

## 1.0 Introduction

- 1.1 In March 2017 the NHS Quality Board issued national guidance on Learning from Deaths. This required Trusts to put in place a policy setting out their approach to mortality review and to publish data relating to deaths.
- 1.2 The Trust has one full time Mortality Reviewer (MR) and a Mortality Administrator Apprentice. The Mortality Reviewer undertakes structured judgment reviews (SJR's) for all East London Foundation Trust (ELFT) managed expected deaths and 25% of hospital and care home deaths. The Trust Mortality Administrator is responsible for the collection, analysis and reporting of data. The roles sit within the Governance & Risk Department working closely with incident review colleagues and are overseen by the Trust's Learning from Deaths Review Panel
- 1.3 The Learning from Deaths Review Panel consists of the following:
- Dr David Bridle (Consultant Psychiatrist and Medical Director/Chair)
  - Dr Paul Gilluley (Chief Medical Officer)
  - Lorraine Sunduza (Chief Nurse)
  - Abiola Ajayi-Obe (Associate Director of Governance & Risk)
  - Dr Ben Braithwaite (Clinical Director)
  - Ruth Bradley (Director of Nursing- Integrated Care)
  - Ruth Cooper (Operational and Strategic Lead for Learning Disability)
  - Sanjay Nelson (Consultant Psychiatrist and Clinical Director for LD)
  - Kim MacGillivray (Mortality Reviewer)

## 2.0 Background

- 2.1 In December 2015, the secretaries of State for Health commissioned the Care Quality Commission (CQC) to carry out a review of how acute, community and mental health Trusts across the country investigate incidents and learn from deaths. This was to find out whether opportunities for preventing deaths have been missed, and identify any improvements needed.
- 2.2 The NHS Quality Board national guidance was followed in July 2018 with specific guidance for NHS Trusts on working with families and carers. This was co-produced with families and carers to provide Trusts with advice on how they should support, communicate and engage with families following the death of someone in their care.
- 2.3 Whilst the guidance from the National Quality Board makes it clear that Trusts should report on inpatient deaths and those inpatients that have died within 30 days of leaving hospital. Locally Trusts are able to determine their own individual approaches to undertaking mortality reviews including definitions of deaths in scope for review.

Consequently, Mortality data is therefore not comparable between Trusts. As such the Trust will continue to evolve its processes and refine reporting over time in accordance with local and national learning. This is in addition to the detailed reporting and investigation of deaths meeting the national criteria for serious incident review.

### **3.0 Learning from Deaths Review Process**

- 3.1 Prior to the COVID 19 pandemic ELFT reviewed 100% of all expected deaths of Community Health and Mental Health patients in contact with ELFT services at the time of their death. These are Structured Judgement Reviews (SJR), a process to effectively review the care received by patients who have died. It also aims to improve learning and understanding about problems and processes in healthcare that are associated with mortality with a view to sharing best practice. 1 in 4 hospital or care home deaths are also reviewed via this process.

Between January and March 2021 the number of Community Health and Community Mental Health expected deaths subject to an SJR was reduced to 50%. Deaths that occurred in acute hospitals, care homes or hospices were also not reviewed between January 2021 and March 2021. These changes were made in agreement with the Learning from Deaths Panel due to the high volume of excess deaths reported during the period and the lack of capacity within the Mortality Team to undertake reviews of all cases. The increase of reported expected deaths was due to the second peak of the Coronavirus outbreak. Notably, in March 2021 reported numbers of expected deaths declined, SJR reviews returned to 100% in April 2021.

COVID 19 deaths were reviewed within the required percentage of SJRs.

- 3.2 Trends and themes are reported to the Learning from Deaths Panel. Any SJR that reveals any concerns around care provision, service provision, or identifies issues which may have contributed to the death of a service user or patient are presented to the Learning from Deaths Panel and, where appropriate, are reviewed via a serious incident Root Cause Analysis investigation.
- 3.3 Unexpected patient safety related deaths are directed to the Serious Incident Review (SI) team and are subject to either a panel led or corporate led investigation as appropriate.
- 3.4 All Learning Disability Deaths (LeDeR) in ELFT are allocated to the mortality reviewer who is also trained in root cause analysis. These findings are reported to NHS England and Bristol University.

### **4.0 Learning from Deaths Review Statistics**

#### **4.1 Total deaths**

A total of 2890 deaths were reported by the Trust between 1 April 2020 and 31 March 2021, this was an increase of 49.66% (1931) from deaths reported between April 2019 and March 2020. This increase can be attributed to the numbers of excess deaths due to the Coronavirus pandemic. There were 2637 expected deaths and 253 unexpected

deaths reported between April 2020 and March 2021. Of the 253 unexpected deaths 47 were subject to the SI process.

## **5.0 Expected Deaths**

### **5.1 Structured Judgement Review Process**

The application of a Structured Judgement Review (SJR) is to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened. At ELFT, SJRs are carried out by the Mortality Reviewer who examines the last 3 months of care provision provided to patients/Service Users (SU) prior to their death.

Any death that has been clinically assessed using a SJR of case records and is more likely than not to have resulted from problems in care provision will be raised and discussed at the monthly Learning from Deaths Panel.

