**Derbyshire Healthcare NHS Foundation Trust**

Report to the Board of Directors – 4 March 2025

**Learning from Deaths/Mortality Report – 1 October to 31 December 2024**

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| **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 October 2024 to 31 December 2024. |

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| **Executive Summary**   * The Trust received 582 death notifications of patients who had been in contact with our services in the last three months. There is very little variation between male and female deaths; 319 male deaths were reported compared to 263 females. * The Trust has reported five Learning Disability deaths in the reporting timeframe and no deaths of patients with a diagnosis of autism. * Medical Examiner Officers have been established at all Acute Trusts in England and their role will be extended to include deaths occurring in the community, including at NHS Mental Health and Community trusts. The implementation of this process came into force on 9 September 2024. Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area. * Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning. * A process has been implemented within the patient Electronic 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. These forms are audited. |

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| **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. |  |
| **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. |  |

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| **Risks and Assurances**  This report provides limited assurance that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths. |

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| **Consultation**   * This report has been reviewed by the Medical Director, Deputy Director of Nursing and the Director of Nursing, AHPs, Quality and Patient Experience * Executive Incident Group * Quality and Safeguarding Committee, 11 February 2025. |

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| **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). |

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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:   * During 1 October to 31 December 2024, there was very little variation between male and female deaths; 319 male deaths were reported compared to 263 female deaths, * No unexpected trends were identified according to ethnic origin or religion. |

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| **Recommendations**  The Board of Directors is requested to accept this Mortality Report with limited assurance from the Quality and Safeguarding Committee and agree for the report to be published on the Trust’s website as per national guidance. |

**Report presented by: Arun Chidambaram**

**Medical Director**

**Report prepared by: Louise Hamilton**

**Safer Care Co-ordinator**

**Rachel Williams**

**Lead Patient Safety/Experience, Patient Safety Specialist**