Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 21 July 2026

Learning From Deaths annual report

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each trust to collect and publish specified information on a quarterly and annual basis. This report covers the period 1 April 2025 to 31 March 2026.

The Quality and Safeguarding Committee accepted this Mortality Report as assurance of the Trust's approach and agree 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

*Generated through use of Microsoft Copilot

This annual Learning from Deaths report 2025/26 sets out Derbyshire Healthcare NHS Foundation Trust's mortality data, learning activity and improvement work for the period 1 April 2025 to 31 March 2026. The Trust reports continued compliance with national Learning from Deaths guidance and has further strengthened its governance arrangements through new Trust-wide and Care Group Learning the Lessons forums, the embedding of mortality red flag identification within the Electronic Patient Record, and ongoing audit processes to improve oversight and dissemination of learning.

During the reporting period, the Trust received 2,067 death notifications, with overall mortality figures broadly consistent with the previous year. Of these, 255 deaths were reported on Datix, with 28 case record reviews and seven patient safety incident investigations commissioned; the report notes that 86.3% of deaths reviewed through completed Incident Review Tools did not identify concerns requiring a further learning response. There were seven Inpatient deaths, 37 learning disability deaths, and two deaths of patients with autism, with most deaths continuing to reflect expected patterns of age-related mortality.

The report identifies recurring learning themes from closed learning responses, particularly around risk assessment and management, care planning and documentation, communication and coordination, governance and accountability, and staff training and supervision. In response, the Trust has introduced or progressed several improvement initiatives, including mandatory suicide prevention, risk assessment and safety planning e-learning, strengthened cross-check and quality monitoring processes, development of an Incident Review Tool Audit Group, and wider quality improvement work through the new AMaT audit platform and Learning the Lessons governance structure.

The report also highlights that one death within 2025/26 met the criteria for Duty of Candour, alongside four cases from the previous year confirmed during this period, with improvement work focused on risk recognition, escalation, communication and policy adherence. In addition, the Trust received one Prevention of Future Deaths notice, with most required actions already completed or in progress. Overall, the report indicates that the Trust has demonstrated clear evidence of actions being taken to strengthen safety, governance and organisational learning.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
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	1A	1.1
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.			
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.			

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

- Reviewed by the Medical Director and colleagues within the Medical Directorate meeting
- Quality and Safeguarding Committee, 16 June 2026.

Governance or Legal Issues

- The report indicates limited adherence to the Patient Safety Incident Response Framework and National Guidance on Learning From Deaths
- 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).

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

There are no expected implications in relation to net zero duty.

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:

Data scrutinised through a health inequalities lens shows that DHcFT's incident profile in respect to patient demographics is in keeping with that established in research and national data and there are no clear causes for concern identified in patient safety incident data. However, gaps in the recording of patient demographic data are evident, which hinder the reliability of the data.

Recommendations

The Board of Directors is requested to:

1. Accept this report with limited assurance of the Trust's approach
2. 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: **Tom Larder**
Interim Patient Safety Lead

Derbyshire Healthcare
NHS Foundation Trust

Learning from Deaths

Annual Report

2025/26

WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

Contents

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.

In line with this national guidance, the trust is required to publish annual reports to public board meetings on to key performance statistics and figures.

This report presents the data for 1 April 2025 to 31 March 2026.

2. Current position and progress

This section of the report will provide an overview of Derbyshire Healthcare NHS Foundation Trust's (DHcFT's) current position and areas of progress in relation to its mortality review process and procedure.

- 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 offices 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 DHcFT patient safety team for patients open to our service in the six months prior to their death. This agreement is in place with 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. We have escalated the delay to the Integrated Care Board (ICB) Patient Safety Lead, who will explore this issue with their contacts to see if a resolution can be found
- 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 May 2026. Red flag deaths are clinical 'red flags' determined through the National Learning from Deaths guidance that indicate the need for care reviews or investigations to determine if the death was potentially avoidable
- 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 stood down and has been superseded by Trust-wide and Care Group Learning the Lessons meetings, which aim to triangulate learning across a broader spectrum of sources, including mortality, patient safety incidents, patient experience, clinical audit and clinical research. The Trust-wide Learning the Lessons forum holds oversight and governance for the dissemination and embedding of learning post-incident and will feed intelligence and directives to the Care Group Learning the Lessons groups to inform and drive forward quality improvement programmes across the Trust.

