Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 25 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 July 2025 to 30 September 2025. The Quality and Safeguarding Committee accepted this Mortality report as assurance of the Trust's approach and agreed for the report to be considered by the Trust Board of Directors and published on the Trust's website as per national guidance.

Executive Summary

The Trust received 456 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; 242 male deaths were reported, compared to 213 females.

There have been 10 Learning Disability deaths in the reporting timeframe, one of which relate to patient with a diagnosis of autism.

There has been one inpatient unexpected death due to physical health causes.

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).

There have been 11 learning responses approved for closure. Main themes include:

- Risk Assessment and Management
- Referral and triage processes, assessment methods
- Awaiting list management
- Communication delays and gaps – internal and external
- Care planning and documentation

These areas will be reviewed through the Learning the Lessons Oversight Committee, where appropriate improvement groups will be established to oversee implementation. The Learning the Lessons Oversight Committee will hold oversight for actions resulting from Learning Responses, quality improvement plans.

The Trust Patient Safety team continues to meet with Medical Examiners to improve the flow of information in relation to cause of death.

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

The mortality process within the EPR is now established with weekly audits to review compliance.

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 provided 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 Interim Medical Director, 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 July 2025 to 30 September 2025, there was very little variation between male and female deaths; 242 male deaths were reported, compared to 213 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.

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Chair, Quality and Safeguarding Committee

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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 July 2025 to 30 September 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. 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 University Hospitals of Derby and Burton (UHDB) 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 for the varies EPR systems and a shortage of medical examiners
- Regular audits continue to be undertaken to ensure compliance with policy and procedure for the reporting of Red Flag deaths. This includes 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 is now embedded 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. procedure
- 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 Derbyshire Healthcare NHS Foundation Trust (DHcFT). 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 is 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.

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 July 2025 to 30 September 2025:

	Jul	Aug	Sep
Total Deaths Per Month	163	148	145
LD Referral Deaths	4	1	5

Correct as at 13 October 2025

Between 1 July 2025 and 30 September 2025, the Trust received 456 death notifications of patients who had been in contact with our services. Of these deaths, 242 patients were male, 213 female and one unknown gender, 365 were white British and nine Asian British. The youngest age was zero years, the oldest age recorded was 101. The Trust has reported ten 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 July 2025 and 30 September 2025 reported on Datix.	57 “Unexpected deaths” Five “Suspected Suicide deaths” Nine “Expected - end of life pathway” one death occurred on inpatient ward NB some expected deaths have been rejected so these incidents are not included in the above figure.
Incidents assigned for a review.	69 incidents assigned to the Operational Incident Group. Two incidents 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 female patient who died due to physical health causes.

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	87 deaths	12	4

Please note: 49 deaths are currently awaiting a decision.

7. Duty of Candour (DoC) for 1 July 2025 to 30 September 2025

Between 1 July 2025 and 30 September 2025, there were zero deaths which met the criteria for DoC. There have been no deaths determined to be DoC for 2025/26. One death has been identified during this financial year as DoC having occurred 2024/25; the Trust continues to support this family in engagement. It should be noted there are Learning Responses for this period which remain active and therefore, DoC figures change.

8. 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 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. Weekly random audits continue for deaths against the red flags to provide assurance that the new process is working as intended.

The Patient Safety team has been revising the function of its Mortality case record review process and developing an Incident Review Tool (IRT) Audit process which will be allocated to Medical and Nursing colleagues. All national mortality red flags sit within the Trust's overarching red flags for the reporting of deaths as an incident.

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.

