

Learning From Deaths report – Quarter 1 (Q1), 2026/27

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 Q1, 2026/27.

The Board of Directors is requested to accept this 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

This report provides an overview of the Trust's Learning from Deaths activity for Quarter 1 (1 April to 30 June 2026). During the reporting period, the Trust received 484 notifications of death, representing a 9% reduction compared to Q1 2025/26, with six Learning Disability deaths reported. No Inpatient deaths occurred during the quarter. Overall, mortality trends have remained stable, and there is no evidence from the available data to suggest significant health inequalities contributing to mortality outcomes.

The Trust continues to strengthen its Learning from Deaths processes through regular audits of red flag deaths, enhanced Electronic Patient Record (EPR) identification processes and the development of an Incident Review Tool (IRT) audit programme. Progress has also been made in embedding the new Trust-wide Learning the Lessons Forum, which now provides organisational oversight of learning from mortality reviews, patient safety incidents, patient experience, clinical audit and research activities. Positive engagement has been reported, with actions being tracked through an organisational action matrix.

A total of 50 deaths met the Trust's red flag criteria and were reported through Datix, resulting in a range of learning responses, including case record reviews, multi-disciplinary reviews, after action reviews, assurance reviews and patient safety incident investigations. Completed reviews provided assurance that in approximately 74% of cases no further learning response was required, indicating that the care provided did not raise concerns warranting additional investigation.

Analysis of completed learning responses identified recurring themes relating to risk assessment and care planning, recognition and escalation of physical health deterioration, clinical documentation, physical health monitoring, care co-ordination and communication, management of disengagement, substance misuse, and family and carer involvement. These themes have been shared with service leaders and will be disseminated through Care Group Learning the Lessons forums to support quality improvement activity across the Trust.

There were no deaths occurring within the quarter that met the threshold for Duty of Candour, although one historic death from 2025/26 was determined during this reporting period to meet Duty of Candour criteria following completion of a case record review. Appropriate engagement, apology and communication with the family were undertaken in line with statutory requirements.

40 learning responses relating to deaths are currently active, with 22 of them being overdue. The collective average of days learning responses are overdue is 142. There has been a significant reduction (55%) of overdue learning recommendations.

Looking forward, key priorities include resolving delays in obtaining cause of death information from external organisations, improving demographic data quality through greater use of EPR-derived information, implementing the IRT audit programme, and continuing to strengthen mechanisms for organisational learning and assurance under the Patient Safety Incident Response Framework (PSIRF).

Conclusion and Assurance Statement

Considering the outstanding actions described above, this report provides limited assurance that the Trust has effective processes in place to ensure that learning from deaths is identified and widely disseminated to inform service improvements.

Further improvements to learning response completion time are required to provide greater assurance. Development of a Patient Safety Dashboard to support real-time monitoring and escalation is underway and proposals to backfill staffing resource in the Patient Safety team have been prepared for the Executive Leadership Team. It is anticipated that the benefits of these actions will be reflected as gradual improvements in the data evidenced in subsequent publications of this report, but it is anticipated that the benefits will not be fully realised until at least Q4, 2026/27.

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, owing to delays in learning response completion and overdue learning recommendations. This presents a risk that opportunities for learning and improvement are not identified in a timely manner
- No concerns have been noted in relation to mortality data.

Consultation

- This report has been shared with the Medical Directorate for review. No further feedback was provided
- This report has been reviewed by the Executive Medical Director and areas of feedback have been addressed prior to submission
- Quality and Safeguarding Committee, 8 September 2026.

Governance or Legal Issues • The report indicates limited adherence to the PSIRF 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).

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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.

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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 the Trust'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.

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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.
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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

Quarter 1, 2026

www.derbyshirehealthcareft.nhs.uk

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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 2026 to 30 June 2026.