### **5.2 Identified concerns from SJR of a death due to a problem in care**

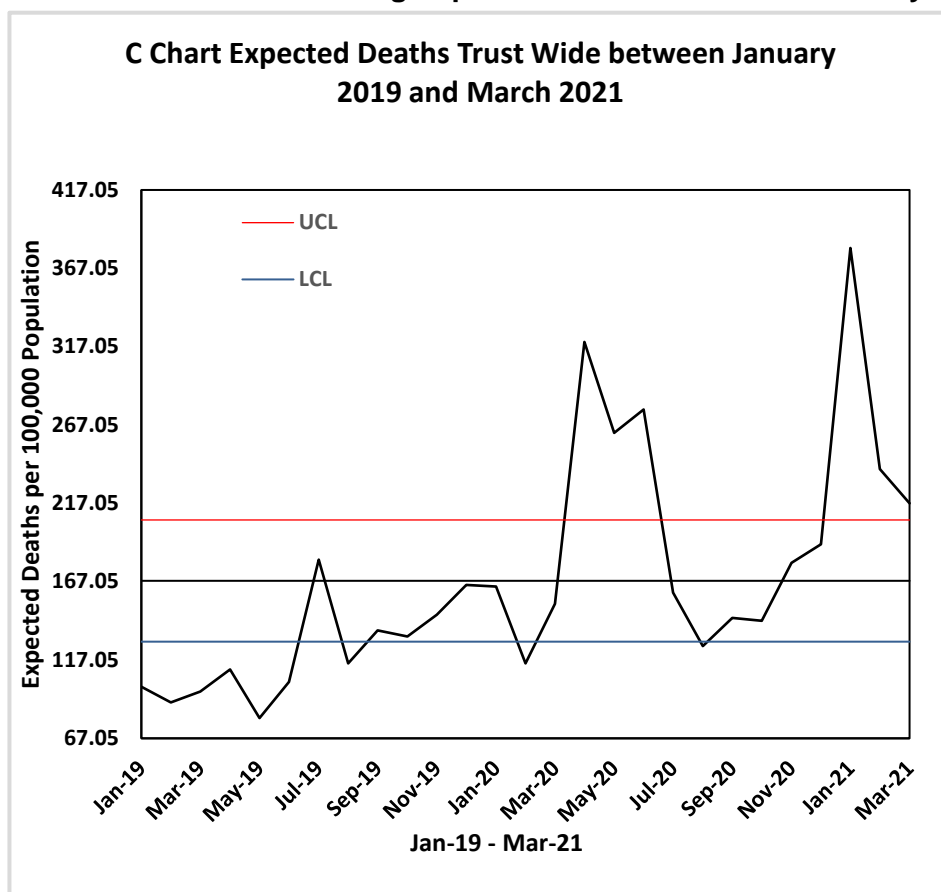
Where there are any concerns identified as a result of a SJR review into a death the panel will request a 48-hour report from the directorate/service to provide additional background information into the care and treatment of a patient /service user whilst under ELFT services.

Any case which requires further investigation will be subject to a Serious Incident (SI) Review and will be investigated by the ELFT SI Team.

Chart 1 below is a C chart showing the data on expected deaths Trust-wide from the start of mortality data collection in January 2019. A total of 2637 patients died expectedly between April 2020 and March 2021, the reporting period.

Table 1 below shows a breakdown of expected deaths Trust Wide by Directorate between April 2020 and March 2021.

Chart 1 - C Chart showing Expected Deaths Trust-wide January 2019 until March 2021



C Chart

2019 - 2021	Expected deaths
Jan 19	100
Feb 19	90
Mar 19	97
Apr 19	111
May 19	80
Jun 19	103
Jul 19	181
Aug 19	115
Sep 19	136
Oct 19	132
Nov 19	146
Dec 19	165
Jan 0	164
Feb 20	115
Mar 20	153
Apr 20	320
May 20	262
Jun 20	277
Jul 20	160
Aug 20	126
Sep 20	144
Oct -20	142
Nov 20	179
Dec 20	191
Jan 21	380
Feb 21	239
Mar 21	217

Table 1. Breakdown of expected deaths by Directorate from April 2020 - March 2021

Breakdown of expected deaths by Directorate	Total
<b>Mental Health Services</b>	
Bedfordshire Mental Health Services	209
City and Hackney Mental Health Services	139
Forensic Services	3
Luton Mental Health Services	90
Newham Mental Health Services	152
Tower Hamlets Mental Health Services	192
<b>Community Health Services</b>	
Tower Hamlets Community Health Services	546
Newham Community Health Services	566
Bedfordshire Community Health Services	694
<b>Specialist Services</b>	
Specialist Services and CHN Children's Services	46
<b>Total :</b>	<b>2637</b>

Mental Health Services reported 782 expected deaths, 29.65 % of the total 2637 reported between 1 April 2020 and 31 March 2021.

Bedfordshire reported the highest number of expected deaths in the Trust's Mental Health Services at 209 in the reporting period, 7.9% of the 782 total reported.

Higher figures in Bedfordshire can be explained by the larger population size; population age and physical health related deaths related to people accessing services such as Memory clinics and Older Persons Occupational Therapy. In addition, the number of patients supported to die at home across Bedfordshire had increased, this coincided with the decrease in deaths in care homes and hospices in the area throughout the summer months of 2020. Public Health England excess mortality reports support findings that unlike Acute Trusts; care homes and hospices, Community Health Services saw an increase in excess deaths.

