability Questionnaire - Behavioural and Emotional	8
Disability Questionnaire - Progressive Conditions and Physical Health	7

There have been 228 deaths with a disability assigned and the remainder were blank or had no assigned disability.

9. Recommendations and Learning

There has been no marked change to the themes emerging for the reporting period. Works are required to consider the way themes are captured within the Datix system and how services access and disseminate these. It is acknowledged that improvement is needed in relation to the following areas:

Improving **Risk Management** to ensure comprehensive risk assessments are completed and reviewed which accurately reflect patient need and mitigate risk. This aligns to the development of the Trust Risk Assessment, Safety Planning and Suicide Prevention works which includes a training package and revised Suicide Prevention strategy. Works have also been initiated for a Trust wide review of the ‘rag rating’ of risk and how this is applied. This will consider national guidance and work as done within service to ensure consistent and appropriate management of risk.

Ensuring that **Care Plans** are individualized and reflect the holistic needs of patients, including their psychological, emotional and physical wellbeing.

Improving **Communication and Teamwork**, a re-occurring theme which identifies the need to enhance communication between MDTs and the importance of open and transparent communication with patients and families, particularly around critical decisions and care pathways.

Supporting Staff with complex case management by identifying gaps in training and guidance, particularly related to safeguarding, risk management, and clinical decision-making to support staff in being equipped with the skills and knowledge they need to deal with complex cases.

Patient Safety Thread and Incident Reporting, to encourage a culture of openness where all incidents, near misses, and concerns are reported and acted upon. Ensuring that incidents are appropriately managed and responded too to support the dissemination of learning to reduce risk to patients.

The table below **Themes Arising from Incident Learning Responses** provides detail in relation active works and improvement needs.

Themes arising from incident learning responses

Improvement issue	Improvement plan
Transfer, Leave and Discharge	**Transfer of the deteriorating patient** Transfer and return of patients between inpatient services for the Trust and Acute providers, including handover of information, and the way patients are conveyed. A quality improvement project was completed between Derby Hospital and DHcFT to develop a transfer and handover proforma. Further works are needed to support its implementation as this appears inconsistently used within inpatient services. The lead for this work is currently not in work and this is under re-allocation. **Self-harm of patients whilst on leave from inpatient services and Section 17 leave arrangements** Issues in relation to leave arrangements for inpatient services including follow up. A further thematic review was completed on conclusion of a cluster of inpatient suspected suicide incidents. An action plan was developed. This will require alignment to current incidents for inpatient services and allocation to an appropriate lead.
Suicide Prevention	**Suicide Prevention training** This is being led by the Trust Medical Director and has been incorporated into the new Risk Assessment, Safety Planning and Suicide Prevention training package currently being rolled out. A Trust Suicide Prevention Lead was appointed and this links into current training development as well as a review of the trust Suicide Prevention strategy.
Training and awareness of Emotionally Unstable Personality Disorder	Development of a training and awareness package for all services in relation to EUPD which is being led by the Trust Medical Director.
Multi-agency engagement following incidents	It is known that patients are often known to multiple services both internally and externally. Works have been commissioned to consider agreements needed to enhance multi-agency working with partner agencies when an incident investigation has been commissioned to improve shared learning and enhance family liaison and support.
Physical Health management within inpatient environments	The recognition of deteriorating patient (RODP) training has been embedded within the Trust level 2 and 3 resuscitation training and has been updated with Mental Health Inpatient specific scenarios, this will be rolled out across Inpatient services with learning form incidents incorporated as part of the training scenarios. In addition to this the check and challenge meetings for adult and Community performance reviews utilise the Power Bi dashboards to focus on specific health metrics for improvement, these are overseen by the Executive Director of Nursing, AHPs, Quality and Patient Experience and the Assistant Director of Practice Compliance.
MDT process improvements within CMHTs	EPR and recording documentation for MDT is in place, further works are needed to ensure its qualitive function. This is an emerging theme from current PSI investigations and an action plan will be developed.
Self-harm within inpatient environments including management of contraband	**Ligature Risk Reduction** **Structural Changes** • Refreshed ligature risk assessments across inpatient and community settings, with targeted upgrades including anti-barricade doors and door replacements • Heat maps and updated floor plans introduced to visually flag high-risk areas, now embedded into assessment workflows • New guidance and SOPs for ligature knife and scissors management implemented, including buffer stock protocols. **Governance Processes** • Ratification of updated Ligature Risk Reduction Policy and Procedure by Health and Safety Committee and CQC Oversight Group