2. Current Position and Progress

This section of the report will provide an overview of 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 University Hospitals of Derby and Burton (UHDB) and Chesterfield Royal Hospital (CRH) 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, and plans are in place to meet with the representatives from UHDB and CRH in September to seek a resolution. If this issue remains unresolved, the Patient Safety team will escalate this to the Director of Nursing to be raised on the ICB Risk Register.

- 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 made to the assurance and oversight of learning post-incident, the Trust Mortality Committee was stood down and 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 feed key information and directives to the Care Group Learning the Lessons groups to inform and drive forward quality improvement programmes across the Trust.

The Trust-wide Learning the Lessons has now met twice. The next meeting is scheduled for 7 September 2026. The meeting has seen good engagement from Operational services and has received positive feedback from attendees. Meeting minutes have provided information to be disseminated to the Care Group Learning the Lesson meetings. An Action Matrix has been generated to track progress with actions discussed and agreed within the forum.

Given the meeting remains in relatively early stages, feedback and review will be continuously considered to further embed this into routine practice.

- DHcFT’s Patient Safety team has re-established the Regional Mortality Review Networking as of March 2026 and the first two meetings received great representation from other external partner agencies across the region. A further meeting is being arranged for September 2026 and will focus on shared learning and practice around integration of Learning from Deaths guidance and procedure with the Patient Safety Incident Response Framework (PSIRF).
- We are developing an Incident Review Tool (IRT) Audit Group to strengthen our approach to incident learning under the 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. It is anticipated that this will be up and running by the end of September 2026.

3. Data Summary of all Deaths

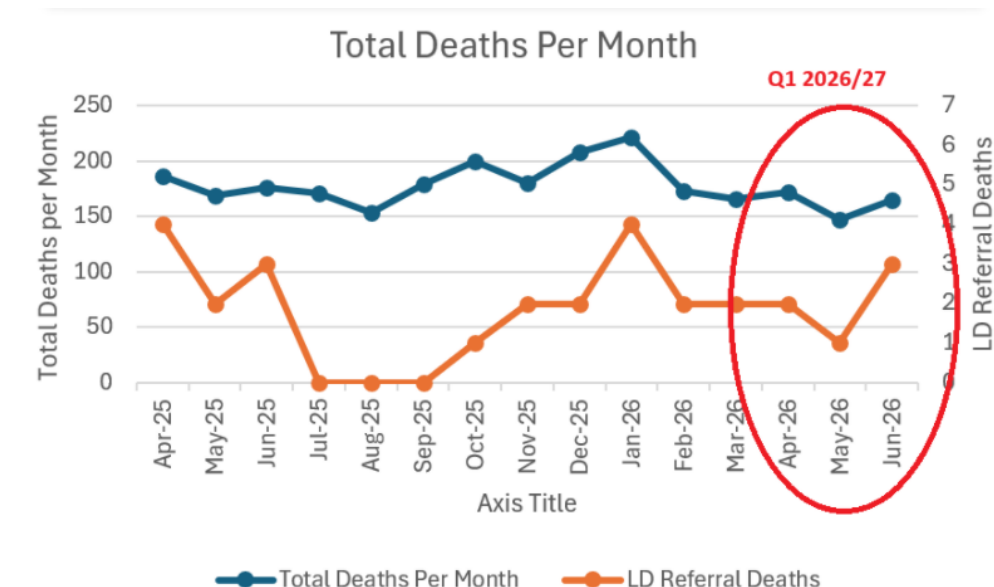
The following table outlines the number of notification of deaths received for the period:

	Apr	May	Jun
Total Deaths Per Month	172	147	165
LD Referral Deaths	2	1	3

*Correct as of 03 August 2026

**Please note that Inpatient and Learning Disability (LD) data is subject to additional scrutiny based upon whether a) the patient has 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 2026 to 30 June 2026, the Trust received 484 notifications of death of patients who had been in contact with our services or discharged within six months of the incident. Of these deaths, 250 patients were male; 234 female. 397 were white British and 50 Other Ethnic Groups. The youngest age was zero years (in Community Paediatrics), the oldest age recorded was 100. The Trust has reported six Learning Disability deaths in the reporting timeframe.