  The first Trust-wide meeting took place on 11 May and will continue on an eight-weekly basis.

- DHcFT's Patient Safety team has re-established the Regional Mortality Review Networking as of March 2026 and the first meeting received great representation from other external partner agencies across the region. A further meeting is being arranged for July 2026 and will focus on shared learning and practice around integration of Learning from Deaths guidance and procedure with the Patient Safety Incident Review Framework
- 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.

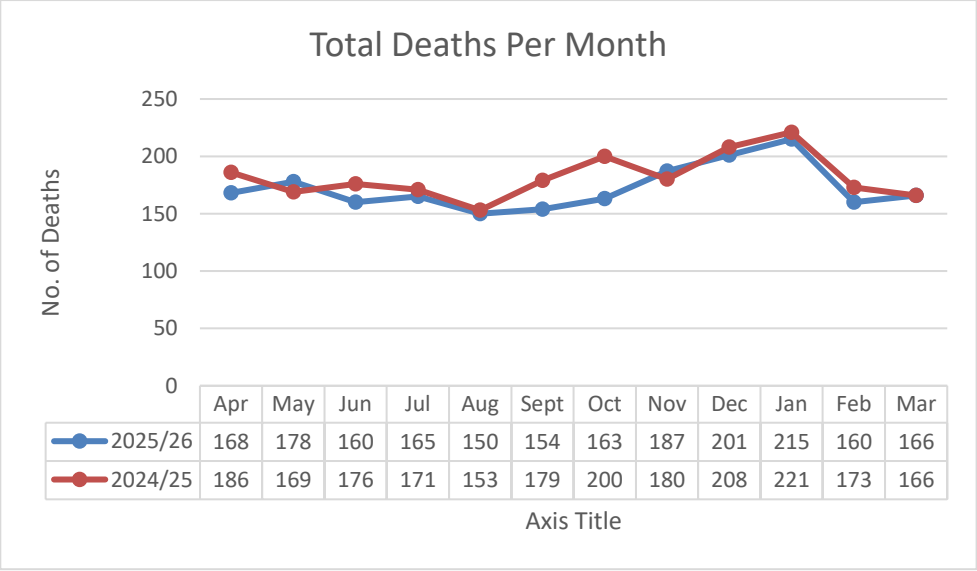
3. Data summary of all deaths

The following table outlines the number of notification of deaths received for the period 1 April 2025 to 31 March 2026:

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Total Deaths Per Month	168	178	160	165	150	154	163	187	201	215	160	166
LD Referral Deaths	3	1	3	4	1	5	1	1	5	4	4	5

*Correct as at 18 May 2026
**Please note that Inpatient and Learning Disability (LD) data is subject to additional scrutiny based upon whether a) the patient was an open Inpatient, and b) there is an open LD referral at time of death regardless of whether the Trust has seen the patient.*

Between 1 April 2025 to 31 March 2026, the Trust received 2,067 notifications of death of patients who had been in contact with our services or discharged within six months of the incident. Of these deaths, 1,103 patients were male, 961 female and three of unknown gender, 1,625 were white British and 41 Asian British. The youngest age was zero years, the oldest age recorded was 105. The Trust has reported 37 LD deaths in the reporting timeframe and two deaths of a patient with a diagnosis of autism.



Comparing data from 2025/26 against that of last year's report for 2024/25 shows relatively consistent mortality figures across both years, but with less deaths in the month of September & October 2025 compared to data from 2024.

4. Review of deaths

Only deaths which meet the clinical 'Red Flags' (laid out in National Learning from Deaths Guidance) are reported through the Trust incident reporting system (Datix). These deaths are reviewed through processes outlined within the Trust's *Incident Reporting and Investigation Policy and Procedure.*

The table below lists the number of deaths reported through the Datix Incident Reporting System and those that met the criteria for reviewed by the organisation:

Total number of deaths between 1 April 2025 to 31 March 2026 reported on Datix	202 “Unexpected deaths”
	33 “Suspected Suicide deaths”
	20 “Expected - end of life pathway” *NB some expected deaths do not meet the criteria for reporting and have therefore been rejected from the Datix Incident Reporting System. These rejected incidents are not included in the above figure.*
Incidents assigned for a review	220 incidents assigned to the Operational Incident Group.
	32 incidents assigned to the Executive Incident Group.
	Three incidents to be confirmed.