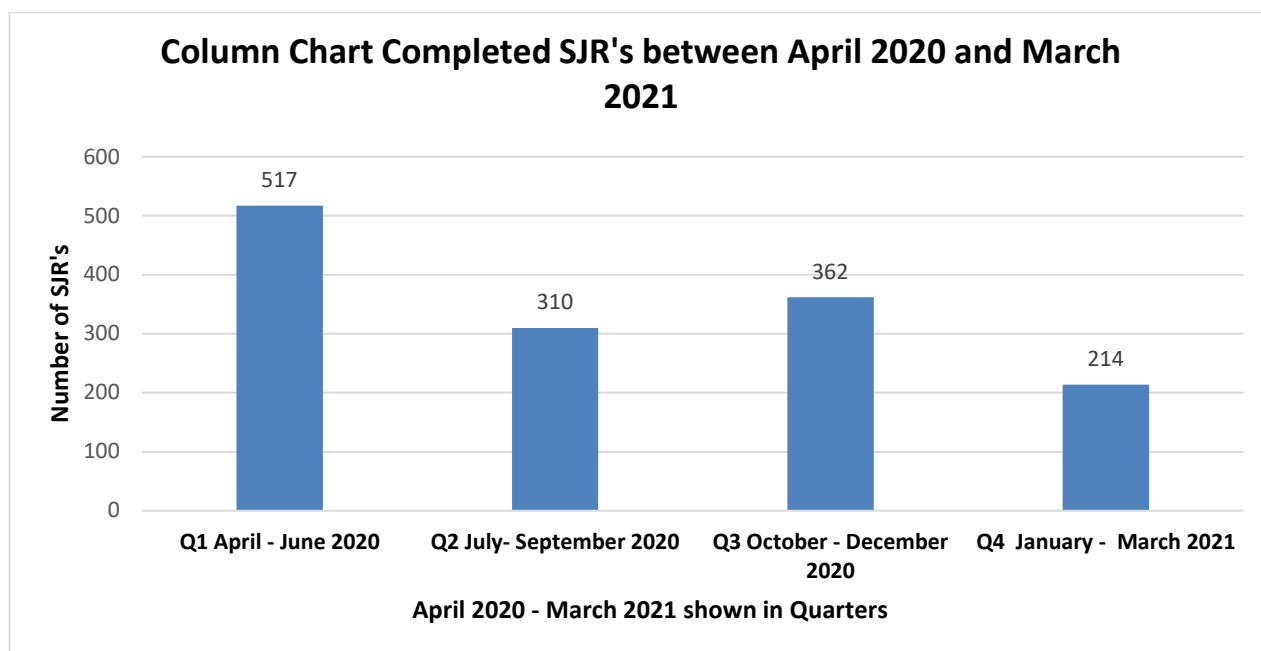
There were 46 expected deaths in Specialist Services, Children's Services and different therapies. Forensic Services reported 3 expected deaths in the reporting period.

The Peaks in expected deaths in March and April of 2020 and January and February of 2021 are directly correlated with the Covid-19 peaks during these periods.

### 5.3 Deaths reviewed under the SJR Process

A total of 1403 SJR's were carried out between 01 April 2020 and 31 March 2021. This was an increase of 72.35% (814) from the previous year between April 2019 and March 2020. The increase in reviews was due to the number of excess deaths reported due to Coronavirus pandemic.

**Chart 2. Column Chart Structure Judgement Reviews from January 2019 until March 2021**



Column chart

A total of 1403 deaths were reviewed in the reporting period April 2020 until March 2021. Patients whose expected deaths resulted in a structured judgement review tended to be older and either accessing Community Health Services or Mental Health Services such as the Memory Clinics and therapies. Many of the older Mental Health Service users were also under continence; podiatry and diabetic services.

Overall expected deaths were higher in Community Health Services as they include more patients' over 65, older and terminally ill patients and patients in receipt of palliative or end of life care. Within this cohort of patients, the highest number of deaths arose in patients with cancer and organ failure. Cancer related deaths were higher in all age ranges followed by deaths from organ failure. Older patients also died from causes related to end stage dementia. There was an overall increase in deaths over the year and excess deaths were due to the Coronavirus pandemic.