Overall, total deaths for Q1, 2026/27 are 9% lower than compared to Q1, 2025/26 and LD Referral deaths have been 33% lower than Q1, 2025/26. Total deaths reported across the past five quarters have maintained a stable rate.

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 2026 to 30 June 2026 reported on Datix.	42 "Unexpected deaths"
	Seven "Suspected Suicide deaths"
	One "Expected - end of life pathway" <i>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</i>
Incidents assigned for a review.	41 incidents assigned to the Operational Incident Group
	Nine incidents assigned to the Executive Incident Group

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 absconson 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

No inpatient deaths were reported during the period of 1 April 2026 to 30 June 2026.

6. Learning Responses for 1 April 2026 to 30 June 2026

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	After Action Review	MDT Review	Assurance Review	Other Patient Safety
2023/24	119 deaths	39	16				
2024/25	141 deaths	23	3				
2025/26	255 deaths	28	7				
2026/27	50 deaths	6	1	2	2	1	1

Please note: 2 deaths are currently awaiting a decision.

This indicates that for 74% of the total deaths so far within the period of April to June 2026 the completed Incident Review Tools provided assurance that there were no concerns with care that warranted the commissioning of a learning response.

7. Duty of Candour (DoC) for 1 April 2026 to 30 June 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 2026 to 30 June 2026, there were no deaths which met the criteria for DoC. It should be noted there are Learning Responses for this period which remain active. Therefore, DoC figures change.

Some catastrophic incidents can be subject to a patient safety learning response (ie Patient Safety Incident Investigation 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. Therefore, the date of which DoC can be assessed for incidents subject to a patient safety learning response can sit outside of the reporting period for which the incident occurred.

One death has been identified during this financial year as DoC having occurred during 2025/26. 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	06-Feb-2025	16-Apr-2026	This catastrophic incident was assessed as meeting DoC threshold on 16 April 2026 because the Case Record Review highlighted that there were two periods of time where there is no documentation that the patient received any support from Derby Drug and Alcohol Complex needs team. These periods are approximately six weeks between the last appointment in late October 2024 and the patient's self-referral on 12 December 2024. Approximately seven weeks between self-referral and the patient's death on 4 February 2025. The CoD was: 1.(a) Left Ventricular Failure 1.(b) Ischaemic and hypertensive heart disease.

			Regulation 20 was met because an apology/explanation was given via 'phone to daughter on 23 April 2026. Report released adhering to daughter's preferences. DoC letter and report was 27 April 2026. Regulation 20 has been completed in line with the daughter's requests. Recommendations for improvement relate to the introduction of processes to: • Ensure follow-up of patients who have not received recent contact from the Trust • Inform Key Workers where duty contacts or self-referrals are received to promote continuity of care.
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8. Learning from Deaths Procedure

Following implementation within the Electronic Patient Record which aids staff in identifying deaths which meet the threshold for Datix reporting, the Patient Safety team continues weekly random audits for deaths against the red flags to provide assurance that the new process is working as intended. 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.

The Patient Safety team has developed 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.

Engagement is planned with clinical colleagues to begin implementing the audit and we expect this to be up and running by the end of September 2026.