9. Analysis of Data

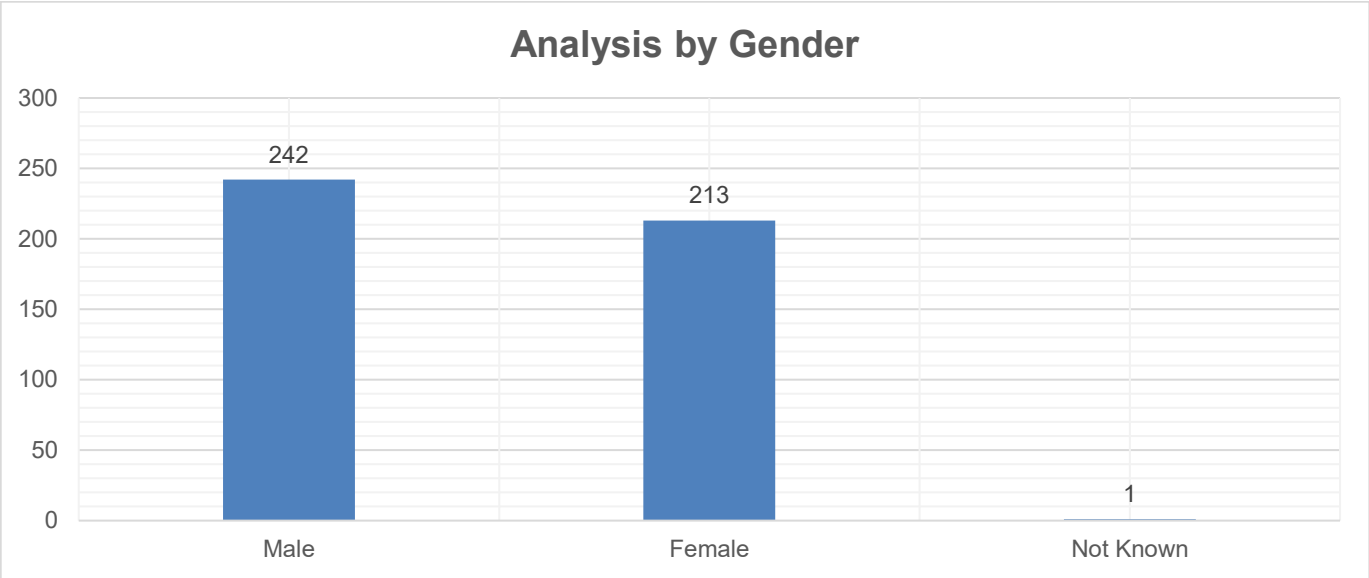
9.1. Analysis per notification system since 1 July 2025 to 30 September 2025

System	Number of Deaths
SystmOne	456
Grand Total	**456**

The data above shows the total number of deaths reported by each notification system. All of the death notifications were 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.

9.2. Analysis by Gender

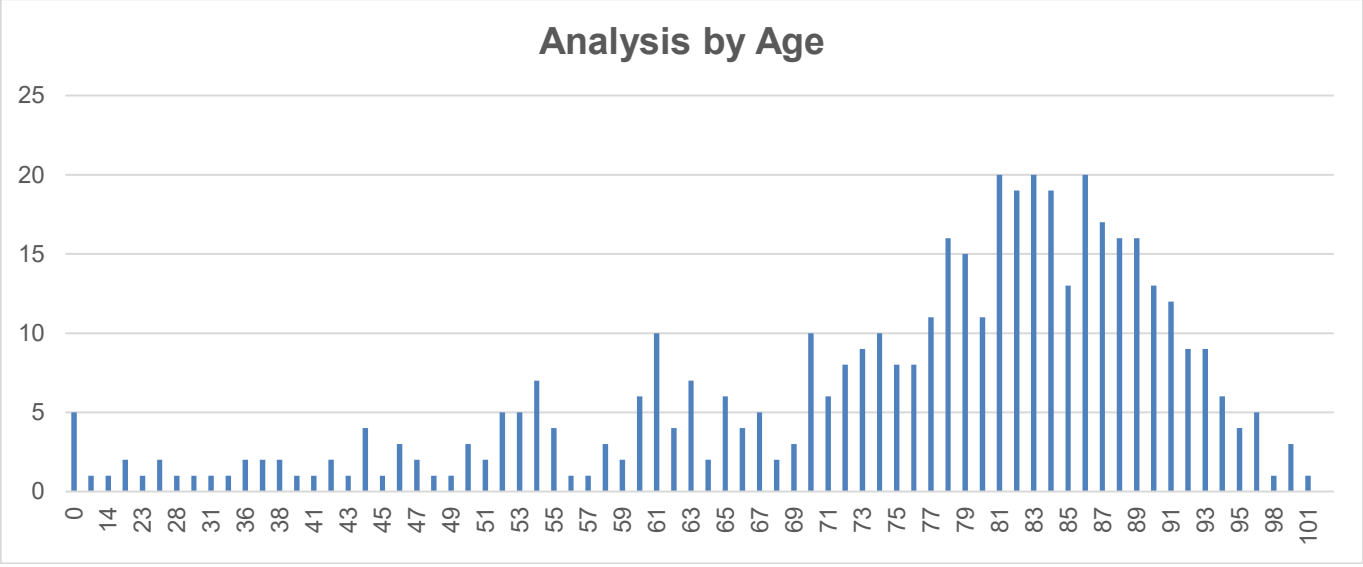
The data below shows the total number of deaths by gender 1 July 2025 to 30 September 2025. There is very little variation between male and female deaths; 213 female deaths were reported. compared to 242 males.