## **6.0 COVID 19**

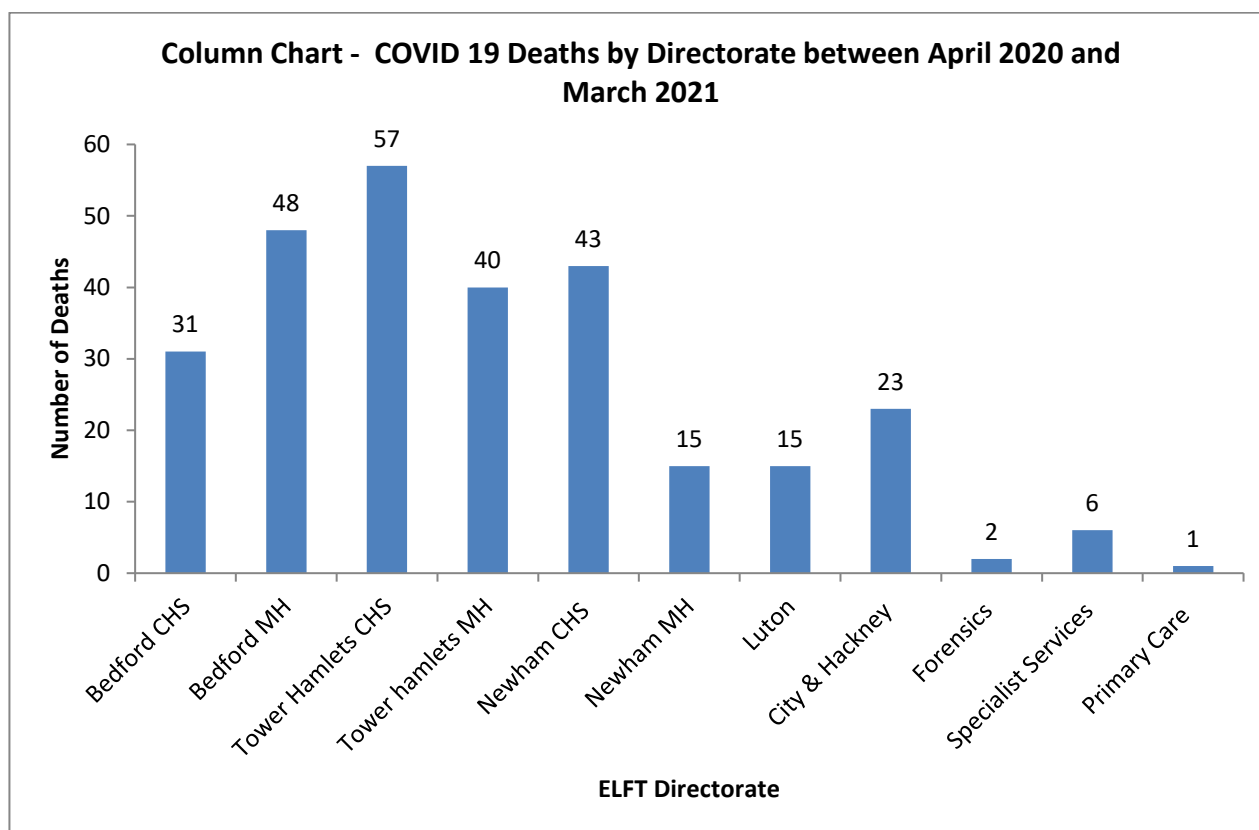
A total of 281 patients died, during the reporting period, Trust Wide who had tested positive for COVID 19 in the 28 days prior to death, of which 30 were inpatient deaths.

The remaining 251 deaths were in the community and death occurred either in a care home; an acute hospital; or in the patient's own home.

The increase in excess deaths due to Coronavirus occurred over two windows where the virus peaked, between March and April 2020 and January and February 2021.

The column chart below shows the total number of COVID 19 related deaths by Directorate. There were 5 deaths where COVID 19 was the primary Cause of death and where 1a COVID 19 was recorded on the patient death certificate.

**Chart 3. Column Chart COVID 19 Deaths by Directorate**



A Palliative Care Review in Bedfordshire and the SystmOne case notes show that swabbing was not carried out on symptomatic patients that were known to be palliative unless they had expressed a wish to be admitted to either a hospice or a care home. This would suggest that numbers of COVID 19 related deaths in Bedfordshire could be higher than reported.

Inpatient Wards with COVID 19 deaths

**Table 2. Showing COVID 19 Inpatient Deaths**

COVID 19 Inpatient Deaths	
Fothergill Ward, (Newham, Older Adults End of Life Care and Rehabilitation COVID 19 ward)	15
Sally Sherman Ward (Newham Older Adults Continuing and Respite Care)	3
Fountains Court (Bedfordshire , Older Persons Mental Health )	2
Crystal Ward (Bedfordshire , Female Acute Mental Health)	1
Willow Ward ( Bedfordshire , Female Acute mental Health)	1
Columbia Ward ( Tower Hamlets - Older Persons Degenerative Brain Disorders/ Dementia)	2
Brett Ward ( City & Hackney, Adult Acute Admission Mental Health )	1
Poplars Ward (Bedfordshire & Luton, Older Persons Functional and Organic Mental Health)	2
Butterfield Ward ( Low Secure Forensic)	1
Bow Ward ( Forensic Medium Secure - Women Service)	1
Archer Unit ( Bedfordshire, Adult mental health Rehabilitation)	1

COVID 19 deaths were reviewed within the samples of SJR's. During the first outbreak a separate review of 16 inpatients' who were not transferred to an acute hospital was completed. These deaths were 'of patients who were on an End of Life Pathway prior to contracting COVID 19 and were not for resuscitation or for ventilation. All had authorised Do Not Attempt Resuscitation (DNAR) in place and they remained under the care of the ELFT wards they were admitted to for End of Life Care.

Fothergill Ward was a dedicated ward for the care of COVID 19 patients and received admissions from Sally Sherman ward, the Community and Newham University Hospital.

Three inpatient deaths where the patient was under a section of the MHA were reviewed under the SI process.