9. Analysis of Data

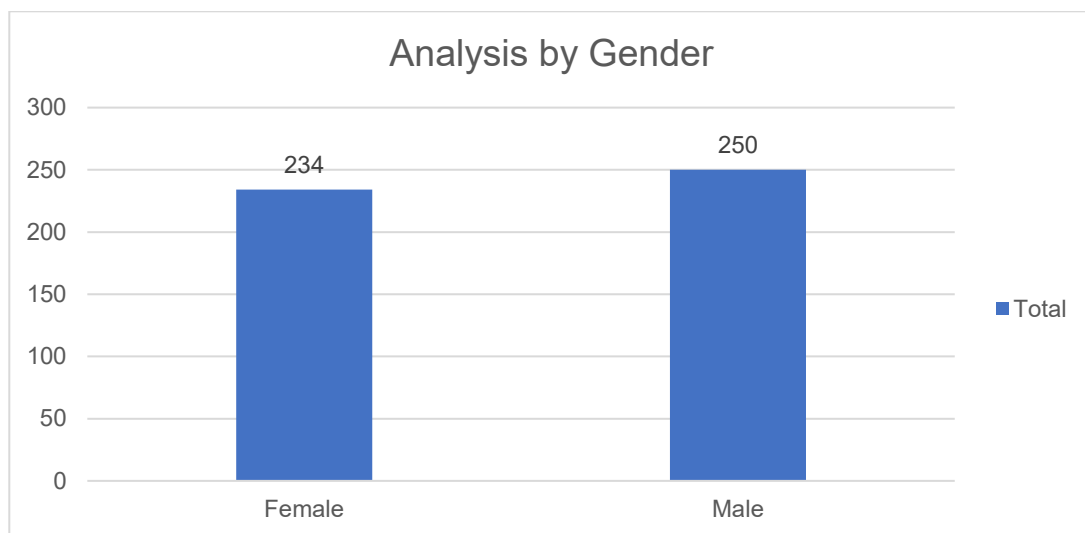
9.1. Analysis per notification system since 1 April 2026 to 30 June 2026

EPR System	Number of Deaths
SystmOne	484
Grand Total	484

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 April 2026 to 30 June 2026. There is very little variation between male and female deaths; 234 female deaths were reported. compared to 250 males.

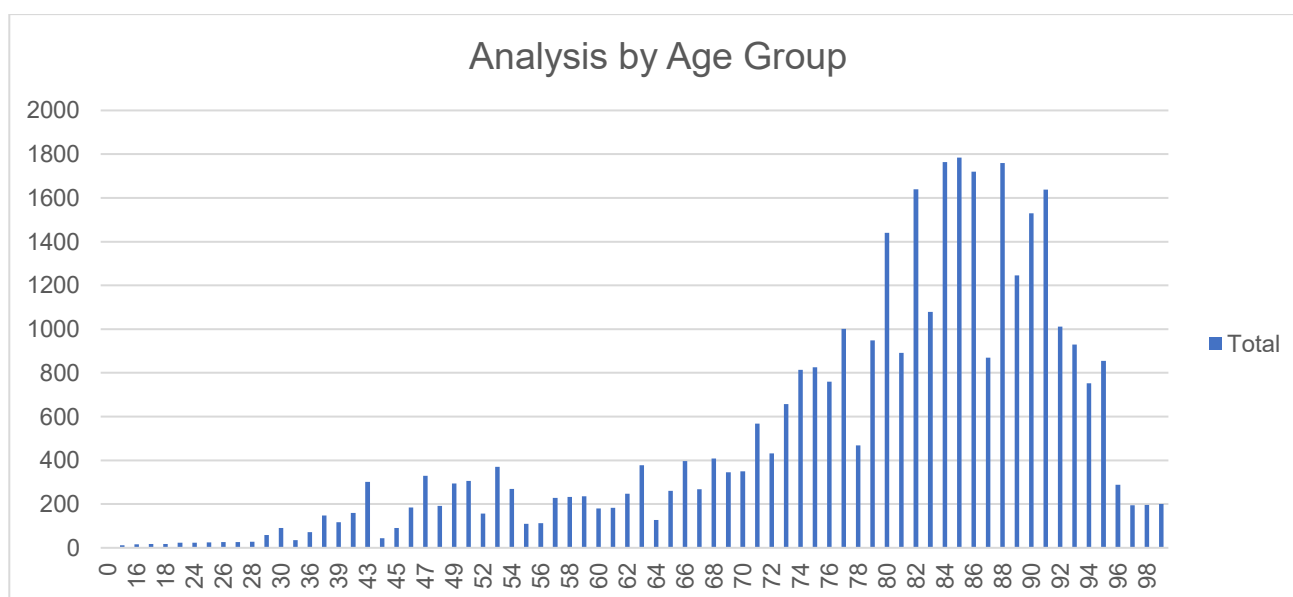


Gender	Number of Deaths	%	Open Referrals to DHcFT
Male	250	52%	52%
Female	234	48%	48%
Grand Total	484		

The data indicates that gender representation in death rates are proportionate to open referrals to DHcFT.