The list below details the criteria for which notification of deaths should be recorded through the Trust’s incident reporting system:

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

A total of seven Inpatient deaths were reported during the period of April 2025 to March 2026.

- Two deaths were expected and related to patients who were being cared for through an end-of-life pathway
- Three deaths were unexpected but related to a medical condition or natural causes. Review of these deaths identified the following:

- The care and treatment of all three patients were found to be of a good standard
- One case has highlighted responsiveness of the duty doctor as an area for improvement.
- One case has generated learning in respect to the consideration of multiple physical health comorbidities in the review of RESPECT forms

- One death was unexpected and related to morphine toxicity. Review of the death found that care and treatment met expected standards, however generated some learning in relation to strengthening the alignment of care plans, risk assessments and safety planning, particularly during periods of leave
- One death was reported to be a suspected suicide. A patient safety incident investigation (PSII) is currently underway and will in due course identify if there is any learning or areas for improvement.

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	PSII
2023/24	119 deaths	39	16
2024/25	141 deaths	23	3
2025/26	255 deaths	28	7

Please note: Seven deaths are currently awaiting a decision.

This indicates that for **86.3%** of the total deaths within the period of 2025/26 the completed Incident Review Tools provided assurance that there were no concerns with care that warranted the commissioning of a learning response.

The author notes that there is a significant difference in deaths reported through Datix between 2024/25 and 2025/26. Further exploration and analysis of the data will be undertaken to determine the contributing factors behind this. Any discrepancies or inaccuracies in data will be updated in future publications of this report.

7. Duty of Candour (DoC) for 1 April 2025 to 31 March 2026

DoC refers to the Trust's obligation under Regulation 20 of the Health and Social Care Act 2008 to be open, honest and transparent with patients (or their families) when mistakes occur in care or treatment that result in significant harm.

Between 1 April 2025 to 31 March 2026, there was one death which met the criteria for DoC. It should be noted there are Learning Responses for this period which remain active therefore DoC figures change. The below provides a brief narrative around the nature of DoC and improvement actions:

No	Incident Date	Date DoC confirmed	Narrative
1	Jun-2025	Nov-2025	DoC was identified following the conclusion of a Case Record Review. An apology was offered to the family in November 2025. The nature of the DoC related to the immediacy of the patient's risks not having been fully recognised and not receiving a timely response. Improvement works are underway in relation to strengthening multidisciplinary discussion and escalation, particularly outside of normal working hours.

Some catastrophic incidents can be subject to a patient safety learning response (ie PSII or Case Record Review). DoC for these incidents can be assessed at the date of the report being signed off by the Executive Incident Group.

The date of which DoC can be assessed for incidents subject to a patient safety learning response can therefore sit outside of the reporting period for which the incident occurred.

Four deaths have been identified during this financial year as DoC having occurred during 2024/25. The Trust continues to support the families involved in engagement with patient safety incident response. The table below provides an overview with narrative around the nature of the DoC and improvement work in place to address this.

No	Incident Date	Date DoC confirmed	Narrative
1	Apr-2024	Sep-2025	DoC was identified following the conclusion of a PSII. An apology was offered to the family in October 2025. Areas for improvement were identified relating to adherence to trust policy around clinical risk assessment and therapeutic observations levels, and the development of a Personality Disorders Pathway. The PSII report is due to be finalised, following which improvement actions will be loaded to our incident reporting system.
2	Dec-2024	Oct-2025	DoC was identified following review at the Trust's Operational Incident Review Group meeting. The nature of the DoC related to harm reduction advice and guidance in relation to illicit substance use not meeting expected standards. The Trust was unable to offer an apology owing to the patient being deceased and having no identified next of kin. Improvement actions generated from the learning have been completed and embedded into practice.
3	Feb-2025	Apr-2026	DoC was identified following the conclusion of a case record review and an apology was offered in April 2026. The nature of the DoC related to gaps in monitoring and follow up from Drug and Alcohol services in Derby City. These services are no longer provided by DHcFT and the learning and improvement actions identified from the Case Record Review have been handed over to the new service providers to inform service delivery moving forward.
4	Feb-2025	Oct-2025	DoC was identified following completion of a PSII and an apology was offered in December 2025. The nature of the DoC related to shortfalls in communication around falls risks during transfer between services and areas for improvement identified in relation to adherence to relevant policy and procedure. 25 of the improvement actions identified from this case have been completed, with learning embedded into practice. Seven broader improvement actions are in progress relating to updates to service policy and procedure.

