South West Yorkshire Partnership Teaching NHS Foundation Trust

Learning from Healthcare Deaths Report 2025/26

Cumulative data covering the period 1/4/2025 – 30/6/2025

(Please note this report is extracted from the Patient Safety Oversight Report Quarter 1 2025/26)

Background context

Introduction

Scrutiny of healthcare deaths remains high on the Government's agenda. The Trust has had a Learning from Healthcare Deaths policy in place since 2017 in line with the National Quality Board guidance. It sets out how we identify, report, review and learn from a patient's death. The Trust has been reporting and publishing our data on our website since October 2017.

Most people will be in receipt of care from the NHS at the time of their death and experience excellent care from the NHS for the weeks, months and years leading up to their death. However, for some people, their experience is different, and they receive poor quality care for several reasons including system failure. The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people. Therefore, it is important that organisations widen the scope of deaths which are reviewed to maximise learning. The Confidential Inquiry into premature deaths of people with learning disabilities showed a very similar picture in terms of early deaths.

The Trust worked collaboratively with other providers in the North of England to develop our approach. The Trust will review reportable deaths in line with the policy. We aim to work with families/carers of patients who have died as they offer an invaluable source of insight to learn lessons and improve services. A representative from the Patient Safety Support Team attends the quarterly Regional Mortality Meetings; this aims to facilitate the dissemination of good practice around learning from deaths between organisations.

This quarterly Learning from Healthcare Deaths paper will be an appendix to the quarterly Patient Safety Oversight Report that is submitted to Quality and Safety Committee and Trust Board.

Scope

The Trust has systems that identify and capture the known deaths of its service users on its electronic clinical information system. The Trust's Learning from Deaths policy sets out how deaths should be responded to, which deaths are reportable and how they will be reviewed, and how we will engage with bereaved families.

For core reporting principles, the Trust is deemed the main provider of care, if at the time of death, the patient was subject to:

1. An episode of inpatient care within our service.

2. Patient discharged from SWYPFT inpatient bed in the 30 days prior to death.
3. An episode of community treatment due to identified mental health, learning disability or substance misuse needs.
4. A Community Treatment Order.
5. A conditional discharge.
6. An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).
7. Guardianship
8. Deprivation of Liberties legislation (DOLS)

It should be noted that there will be some overlap in reporting with other providers due to complexities in healthcare provision.

Each reported death that meets the scope criteria is reviewed in line with the three levels of scrutiny the Trust has adopted in line with the National Quality Board guidance:

In scope deaths should be reviewed using one of the 3 levels of scrutiny:		
1	Death Certification	Details of the cause of death as certified by the attending doctor. In some cases, we may only be aware that death was certified (or reported to the coroner), without any information about the specific cause of death.
2	Case record review	Includes: (1) Managers 48-hour rapid review (2) Structured Judgement Review (3) Case note review
3	Investigation/ learning response	The Trust began working under the Patient Safety Incident Response Framework on 1 December 2023 and reviews of deaths may include: • After Action Review • Specialist Learning Review • Patient Safety Incident Investigation (PSII) • Learning from Life and Death Reviews (LeDeR) (learning disability and autism deaths) • Safeguarding review

Reported deaths are mainly service users/patients who have died whilst receiving current care in the community, or where this was within the 6 months leading up to their death. All reported deaths are reviewed to understand if the death meets the critieria for being in scope for mortality review using the criteria described earlier.

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Annual Cumulative Dashboard[1] Report 2025/26 covering the period 01/04/2025 – 30/06/2025

Figure 1 Summary of 2025/26 Annual Death reporting by financial quarter to 30/06/2025

Reporting criteria		2024/ 2025 total	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4	2025/ 2026 Total
1	Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death[2]	2150	456				456
2	Total number of deaths reported on Datix by staff (by reported date, not date of death) and reviewed	427	101				101
3	Total Number of deaths which were in scope	282	74				74
4	Total Number of deaths reported on Datix that were not in the Trust's scope	145	27				27

Figure 2 Statistical Process Control charts for all deaths reported 01/07/2023 – 30/06/2025 by date reported and all deaths which were in scope for further review