9.3. Analysis by age group

The youngest age was classed as zero (in community paediatrics), and the oldest age was 100 years. Most deaths occurred within the 79 to 89 age groups – this is largely consistent with our 2024/25 report.

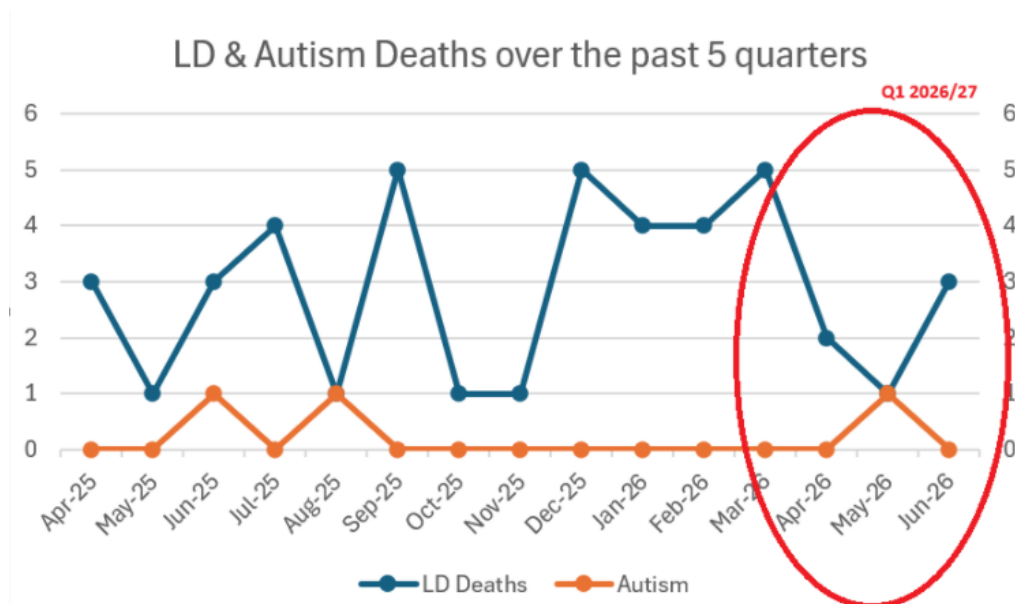


The data indicates that most reported deaths correlate with mortality rates related to natural aging.

9.4. Learning Disability (LD) deaths

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all LD deaths that have been reported through the Datix system to the LeDeR programme.

	Apr	May	Jun
LD Deaths	2	1	3
Autism	0	1	0



During, 1 April 2026 to 30 June 2026 the Trust has recorded six LD deaths. Of these six deaths, five were reported through the Trust's Datix system.

Data over the past five quarters shows variability in LD Death rates, whereas Autism rates remain consistently low. Within Q1, 2026/27, LD Deaths were lower than rates throughout Q2, Q3 and Q4 of 2025/26 but comparable to Q1, 2025/26.

9.5. Analysis by ethnicity

White British is the highest recorded ethnicity group with 397 recorded deaths; 50 deaths were from Other Ethnic Groups. 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	%	Open referrals to DHcFT
Asian or Asian British - Any other Asian background	0%	1%
Asian or Asian British - Bangladeshi	-	0%
Asian or Asian British - Indian	-	1%
Asian or Asian British - Pakistani	1%	1%
Black or Black British - African	-	1%
Black or Black British - Any other Black background	0%	0%
Black or Black British - Caribbean	-	0%
Mixed - Any other mixed background	-	1%
Mixed - White and Asian	-	0%
Mixed - White and Black African	0%	0%
Mixed - White and Black Caribbean	-	1%
Not Known	4%	4%
Not stated	2%	1%
Other Ethnic Groups - Any other ethnic group	10%	15%
Other Ethnic Groups - Chinese	-	0%
White - Any other White background	1%	2%
White - British	81%	71%
White - Irish	1%	0%

The data shows that deaths by ethnicity are largely proportionate with the demographic profile of all patients open to DHcFT, with the exception of White British groups who are slightly overrepresented mortality data.