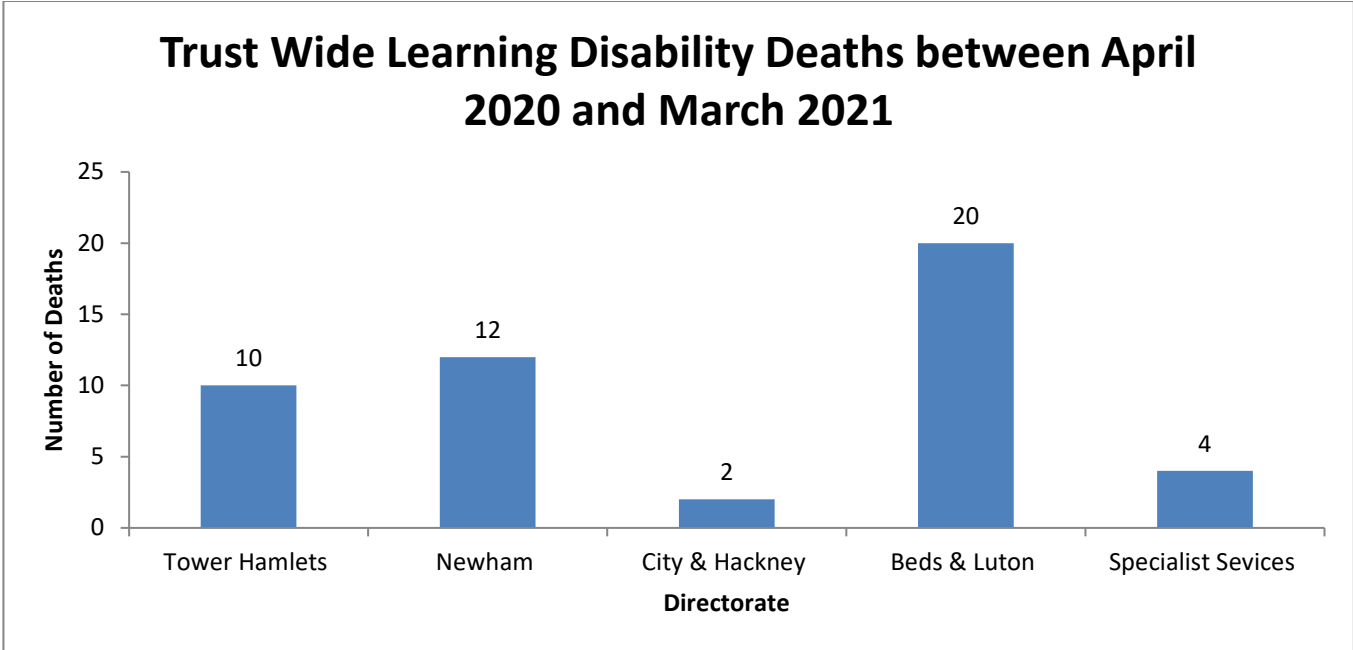
Notably, all COVID 19 deaths amongst ELFT community and inpatients had co-morbidities

**7.0 Deaths reported to the Learning Disability Mortality Review (LeDeR)**

48 deaths were reported where the patient had a Learning Disability between April 2020 and March 2021. There were 4 deaths from Specialist Children's Services, a 6-year-old under the care of the Children's Community Nursing Team in Newham; A 19-year-old, an 18-year-old and a 7 year old. All of whom were under Newham Complex Care Dianna Team. There were 20 deaths in total under Beds and Luton Learning Disability Services.

24 Learning Disability deaths were COVID 19 related. Beds and Luton Learning Disability Services had the highest number with 17.

**Chart 4. Column Chart showing Learning Disability Deaths by Directorate between April 2020 and March 2021**



Column Chart



The high number of deaths in Bedfordshire and Luton reflect the large number of people that live in either residential or supported living accommodation in the locality - there were a number of significant outbreaks in homes that sadly resulted in the loss of many people who have a Learning Disability. It is also of note that many of these people had high levels of physical health co-morbidities.

The criteria for shielding also changed prior to the second wave to include people who have Down's syndrome which supported both primary and secondary care to consider delivery in a different way.

## **8.0 Unexpected Deaths**

A total of 253 unexpected deaths were reported Trust Wide between April 2020 and March 2021. Notably, not all unexpected deaths meet the threshold to be investigated as a Serious Incident Review. Of the 253 reported on DATIX, the Incident Reporting database used by ELFT, 47 met the threshold for review via the SI process. The remaining 206 reported unexpected deaths were either – unexpected where the cause of death was known; unexpected, under palliative care but did not die within the expected timeframe or unexpected but not patient safety related.

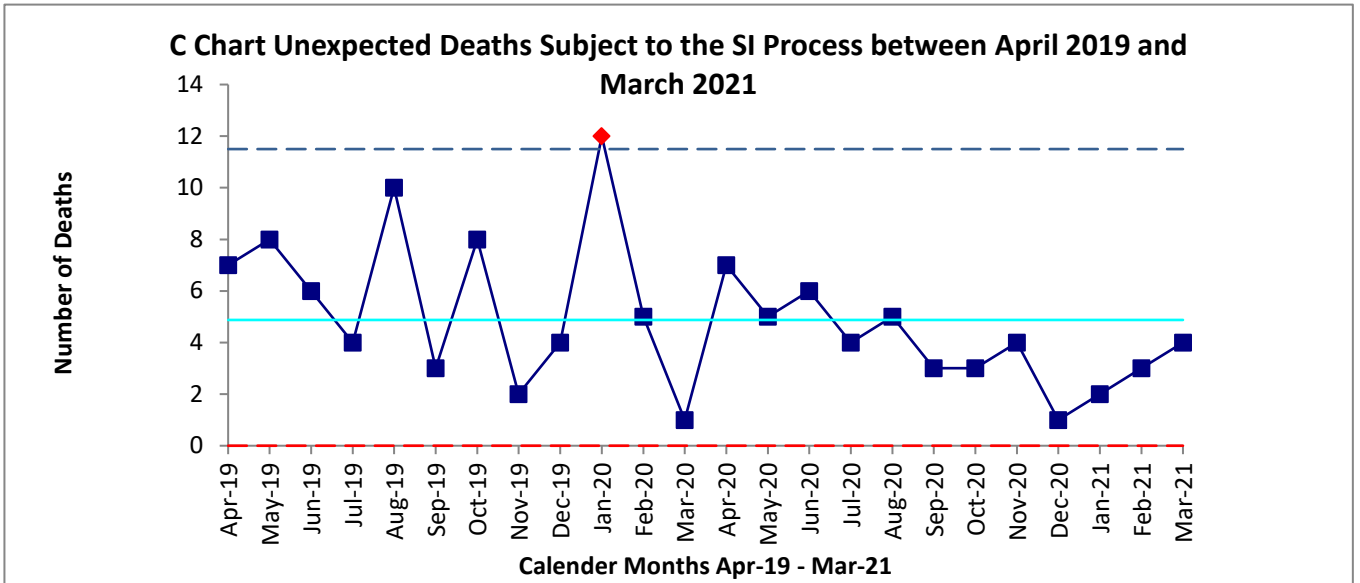
### **8.1 Serious Incident Review Process (SI)**

An SI review is a systematic analysis of an iatrogenic or naturally occurring incident, including unexpected deaths, to identify what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to, where possible, reduce the risk of future occurrence of similar events.