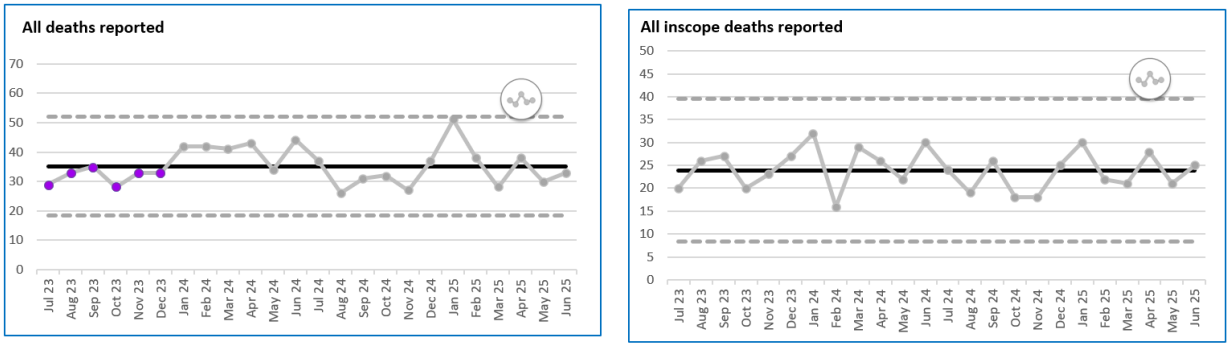

Figure 2 shows two Statistical Process Control charts over the period between 01/07/2023 - 30/06/2025. Firstly this shows all reported deaths (by reported date). There is natural variation in the data relating to those who have died which have been reported as incidents. January 2025 showed an increase in the number of deaths reported, however there are no areas of special cause variation that require further exploration at this time. Many of these deaths were not in scope in line with the critieria described above. The second chart shows those deaths which were in scope, and these were in normal variation.

[1] Dashboard format and content as agreed by Northern Alliance group.
[2] Data extracted from Business Intelligence Dashboards. Data is refreshed each quarter so figures may differ from previous reports. Data changes where records may have been amended or added within live systems

Figure 3 Breakdown of the total number of in scope deaths reviewed in 2025/26 by Care Group by financial quarter

Financial quarter - date reported	Barnsley Physical Health & Wellbeing Care Group	Mental Health Care Group (Inpatient)	Mental Health Care Group (Community)	Learning Disability and ASD/ADHD Care Group	Forensic Services Care Group	Cheswold Park Hospital	Children Young People and Families Care Group	Total
2025/26 Q1	0	4	59	10	0	1	0	74
2025/26 Q2								
2025/26 Q3								
2025/26 Q4								
Total	**0**	**4**	**59**	**10**	**0**	**1**	**0**	**74**

Figure 4 Summary of total number of all in scope deaths in 2025/26 by the respective level of mortality review process

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review			Level 3: Learning Response					
	Certification of death	Manager's 48-hour review (1st stage case note review)	Structured Judgment Review (SJR)	Case Note Review	After Action Review	Specialist Learning Review	Patent Safety Incident Investigation (PSII)	Learning Disability Death process (LeDeR)	Other reviews	Total
2025/26 Q1	7	53	5	0	1	0	0	8	0	74
2025/26 Q2										
2025/26 Q3										
2025/26 Q4										
Total	**7**	**53**	**5**	**0**	**1**	**0**	**0**	**8**	**0**	**74**

Figure 3 above shows the total number of all in scope deaths in 2025/26 to date by care group. Figure 4 shows how those deaths were reviewed, with the majority of mortality reviews are undertaken through a first stage case record review (a Manager's 48 hour rapid review). This report has a singular review process for each death, although many will have also had other levels of review to aid decision making.

Learning Disability deaths

The death of any patient with a diagnosis of Learning Disability and/or Autism is reported to the Learning from Life and Death Reviews LeDeR[3] process. It should be noted that the figures in the sections below may not tally with the numbers by care group (in figure 3 above). This is because we identify Learning Disability and Autism diagnosis not just through the reporting team, but by a field on Datix to determine if any patient who died had a learning disability or autism diagnosis, irrespective of where they were cared for. For example, in figure 6, of the 13 deaths, 10 patients were under the care of learning disability teams, and three were under Core Team care. Of those three patients, 2 were reported to have a learning disability, and one had an autism diagnosis.

The Learning from Life and Death Review (LeDeR) programme was previously known as the Learning Disabilities Mortality Review. The LeDeR work originated from the Confidential Inquiry into the Premature deaths of people with Learning Disabilities (CIPOLD). Information available here: https://www.england.nhs.uk/wp-content/uploads/2021/03/B0428-LeDeR-policy-2021.pdf In line with the national reporting of deaths, we are required to separate our reporting of in scope deaths into learning disability deaths and all other deaths. Figures 5 and 6 below provide this breakdown.

Figure 5 below shows the number of learning disability/autism deaths and their status of being reported to the Learning from Life and Death Review Programme (LeDeR).