9.6. Analysis by religion

Christianity is the highest recorded religion group with 253 recorded deaths, 93 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 to DHcFT
Baha'i	-	-	0%
Buddhist	-	-	0%
Christian	253	42%	23%
Declines to Disclose	2	0%	1%
Hindu	-	-	0%
Jewish	-	-	0%
Muslim	7	1%	1%
None	208	34%	36%
Not Recorded	93	15%	29%
Other	2	0%	2%
Pagan	-	-	0%
Sikh	1	0%	0%
Unknown	43	7%	9%
Grand Total	484		

People within the 'Christian' religious group appear over-represented in mortality data. This aligns with research findings that attribute this to Christians largely being an older age population, and therefore, more represented in death rates (Sherwood, 2022). There is no overt indication of any health inequalities in mortality data relating to deaths.

9.7. Analysis by sexual orientation

Heterosexual or straight is the highest recorded sexual orientation group with 352 recorded deaths; 97 have no recorded information available. The chart below outlines deaths in all sexual orientation groups compared against open referrals to DHcFT:

Row Labels	%	Open referrals
Bi-sexual	0%	2%
Gay/Lesbian	1%	1%
Heterosexual	71%	46%
Not Recorded	21%	44%
Not Stated (PERSON asked but declined to provide a response)	7%	8%
PERSON asked and does not know or is not sure	0%	-
Grand Total		

Mortality data would indicate that Heterosexual groups are overrepresented compared to open referrals to the Trust. However, in open referral data, heterosexual groups are the most highly represented group and there are a significantly high number of patients whose sexual orientation is not recorded. Therefore, there is no clear indication of health inequalities in the data.

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, and 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. However, we have been advised that there is no fix for this solution. Moving forward, we will be able to collate information as to whether a disability is present or not and unfortunately will not be able to provide statistics relating to the nature of the disability.

Disability Present	%	Open Referrals to DHCFT
No	37%	62%
Yes	64%	38%

The data does not indicate any over representation of disabled persons within mortality data.

9.9. Data quality improvements

A 'demographic comparison report' has been developed by the IMT&R team which allows for the demographic data associated with NHS numbers of reported deaths to be compared to demographic data for all open referrals to DHCFT. Therefore, demographic data in compared and analysed in this report has been generated from the EPR, resulting in greater accuracy and validity.

NB. Please note that our Mortality Database is continuously updated as deaths are reported to us. Many deaths are reported retrospectively and as such the data is rarely static. Data presented in this report is accurate to the time it was generated but is likely to change over time as further deaths are retrospectively reported.

10. Closed Learning response outcomes for the period

11 Learning responses were completed within the last quarter. These consisted of:

- Two After Action Reviews
- One Assurance Review
- Two Multi-disciplinary Reviews
- Six Case Record Reviews
- One Patient Safety Incident Investigation
- One Other Patient Safety Learning Response

The following table details an executive summary of the key learning themes that have emerged from learning responses that were approved by the Executive Incident Review Group over this quarter.

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.

Learning Theme:	Detail:
1. Risk Assessment Quality, Dynamic Review and Documentation	The most recurrent theme is the need for more robust, formulation-led risk assessment and ongoing review of risk. Several reports identified that risk assessments were completed but did not always reflect changing presentation, cumulative risks, disengagement, substance misuse, physical deterioration, family concerns or relapse indicators. Care plans were often present but lacked sufficient depth, contingency planning, escalation thresholds or dynamic risk formulation. Learning: Risk assessments and care plans need to be living documents that are routinely updated when risks, engagement levels or clinical presentation change.
2. Escalation of Deterioration and Early Intervention	Several investigations highlighted missed opportunities to recognise and escalate deterioration, whether this related to mental state, increasing suicide risk, mobility decline, physical deterioration, infection, substance misuse or increasing vulnerability. Evidence suggested deterioration was often visible but not always fully reflected within escalation processes or care planning.