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

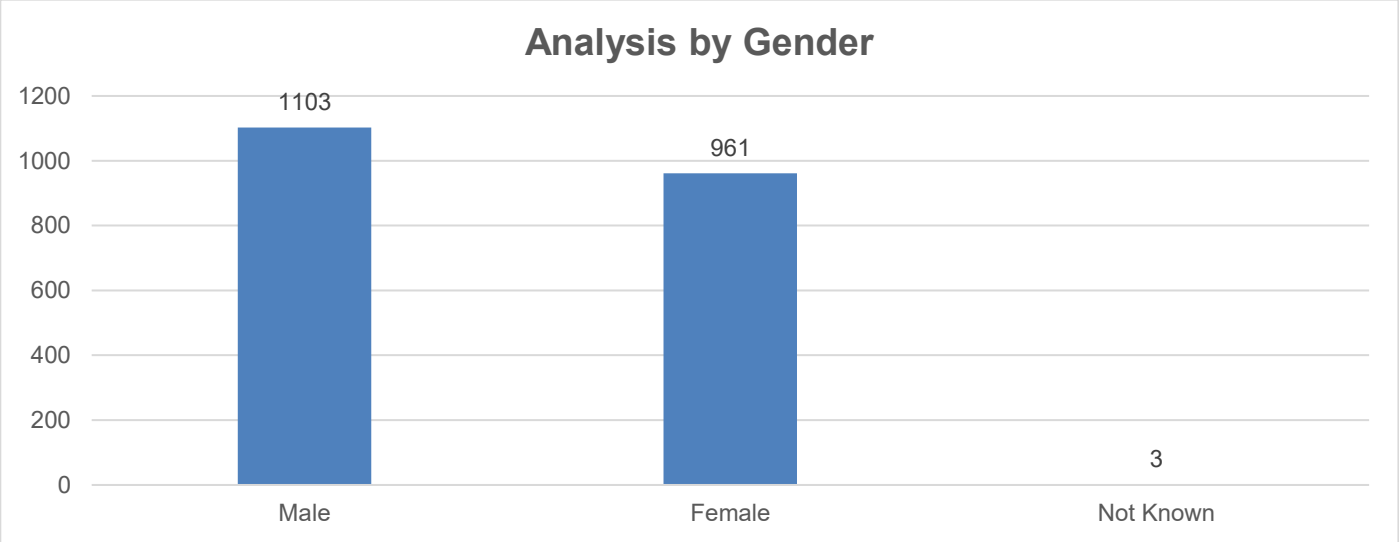
9.1. Analysis per notification system since 1 April 2025 to 31 March 2026

System	Number of Deaths
SystmOne	2,065
IAPT	2
Grand Total	**2,067**

The data above shows the total number of deaths reported by each notification system. All of the death notifications apart from two 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 April 2025 to 31 March 2026. There is very little variation between male and female deaths; 961 female deaths were reported. compared to 1,103 males:

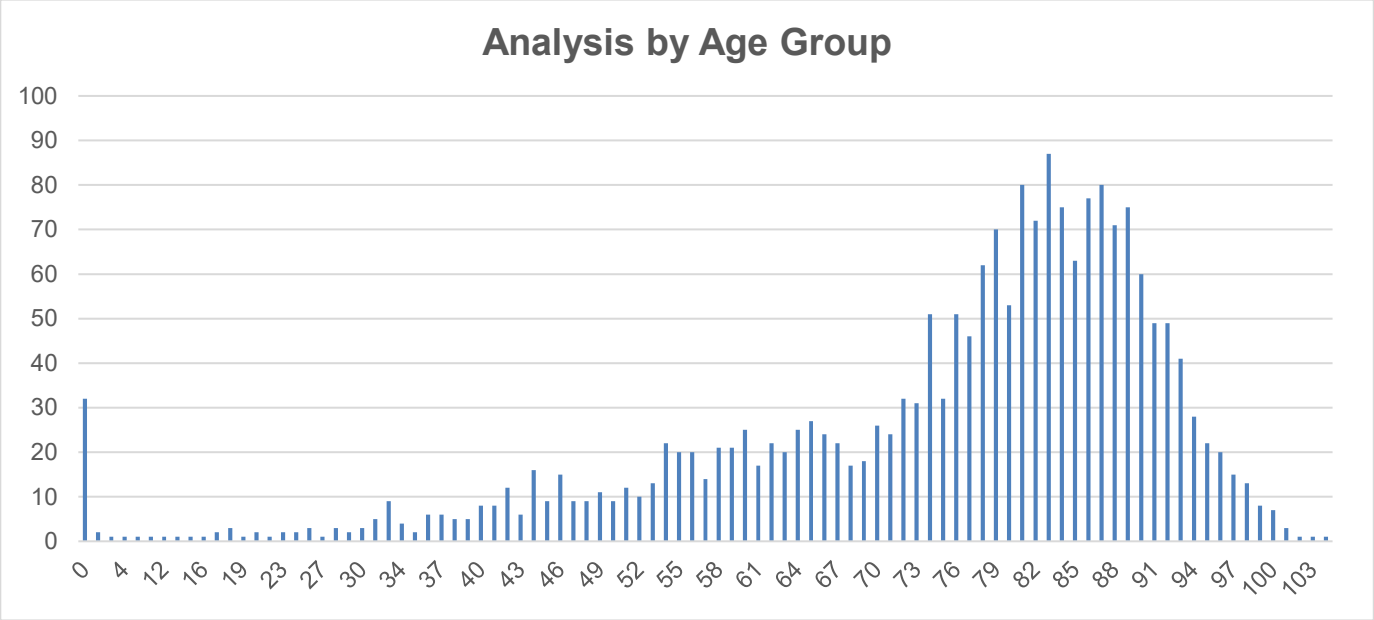


Gender	Number of Deaths	%	Open Referrals to DHcFT	Increase/Decrease from 2024/25
Male	1,103	53.4%	43%	-3.6% decrease
Female	961	46.5%	53%	-7.1% decrease
Not Known	3		-	-
Grand Total	**2,067**			

The data shows more deaths for men than women, despite more women being open to DHcFT services. However, this data is consistent with national statistics and research which reflect that men have a lower life expectancy than women (see Office for National statistics data, 2020).

9.3. Analysis by age group

The youngest age was classed as zero, and the oldest age was 105 years. Most deaths occurred within the 79 to 89 age groups – this is largely consistent with our 2024/25 report.



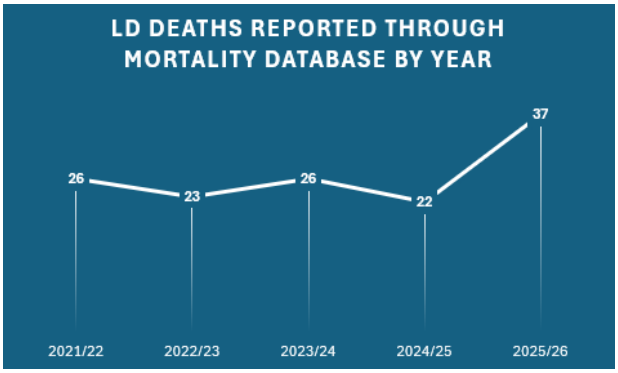
The data indicates that most reported deaths correlate with mortality rates related to natural aging. When compared to data relating to open referrals to DHcFT, ages 70+ are the joint highest age group currently open to our services (alongside ages 30-39yrs).

9.4. Learning Disability (LD) deaths

The Trust reviews all deaths relating to patients diagnosed with an LD. The Trust also currently sends all LD deaths that have been reported through the Datix system to the Learning Disabilities Mortality Review (LeDeR) programme:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
LD Deaths	3	1	3	4	1	5	1	1	5	4	4	5
Autism	0	0	1	0	1	0	0	0	0	0	0	0

During 1 April 2025 to 31 March 2026, the Trust has recorded 37 Learning Disability deaths. Of these 37 deaths, 21 were reported through the Trust's Datix system:



Comparing the data to last year's report, there has been an increase in LD deaths of 68% (from 22 in 2024/25 to 37 in 2025/26). However, liaison with Derbyshire's LeDeR programme has revealed static figures for 2024/25 and 2025/26, indicating that this increase has not been reflected in overall LD deaths in Derbyshire, but they have similarly seen more reports from DHcFT. It is felt that the increase in reporting by DHcFT may be attributed to improved reporting practices by the organisation.