Figure 5 Summary of total number of in scope deaths in 2025/26 by the Review process (including people with Learning Disability and/or Autism deaths)

	Reported to Learning Disability Death process (LeDeR)	Reported on LEDER by another organisation	Not reportable to LEDER as under 18 years of age	Total
2025/26 Q1	12	1	0	13
2025/26 Q2				
2025/26 Q3				
2025/26 Q4				
Total	12	1	0	13

LeDeR reviews are led by colleagues outside of the Trust services, such as from an Integrated Care Board. This gives them objectivity and the ability to review the whole care provision of the person who has died. As these reviews can take some time to conclude, we as managers complete the Manager's 48-hour rapid review to ensure any internal learning and reflection can take place.

Other deaths

Figure 6 below shows all deaths where the patient is recorded as not having a learning disability or autism diagnosis and what level of review was completed. All deaths reported have the Manager's 48 hour review completed to ensure the care and treatment leading up

[3] Learning Disability deaths reportable to Learning from Life and Death Reviews (LeDeR)

to a death was considered, although if there is another review process followed or the death was certified, this will be what is reported on.

Figure 6 Summary of total number of in scope deaths in 2025/26 by the Review process (excluding Learning Disability deaths)

Financial quarter - date reported	Level 1: Certified	Level 2: Case note review			Level 3: Learning Response			
	Certification of death	Manager's 48-hour rapid review (1st stage case note review)	Structured Judgment Review (SJR)	Case Note Review	After Action Review	Specialist Learning Review	Patient Safety Incident Investigation (PSII)	Total
2025/26 Q1	7	48	5	0	1	0	0	61
2025/26 Q2								
2025/26 Q3								
2025/26 Q4								
Total	7	48	5	0	1	0	0	61

Inpatient deaths

Figure 7 below shows that over the year 2025/26 to date there have been five inpatient deaths. All inpatient deaths are considered for the most appropriate level of review, and reported to LeDeR where necessary.

Figure 7 Trust wide Inpatient deaths in 2025/26 by date reported

Care Group	Service	Ward	Financial quarter - date reported				Total
			2025/26 Q1	2025/26 Q2	2025/26 Q3	2025/26 Q4	
Mental Health Care Group (Inpatient)	Older People Inpatient	Beechdale	1				1
		Crofton	1				1
		Poplars	1				1
		Ward 19	1				1
Cheswold Park Hospital	Low secure	Esk Ward	1				1
Total			**5**				**5**

The inpatient related deaths in Quarter 1 all related to physical health causes. Two patients had been discharged from a mental health inpatient ward at the time of death (within 30 days of discharge, and are reported in association with the ward in line with the learning from healthcare deaths policy. This is to ensure we can review to ensure any issues related to discharge can be reviewed. The other three deaths were of mental health inpatients who were detained patients, who were transferred to the acute hospital for treatment. Two of these patients died due to deterioration in their physical health. The third patient died suddenly whilst under the acute hospital care following surgery for a fractured neck of femur. The ethnicity of all five patients was the White - English/Welsh/Scottish/Northern Irish/British group.

Updates

- During Quarter 1, a review of the Mortality review group took place as part of the review of our Patient Safety Incident Response Plan. It was identified that the majority of the meeting's content focussed around processes rather than learning themes from our own deaths. As such it was felt that themes emerging from deaths we have reviewed was more appropriate to link with the re-launched Patient Safety Improvement Group. A refreshed agenda which includes learning from deaths will commence from September 2025. Processes that support the decision making around how we determine if a death resulted from a problem in care has also been reviewed in our PSIRF bi-annual review.
- The outcome of Structured Judgement Reviews are reviewed/approved by care groups, and where needed, they will create action plans for identified areas of concern.
- Resource for maintaining the administration process of SJRs has reduced, adding pressure to the Patient Safety Support team. Structured Judgement Review training continues to ensure we have staff in our pool of reviewers who can undertake reviews.
- The Bereavement Link Supporter role job description was launched on 5 May 2025 to coincide with the 'Dying Matters' week.
- Three sessions of Postvention Assisting those Bereaved By Suicide (PABBS) have been delivered this year, Feedback has been very positive.
- A questionnaire for family members about the experience of working with the Trust's family liaison officer has been developed and consulted on with Patient Safety Partners and the Quality Governance team. This is now ready to be rolled out for use by the family liaison officer when final contact with a family has taken place.
- Representatives from patient safety support team continue to attend both the Regional Mortality group (hosted by the Improvement Academy) and the Northern Alliance Group (mental health and learning disability Trusts). Both groups aim to support providers with sharing common themes across the region or Mental health settings.

Next steps

- Production of learning from deaths themes/data that will feed into the Patient Safety Improvement Group (PSIG) as described earlier
- Ensuring our PSIRF processes include identification of any case where a problem in care lead to a death occurring
- Reviewing the mortality agenda to ensure all aspects are covered.

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Patient Safety Support Team
14 July 2025