	Learning: Staff should place greater emphasis on cumulative risk factors and ensure clear escalation when deterioration, disengagement or increasing complexity becomes evident.
3. Documentation, Record Keeping and Clinical Rationale	Poor or inconsistent documentation was a frequent finding. Reviews identified gaps in risk assessments, post-incident monitoring, care planning, physical healthcare records, wound management documentation, neurological observations, and recording of clinical rationale for decisions. In several cases, care may have been appropriate, but inadequate documentation limited assurance. Learning: Clear documentation of assessment findings, clinical reasoning, escalation decisions and follow-up actions is essential for safe, coordinated care.
4. Physical Health Monitoring and Holistic Care	A number of reports highlighted the importance of maintaining focus on physical healthcare alongside mental health needs. Issues included delayed recognition of infection, inconsistent physical health monitoring, failure to respond to physical deterioration, and the interaction between physical and mental health conditions. Learning: Mental health services must continue to adopt a holistic approach, ensuring physical health concerns are actively monitored, escalated and reviewed alongside mental health care.
5. Care Coordination, Communication and Handover	Several reviews identified fragmented communication between teams, services or wards. Concerns related to ward transfers, information sharing, multidisciplinary oversight, communication with primary care and ensuring important information was handed over effectively. Learning: Stronger multidisciplinary communication, structured handovers and clearer ownership of actions are required to reduce the risk of information being lost across care pathways.
6. Engagement, Disengagement and Assertive Follow-Up	Many cases involved fluctuating engagement, missed contacts, non-attendance or difficulties maintaining involvement with services. Reviews identified ongoing efforts by staff to engage patients but also highlighted the need for clearer escalation pathways and contingency planning when patients disengage. Learning: Disengagement itself should be regarded as a significant clinical risk factor and reflected within care planning, relapse prevention and risk management.
7. Substance Misuse and Co-Occurring Mental Health Needs	Several incidents involved alcohol or substance misuse as a significant factor influencing risk, emotional dysregulation, impulsivity, engagement and vulnerability. Reviews emphasised the need for better joint working, care planning and management of co-occurring mental health and substance misuse issues. Learning: More integrated approaches are required when managing people experiencing both mental health difficulties and substance misuse.
8. Family, Advocacy and Carer Involvement	A recurring positive theme was the value of family involvement in identifying concerns and supporting patients. Conversely, some reports found missed opportunities to involve carers, advocates or important social contacts, particularly where capacity concerns existed or deterioration was reported by family members. Learning: Families, carers and advocates can provide valuable collateral information and should be involved wherever appropriate and lawful.

11.Prevention of Future Death Notices (PFDs)

The Trust did not receive any prevention of future death notices for this quarter.

12.Active Learning Responses & Recommendations

Moving forward, this report will incorporate the data on Learning Response Completion across each quarter (up to a maximum of five quarters) to demonstrate progress over time. Unfortunately, as this data was not captured in previous publications of this report it is not possible to refer to previous Quarter's data at this time.