Review of Datix incident reporting data indicates that deaths of patients with an LD were mainly associated with advanced physical illness, complex comorbidity, dysphagia-related risk, infection and end-of-life care needs.

The most prominent organisational themes relate to waiting lists, staffing pressures, triage, escalation and communication across services, rather than evidence of direct harm caused by Specialist LD teams. The learning identified is largely focused on strengthening systems, timely review, and co-ordination between services.

DHcFT's Speech and Language Therapy services (SaLT) have an improvement project in place to address waiting lists for people accessing these services. They are also supporting a greater number of their SaLT Therapists to complete their dysphagia training so that the Trust can enhance it's offer to patients with a learning disability who present with respiratory conditions that may affect their breathing and swallowing. Over the last year the Trust's Neurodevelopmental services have also been offering outreach to care homes to increase awareness of dysphagia and promote earlier identification and referral into services.

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.

The Trust receives annual reports from Derbyshire's LeDeR programme which highlights national good practice and identified learning; this is shared with our ND service leads and will disseminated through the Trust's Learning the Lessons meetings, which have now been established in our Neurodevelopmental services to support the dissemination of learning to improve practice and reduce avoidable deaths moving forward.

9.5. Analysis by ethnicity

White British is the highest recorded ethnicity group with 1,625 recorded deaths; 114 deaths had no recorded ethnicity assigned. The following chart outlines all ethnicity groups, representing the number of deaths, the percentage of total deaths, and a comparison to the number of total open referrals to DHcFT:

Ethnicity	Number of Deaths	%	Open referrals to DHcFT
White - British	1,625	78.62%	74.58%
Other Ethnic Groups - Any other ethnic group	212	10.26%	11.53%
Not Known	96	4.64%	-
White - Any other White background	37	1.79%	2.19%
Asian or Asian British - Indian	19	0.92%	1.31%
Not stated	18	0.87%	3.74%
Asian or Asian British - Pakistani	16	0.77%	1.43%
White - Irish	13	0.63%	0.37%
Black or Black British - Any other Black background	7	0.34%	0.60%
Black or Black British - Caribbean	5	0.24%	0.73%
Mixed - White and Black Caribbean	5	0.24%	0.86%
Mixed - Any other mixed background	5	0.24%	0.59%
Asian or Asian British - Any other Asian background	4	0.19%	0.63%
Asian or Asian British - Bangladeshi	2	0.10%	0.07%
Black or Black British - African	1	0.05%	0.67%
Other Ethnic Groups - Chinese	1	0.05%	0.11%
Mixed - White and Black African	1	0.05%	0.15%
Grand Total	**2,067**		

The data shows that deaths by ethnicity are proportionate with the demographic profile of all patients open to DHcFT and there is no indication of health inequalities contributing to deaths.

9.6. Analysis by religion

Christianity is the highest recorded religion group with 810 recorded deaths, 1,079 deaths had no recorded religion assigned. The chart below outlines all religion groups compared to the religious profile of patients with an open referral to DHcFT:

Religion	Number of Deaths	%	Open Referrals
Christian	783	37.88%	32.11%
Not religious	616	29.80%	34.44%
(blank)	316	15.29%	26.83%
Patient religion unknown	139	6.72%	-
Church of England, follower of	50	2.42%	-
Church of England	40	1.94%	-
Christian religion	27	1.31%	-
Muslim	16	0.77%	1.70%
Roman Catholic	13	0.63%	-
Sikh	11	0.53%	0.76%
Methodist	10	0.48%	-
Religion not given - patient r	8	0.39%	1.62%
Catholic religion	8	0.39%	-
Religion NOS	4	0.19%	-
Pagan	3	0.15%	0.39%
Baptist	3	0.15%	-
Catholic: non Roman Catholic	3	0.15%	-
Jehovah's Witness	3	0.15%	-
Buddhist	2	0.10%	0.39%
Atheist	2	0.10%	-
Protestant	2	0.10%	-
Atheist movement	2	0.10%	-
Protestant religion	1	0.05%	-
Greek Orthodox	1	0.05%	--
United Reform Church	1	0.05%	
Rastafarian movement	1	0.05%	-
Anglican	1	0.05%	-
Jehovah's Witness religion	1	0.05%	-
Grand Total	**2,067**		

There is discrepancy between databases regarding religious categories used which creates challenges in contrasting different data sources. While people within the ‘Christian’ religious group are represented 5% higher than in DHcFT open referral data, overall the comparison of religious groups represented in mortality data against that in open referrals to DHcFT does not indicate any significant inequalities warranting further exploration.