Improvement issue	Improvement plan
	• Launch of a centralised risk assessment tool by IMT to track actions, assign ownership, and maintain audit trails • External audit by 360 Assurance completed, highlighting areas for improved socialisation and red risk resolution. **Training and Staff Awareness** • Ligature risk training embedded into staff passports and delivered via train-the-trainer model • Compliance monitored through dashboards and local audits; system notification issues under review • MDT roles clarified in policy and reinforced through training to promote shared accountability. **Contraband Management & Search Policy - Enhancements** • Clarification of Contraband Definitions: Staff guidance has been reinforced to clearly define prohibited items, including weapons, sharp objects, illicit substances, alcohol, tobacco, and non-prescribed medications • PICU-Specific Controls: The SOP for PICU outlines restricted access to personal property, cutlery tracking protocols, and airlock-controlled entry to Kingfisher House • Delivery Handling SOP: A new SOP introduces structured procedures for parcel receipt, patient consent, and lawful search and confiscation. **Search Policy updates** • Expanded Search Types: The revised policy includes detailed procedures for body, belongings, room, strip, and environmental searches, with clear guidance on consent and proportionality • Consent and Cultural Sensitivity: The policy now includes provisions for patients who may object to searches on religious or cultural grounds, and outlines gender-sensitive practices • Visitor Protocols: New guidance addresses actions when visitors are suspected of carrying dangerous or illicit items, including documentation and disposal procedures. **SOP Revisions and Governance** • Policy Communication: Despite rapid implementation, concerns were raised about consultant awareness of policy changes. A briefing was proposed to clarify roles and responsibilities across MDTs • SOP Adjustments: Updates include changes to leave arrangements and post-hospital visit protocols, reducing restrictions for patients not on red pathways • Governance Oversight: SOPs for PICU and Female Enhanced Care Unit were reviewed and aligned with mobilisation plans for new builds under the “Making Room for Dignity” programme.
Dissemination of learning and service improvements following incidents including assurance and governance	Improve the way the trust learns and improves from incidents, to include a revision to processes in place in relation to internal investigation recommendations, Case Record Review learning, Incident Review Tool learning and the revised Trust Mortality process. Develop pathway to offer clear governance processes. Embed service line learning briefings specific to service learning. Trust-wide learning the lessons to share high level responses and learning. Develop better ways for monitoring and reporting emerging themes. Joined up working between services. Improved monitoring of high-profile cases and joined up working between services involved. Development of more collaborative Learning Responses.

Improvement issue	Improvement plan
Application of red flags and flow of incidents resulting in death	Improvement in the application and identification of red flags for reporting death. Revision of current red flags for relevance given changes both nationally and locally. Redesign the function of the 'Mortality' process within structures through the Learning the Lessons subgroups. Review the purpose and function of the Mortality Case Record Review panel and redesign this to one of audit and assurance is underway. This will now act as an assurance audit over deaths closed to the Operational Incident review group and thematic analysis by service for service identified themes.
Interface between Mental Health and Substance Misuse service	Suspected Suicide of a patient who has a dual diagnosis of substance misuse and mental health but has been rejected by Community Mental Health services, is an area which has been noted through Case Record Review. This has been selected as a new local priority for the trust. Themes will be feed into Learning the Lessons subgroups for both services to jointly develop and improvement plan.
Substance Misuse services and Adult Acute Inpatient environments	Learning Responses for unexpected deaths post discharge/ whilst on leave have highlighted gaps around knowledge, support and process for the management and support of risk in relation to addiction and substance misuse. This will be a focus for the Inpatient Service Learning the Lessons process. Currently impacted by structure redevelopment.
Risk assessment, management, and care planning	Included within the Risk Assessment, Safety Planning and Suicide Prevention training package which will consist of four modules and incorporate suicide prevention. Working group established in relation to the application and effectiveness of risk 'rag rating' Trust-wide.