### **8.2 Unexpected Deaths subject to investigation**

There were 47 deaths that were escalated to an SI between April 2020 and March 2021. Chart 6 below shows the number of unexpected deaths that were subject to an SI between April 2019 and March 2021.

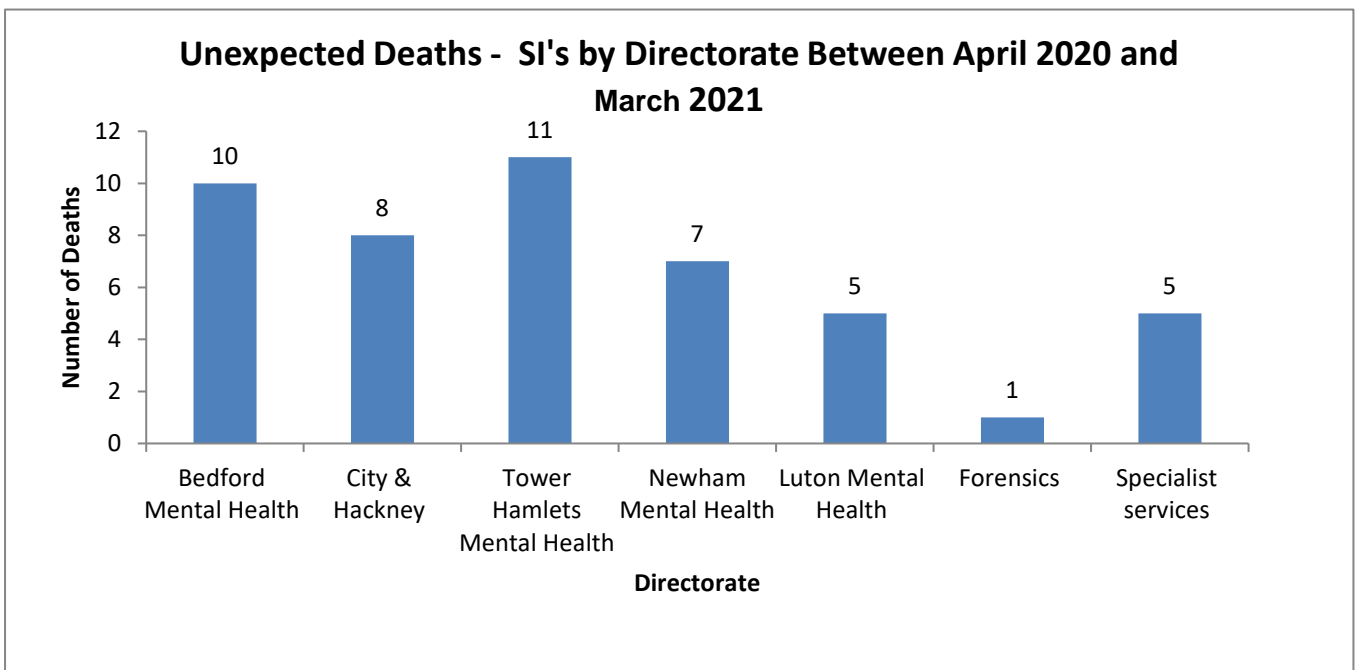
**Chart 5. C Chart - Unexpected Deaths Subject to the SI Process between April 2019 and March 2021**



C chart

Chart 6 below shows the number of unexpected deaths reviewed as an SI by Directorate. Tower Hamlets Mental Health and Bedford Mental Health had the highest number of patient safety related deaths. The highest number of deaths reported by Mental Health Services was suspected suicides. There were 40 that were subject to the SI process.