9.7. Analysis by sexual orientation

Heterosexual or straight is the highest recorded sexual orientation group with 1,482 recorded deaths, 569 have no recorded information available. The chart below outlines deaths in all sexual orientation groups compared against open referrals to DHcFT:

Sexual Orientation	Number of Deaths	%	Open Referrals
Heterosexual	1,482	71.70%	50.71%
(blank)	466	22.54%	36.45%
Sexual orientation not given - patient refused	55	2.66%	1.69%
Sexual orientation unknown	36	1.74%	5.00%
Not stated (person asked but declined to provide a response about their sexual orientation)	10	0.48%	2.28%
Homosexuality NOS	6	0.29%	0.40%
Bisexual	6	0.29%	1.67%
Homosexual	2	0.10%	0.08%
Person asked and does not know or is not sure (about their sexual orientation)	1	0.05%	0.76%
Unknown	1	0.05%	0%
Female homosexual	1	0.05%	0.65%
Male homosexual	1	0.05%	0.30%
Grand Total	**2,067**		

The data suggests that heterosexual people are much more highly represented in mortality data than in DHcFT open referral data (+21%). However, there is a significant proportion of people for whom sexual orientation is unknown in both mortality and open referral data (27.47% and 46.18% respectively), reducing the validity of this data and making it difficult to analyse with any degree of confidence.

This raises the question as to how reliable data collection practices are, particularly in referral data for DHcFT. These findings will be distributed through the Trust-wide Learning the Lessons forum to promote greater understanding of the challenges to data capture and to inform improvements to future data collection.

9.8. Analysis by disability

This section of the report usually focuses on analysis of data relating to the representation of disabilities in mortality data. Unfortunately, recent changes to data capture relating to disabilities within the SystmOne Electronic Patient Record mean that this data is not currently extractable for the mortality database. Regrettably we are unable to provide valid data in this report.

This has been escalated to our colleagues in the Information Management, Technology and Records (IMT&R) team and we aim to see this resolved for future publications of this report.

9.9. Data quality improvements

As has been noted within the data of this report, there are discrepancies in regard to how demographic data is recorded across different databases (SystmOne EPR, Datix system, mortality database).

Early discussions have already taken place with Risk Systems and IMT&R colleagues regarding improving data quality within the Datix system. Unfortunately, solutions to automate the generation of patient demographic data through the Trust's Electronic Patient Record system are cost prohibitive. The Datix system relies on users to populate patient demographics and is therefore, subject to human error. Efforts to introduce additional checks and procedures around Datix quality are likely to be cumbersome to frontline staff.

Therefore, the proposed solution moving forward will be to use the NHS numbers from the Datix system and mortality database and provide these to the IMT&R team with a request to extract the data from the Electronic Patient Record system (which is noted to have a much higher rate of data quality). This will ensure that demographic data is being sourced from the same system and will improve the validity of data analysis moving forward.

10. Closed learning response outcomes for the period

There have been 34 learning responses approved for closure through the Executive Incident Review Group.

The following table details an executive summary of the key learning themes that have emerged from patient safety learning responses that were approved by the Executive Incident Review Group over the period of April 2025 to March 2026, mapped against improvement initiatives that are currently underway.