Gender	Number of Deaths
Male	242
Female	213
Not Known	1
Grand Total	**456**

9.3. Analysis by Age Group

The youngest age was classed as zero, and the oldest age was 101 years. Most deaths occurred within the 78 to 89 age groups:



9.4. 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.

	Jul	Aug	Sep
LD Deaths	4	1	5
Autism	0	1	0

Since 1 January 2022, the Trust has been required to report any death of a patient with autism. To date, 16 patients have been referred.

During 1 July 2025 to 30 September 2025, the Trust has recorded 10 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. Benchmarking will take place in relation to the use of DATIS to manage the reporting requirements around Learning Disability deaths.

9.5. Analysis by Ethnicity

White British is the highest recorded ethnicity group with 365 recorded deaths; 24 deaths had no recorded ethnicity assigned. The following chart outlines all ethnicity groups:

Ethnicity	Number of Deaths
White - British	365
Other Ethnic Groups - Any other ethnic group	46
Not Known	22
White - Any other White background	5
Asian or Asian British - Indian	4
White - Irish	4
Asian or Asian British - Pakistani	3
Not stated	2
Asian or Asian British - Any other Asian background	2
Mixed - Any other mixed background	1
Black or Black British - African	1
Mixed - White and Black Caribbean	1
Grand Total	**456**

9.6. Analysis by Religion

Christianity is the highest recorded religion group with 176 recorded deaths, 237 deaths had no recorded religion assigned. The chart below outlines all religion groups:

Religion	Number of Deaths
Christian	176
Not religious	130
(blank)	79
Patient religion unknown	28
Church of England	11
Church of England, follower of	11
Christian religion	7
Sikh	4
Roman Catholic	3
Muslim	3
Catholic religion	1
Methodist	1
Atheist	1
Jehovah's Witness religion	1
Grand Total	**456**

9.7. Analysis by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 326 recorded deaths, 130 have no recorded information available. The chart below outlines all sexual orientation groups:

Sexual Orientation	Number of Deaths
Heterosexual	326
(blank)	105
Sexual orientation not given - patient refused	15
Sexual orientation unknown	8
Not stated (person asked but declined to provide a response about their sexual orientation)	2
Grand Total	**456**

9.8. Analysis by Disability

The table below details the top eight categories by disability. Gross motor disability was the highest recorded disability group with 95 recorded deaths:

Disability	Number of Deaths
Gross motor disability	87
Disability	44
Intellectual functioning disability	27
Hearing disability	15
Emotional behaviour disability	10
Disability Questionnaire - Mobility and Gross Motor	8
Disability Questionnaire - Behavioural and Emotional	7
Disability Questionnaire - Progressive Conditions and Physical Health	6

There have been 220 deaths with a disability assigned and the remainder were blank or had no assigned disability.

10. Closed Learning response outcomes for the period

There have been 11 learning responses approved for closure through the Executive Incident Review group. Below are the main findings and areas for recommendation which highlight both systemic and process-level issues.

Risk Assessment and Management

Risk assessments must be dynamic and regularly updated. Every patient should have a comprehensive risk management and safety plan, including community safety strategies.

Perinatal Community Mental Health team (CMHT)

Key areas for improvement: referral and triage processes, assessment methods, waiting list management, and information sharing with GPs, professionals, families, and carers.

Falls Monitoring

Enhanced processes are in place and reviewed at multiple levels.

Recognition of Deteriorating Patients

- Ongoing work to improve training and physical health monitoring for early detection
- End-of-Life Care: Staff need further training in communication, especially for care planning and discharge.

Handover and Communication

- Handover checklists must be meaningful; communication with families requires strengthening
- Effective handovers and staff familiarity with patients
- Referrals to Substance Misuse teams where appropriate.

Care Planning and Documentation

- Some cases lacked formal Care Plans, though planning was evident in notes or letters
- Naloxone was not consistently discussed/offered for patients with substance use history
- Reasonable adjustments for neurodiverse patients were not always documented
- Use of unlicensed medicines requires better documentation and oversight.

Delays and Communication Gaps

- Delays in mental health assessments due to physical health present a risk
- Address changes, communication lapses led to missed correspondence and gaps in care.

These areas will be reviewed through the Learning the Lessons Oversight Committee, where appropriate improvement groups will be established to oversee implementation. Some main areas of focus will be:

- Managing patient consent, including for photos
- Adherence to observation and engagement policies
- Exploring methods of communication. including text messaging for appointment reminders
- CPN allocation, triage and prioritisation
- Multi-disciplinary team (MDT) functioning and recording
- Use templates to highlight risk indicators and ensure care plan consistency
- Improve processes for geographic transitions and handovers
- Ensure alerts and risk indicators are entered into electronic records.

It should be noted that some of the above will be team/service specific.