**Chart 6. Column Chart - Unexpected Deaths SI's by Directorate**



Column chart

## 9.0 Learning from Inquests

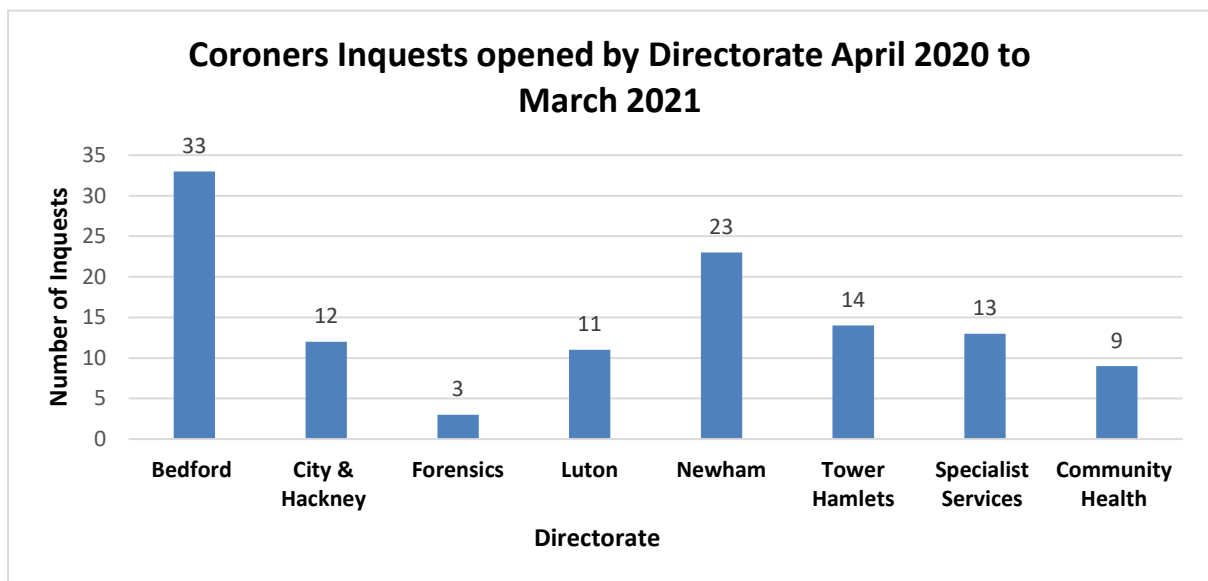
A death is reported to a Coroner in the following situations:

- a doctor did not treat the person during their last illness
- a doctor did not see or treat the person for the condition from which they died within 28 days of death
- the cause of death was sudden, violent or unnatural such as an accident, or suicide
- the cause of death was murder
- the cause of death was an industrial disease of the lungs such as asbestosis
- the death occurred in any other circumstances that may require investigation

A death in hospital should be reported if:

- There is a question of negligence or misadventure about the treatment of the person who died
- they died before a provisional diagnosis was made and the general practitioner is not willing to certify the cause
- the patient died as the result of the administration of an anaesthetic
- death should be reported to a Coroner by the police, when a dead body is found death is unexpected or unexplained, or when a death occurs in suspicious circumstances

**Chart 7. Coroners Inquests opened by Directorate**



Column Chart

### 9.1 Number of deaths subject to Coroner's Inquest and Verdicts between April 2020 and March 2021

Notably, not all the deaths heard at Coroners Court between April 2020 and March 2021 occurred during the time period being considered. And not all of the Coroners Inquests that have been opened during the reporting time period have been closed.

A total of 118 inquests into deaths of ELFT patients' / service users were opened at Coroners Court during the reporting period, 88 of which were concluded.

There were 9 Community Health Service related deaths heard at inquest. The highest number of deaths heard at inquest were from Bedford Mental Health services with a total of 33. The highest number of ELFT deaths which resulted in a Coroner's Inquest relate to death by drug use.

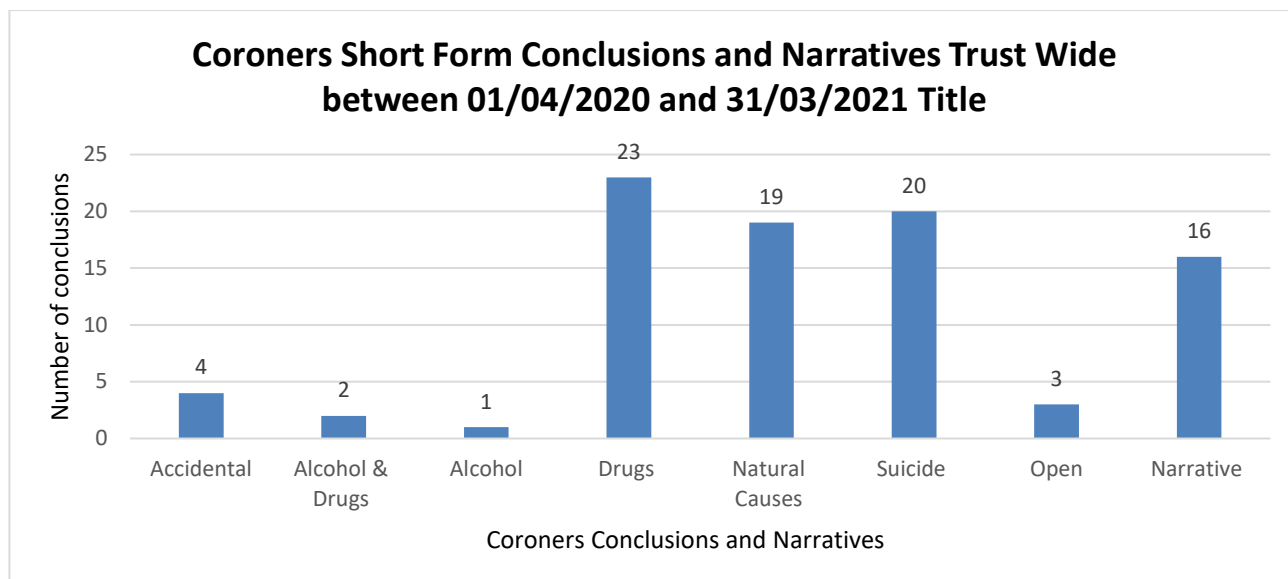
Nationally deaths as a result of suicide are, sadly, one of the most frequent causes of death to people who have accessed mental health services. The Trust together with NHS England are actively working to reduce the number of deaths by suicide with a number of initiatives including; adopting the 10 Key Elements of the National Confidential Inquiry into Suicide and Safety.