Theme	Learning	Improvement Initiatives
Risk assessment and management	There were repeated findings that risk was not reviewed dynamically, important warning signs were missed or underestimated, and decisions or escalation plans were not clearly documented.	As of March 2026, all four Suicide Prevention, Risk Assessment and Safety Planning e-learning modules are now live and considered mandatory training for clinical employees. Positive progress is being made in completion rates and is monitored on a quarterly basis through the Patient Safety report. There are plans for the Trust's Suicide Prevention Lead to facilitate some face-to-face follow-up training for teams who have been identified through patient safety learning responses.
Care planning and documentation	Records were often incomplete, inconsistent, or outdated, reducing the quality of clinical decision-making and continuity of care.	The Trust has been embedding higher standards of care documentation quality through the introduction of frequent 'cross-check' meetings for each service line, increasing accountability for service and clinical leads in demonstrating timely improvement in quality metrics. In addition to this, the Trust has introduced 'Fundamentals of Care' visits as an additional quality monitoring mechanism. The visits function similarly to a 'mock' CQC inspection, where teams are reviewed by peer services who provide feedback around areas of good practice and areas for improvement. The Trust is also investing in a new digital clinical audit platform called 'AMaT'. This platform will promote greater consistency in clinical audit standards and practices across the organisation and provide clearer data analysis to evidence the effectiveness of quality improvement initiatives.
Communication and co-ordination	Problems were noted both within multi-disciplinary teams and with patients, families, carers and partner agencies, leading to missed opportunities to share critical information and respond effectively.	Improvement actions have been targeted towards specific teams identified within learning responses to enhance their governance and processes around multi-disciplinary working and escalations. The Trust's Suicide Prevention Lead will also be leading a piece of work around developing greater governance and structure around multi-disciplinary risk management through developing standardised procedures to support risk strategy meetings. The Trust continues to drive adherence to the 'Triangle of Care' scheme to increase collaborative working with patients, families and carers in the delivery of care, and this is being directly scrutinised through the aforementioned cross-check meetings and Fundamentals of Care visits. The Trust is also partnering with Experts by Experience to undertake the '15 steps challenge' – a quality improvement initiative that places the experience of patients and carers at the core. DHcFT utilises the SystmOne Electronic Patient Record system, which is largely utilised by GPs within Derbyshire. However, improvement initiatives have targeted GP surgeries and partner agencies who do not utilise

		SystmOne to make them aware of risks related to poor information sharing and to promote good information sharing practices. Conversations also continue within the Derbyshire Integrated Care System in relation to voluntary, community and social enterprise partner organisations, who provide key aspects of Derbyshire's Crisis Alternative Support services, accessing SystmOne.
Governance, oversight and accountability	A further theme is the need for stronger governance, oversight and accountability, including clearer pathways, better action tracking, more robust audit and assurance processes and improved recording of multi-disciplinary team discussions and clinical rationale.	As referenced previously, the Trust is investing in the AMaT platform to strengthen governance and accountability in relation to clinical audit standards and practices. The Trust-wide Learning the Lessons forum was launched in May 2026, which serves as a parent forum to the Care Group Learning the Lessons subgroups. The Trust-wide Learning the Lessons forum provides oversight and governance for the dissemination and embedding of learning and improvement throughout the organisation and aims to triangulate learning from a variety of sources (learning from deaths, patient safety incidents, patient experience, clinical audit, clinical research, etc) to inform quality improvement initiatives. The Trust's Transformation team continue to develop the organisation's staff and leaders through Quality Improvement training and through promoting quality improvement methodology and use of the LiveQI system to develop and support QI projects and evidence outcomes.
Training, supervision and staff support	There is an emphasis on the role of training, supervision, and staff support, particularly to help staff manage complex presentations, embed Trust policies in practice and improve safeguarding, clinical decision-making and risk formulation.	As referenced previously, all four Suicide Prevention, Risk Assessment and Safety planning modules are now live and follow-up face-to-face training offers are being planned for teams who have been identified within learning responses. Additionally, the organisation has been through a recent restructure and redefining of leadership roles. This is anticipated to result in greater clarity and emphasis on the role of Clinical Leads to develop and deliver regular training at service level.
Less common themes	Additional learning points include the need to strengthen safeguarding and professional curiosity, improve medication and physical health monitoring, address delays and handover failures, and ensure better carer involvement and individualised safety planning.	Individual learning actions have been developed for specific teams involved in these patient safety incidents and continue to be monitored through the Learning the Lessons meetings and Care Group Performance meetings.

Learning themes have been directly fed back to service leaders and involved staff. They will also be added to the agendas for the Care Group Learning the Lessons forums for dissemination and to incorporate into quality improvement projects.

11. Prevention of Future Death Notices (PFDs)

The Trust received one PFD notice within the period 2025/26 relating to Mrs HB (Datix Incident Ref. W103255) the completion of which is due to be reported back to HM Coroners by August 2026. **Five out of eight** of these actions have been completed. A further two actions are partially complete, pending launch of the Perinatal services 'micro-site' and a confirmed date for their next state stakeholder event. Only one action remains outstanding. The remaining three actions are expected to be completed by the August 2026 deadline.

The main learning from this death pertained to the patient's GP utilising a different electronic patient record system to that of the Trust's Perinatal services, which resulted in important information not being shared, in addition to vital information recorded in the baby's notes not being added to the mother's record.