Outstanding Learning Responses for reported Deaths:

	Q1, 2026/27
Investigation awaiting	14
Report to be finalised by PST	12
Amendments	7
Allocation	2
COD awaiting	2
Investigation received	3
Total	40

	No
No of Overdue Learning Responses	22
Longest Overdue	344 days
Collective Average Overdue	142 days
Collective Median Overdue	119 days
Collective Mode Overdue	196 days

Analysis:

- There are 22 overdue learning responses relating to deaths as of this reporting period. The primary challenge for completion is capacity of learning response leads who sit within Operational services and also delays in learning response allocation, review and approval as a result of the Trust's organisational restructure. The restructure process has now concluded, and there is much greater clarity in roles and responsibilities which is anticipated to aid in progression of incidents through the review process.
- The data indicates that while overall there has been a positive reduction in outstanding learning responses from previous quarters, there remains a significant challenge in progressing vastly overdue learning responses that have been allocated to learning response leads throughout the Operational services.
- The Patient Safety team has now launched 'After Action Reviews' as a formalised learning response methodology and a training video resource has been developed and is accessible to staff on Focus. After Action Reviews are promoted within the PSIRF and learning from peer providers within the Midlands region reflects that these have become their learning response of choice in responding to most incidents. They take the format of a multi-disciplinary discussion with staff involved in the incident, local leads and subject leads/experts where the incident is reviewed using a structured approach, informed by the Systems Engineering Initiative for Patient Safety (SEIPS) framework.

After Action Reviews have been stipulated within our Patient Safety Incident Response Plan since its implementation in March 2024, but prior to this quarter have not been formally introduced or utilised.

- The Patient Safety team has also launched 'Multi-agency/Multi-disciplinary Reviews' as another formalised learning response. Plans are in place to develop training resources which will be uploaded to Focus to support learning response leads in conducting these moving forwards.

Multi-agency/Multi-disciplinary Reviews are utilised to review learning and improvement themes from multiple patient safety incidents that all share similar the circumstances. They are underpinned by human factors theory and acknowledge that 'Work as done' often does not align with 'work as prescribed' by policy, procedure and guidance owing to sub optimal work systems. Rather than explore individual incidents in great depth, participants review several incidents to consider what 'work as done' looks like, and to understand this through a SEIPS lens.

- The introduction of After Action Reviews and Multi-agency/Multi-disciplinary Reviews as additional learning response methodology represents a significant step towards further embedding the PSIRF and will provide much more proportionate and timely learning response moving forward.

Recommendations post learning response:

**Please note, it is not possible to separate this data between death and non-death incidents. Therefore, data relating to outstanding learning recommendations also refers to those generated through review of major incidents that did not result in a death.*

Active		
Rating	Q4 2025/26	Q1 2026/27
High Priority – Cause of Incident	6	1
Medium Priority – Indirectly related to cause of incident	112	95
Low Priority – Not related to cause of incident	63	40
Total	181	136
Overdue		
Rating	Q4 2025/26	Q1 2026/27
High Priority – Cause of Incident	3	1
Medium Priority – Indirectly related to cause of incident	87	39
Low Priority – Not related to cause of incident	37	30
Total	127	70

The table below summarises the number of current overdue patient safety recommendations by year of which they were uploaded to the Datix system:

No of overdue recommendations by year as reported in each quarter:		
Year	Q4, 2025/26	Q1, 2026/27
2020/21	1	1
2021/22	2	1
2022/23	7	2
2023/24	5	0
2024/25	47	7
2025/26	65	37
2026/27	-	22

Analysis:

- The total number of overdue recommendations has reduced by 57 and the total number of active recommendations has reduced by 45 since the last quarter.
- Comparison of overdue recommendations by the year they were uploaded to the Datix system demonstrates progress in closing and completion of older incidents.

- Much of the positive reduction in patient safety recommendations has been achieved through:
 - Updating the records, evidence and audit trail of recommendations that had already been completed but not updated on the Datix system
 - Reviewing and updating recommendations that have been superseded by developments to practice and service delivery (these have been brought to the Executive Incident Review Group for oversight and approval of recommendation closure)
 - Linking and closing duplicate actions where the same recommendation already exists
 - Liaising with relevant leads within the new organisational structure to ensure action ownership is passed on to the correct lead.

References:

Sherwood, H. (2022). Why is the Christian Population of England and Wales declining? The Guardian. Available online: <https://www.theguardian.com/world/2022/nov/29/why-is-the-christian-population-of-england-and-wales-declining>