The Trust has a designated Lead for Suicide Prevention who has been in role since March 2020. Following the success of a Trust wide workshop on Suicide Prevention the previous year it was recognised that further regular sessions and workshops would share good practice and identify interventions that are taking place. Weekly sessions are now being facilitated. A Suicide Prevention Webinar to mark World Suicide Prevention Day was held for anyone who lived or worked in Bedfordshire in September 2020.

The Trust has a legal team who provide support and advice to all staff who are summonsed to inquests as witnesses.

## 9.2 Coroners Short Form Conclusions

**Chart 8. Coroners Short Form Conclusions and Narratives**



Column Chart

There was a total of 20 suicide verdicts Trust-wide. Suicide, sadly, was the second highest cause of death during this period. Drug use caused the highest number of deaths at 23 patients Trust Wide.

### 9.3 Coroners Narrative Conclusions

There were 16 narrative conclusions made between 01 April 2020 and 31 March 2021

<b>Coroners Narrative Verdicts</b>
The patient died as a result of a chronically-infected hemi-arthroplasty of the right hip. Concerns about the wound were immediately apparent upon him returning home from hospital, following admission for his hemi-arthroplasty surgery. There are no hospital records to show the condition of the wound on discharge from hospital. There was thereafter, a delay in his returning to the hospital for treatment of the infected hemi-arthroplasty site. It cannot be proven, on the balance of probabilities that earlier re-admission to hospital would have avoided his death on the 27 August 2019.
The patient died on the 15th June 2020 after taking his own life. He fell to his death from a car park. He had a long history of psychiatric illness made worse by his substance misuse and alcohol and the combination made him depressed leading to his untimely death.
The deceased died from self-inflicted injuries after becoming overwhelmed by his depression.
The deceased left the third floor window of his home as a result of a drug induced psychosis and died. His death was not a suicide, it was drug related. He spoke to a Crisis line nurse whom did not call him back and had failed to arrange a visit by the urgent assessment team. Five hours later he left the window. The ambulance service then attended and failed to appreciate the severity of his injuries, but that did not impact upon the outcome as the injuries were too severe to allow his life to be saved.
Deceased died as a result of cor pulmonale (right ventricular failure) and further strain on his heart from amphetamine use which he found helped relieve symptoms of suspected attention deficit hyperactivity disorder while awaiting assessment.
Patient died as a result of his own deliberate act whilst suffering symptoms of psychosis, such that his true intention cannot be established by the evidence
Deceased sustained serious head injuries in a fall from a balcony in 2010. Following the fall, deceased developed manic depression and made a number of attempts to take her life. She was known to mental health services but was discharged in 2016. She had stopped taking antidepressants around the same time. Arrested by police on 20 February 2019. Following her arrest, she expressed thoughts of wanting to die and attempted to gain access to her balcony. The arresting officer believed that she wanted to jump from the balcony and restrained her. She was taken to the custody suite at the Police Station. Risk assessed and seen by psychiatric liaison nurse, who told the custody sergeant that she needed no further mental health assessment, she was released but unable to return to her own flat which was crime scene4. It is not clear what she did over the following days but she returned and jumped from her balcony sustaining injuries incompatible with life. Multiple suicide notes were found.
Deceased died after being struck by a train. There is no evidence he intended to end his own life. His intentions in entering the track level are otherwise unclear. It seems likely that alcohol intoxication obviated against him taking evasive action.
The deceased fatally suspended himself with a belt, but the evidence does not disclose whether he intended to end his own life.
The Coroner was satisfied that the deceased took the action that led to his death and at the moment he had the intention of bringing about his death on the balance of probabilities.
The Coroner said she hadn't yet decided whether to issue the Trust with a Pfd. She said she was concerned in particular about how the GP's referral to the HTT was received and processed; and the GP's evidence about the difficulties referring a patient to the HTT. GP

was also concerned that the deceased wasn't referred to EPC, and that GP had not been informed of discharge in Jan 2019 from CMHT.
Deceased was treated in the community by carers and district nurses. In July she deteriorated and her ulcer became infected. On 27 July an ambulance was called and following an assessment by the paramedics she was not admitted to hospital. On 29 July there were clear signs of sepsis, she was admitted to hospital where she was treated but she deteriorated and died on 18 August.'
Deceased died as a result of the natural cause of pulmonary embolism. The pulmonary embolism is likely to have been, in part, contributed to by a pressure ulcer and immobility both of which had developed whilst in NHS care. The Coroner will be issuing a paragraph 37 letter to the Trust about glucoboost gel use which requires a Trust response.
The deceased died as a result of a fall caused by a seizure.
The deceased jumped to his death but his intentions in doing so remained unclear.
The deceased died from a combination of natural causes and recognised complication of surgery.

#### 9.4 Themes for Unexpected Deaths

- Poor or no follow up after discharge from a ward and lack of appropriate referral
- Failure to document information on the patient electronic recording systems
- Poor or no communication between multi services, Drug and Alcohol; Psychiatric Liaison and Community Mental Health Services
- Failure to follow intermittent/general observation policy
- Failure to monitor physical health observations and follow policy
- Poor record keeping
- Poor communication between professionals
- Poor assessments

#### 9.5 Suicides and Homicide

There were a total of 20 suicides determined by concluded Coroner's inquests during the reporting period.

#### 9.6 Themes from Prevention of Future Deaths Reports

There were no prevention of Future Deaths reports between April 2020 and March 2021

#### 9.7 Themes from Inquest Verdicts

Themes

The data captured at the end of Quarter 4 was not as complete as has been the case in Quarters 1-3 of the reporting period. This is due to a number of deaths that have not yet been heard at Coroners Court.

A review of all deaths heard at inquest has been undertaken and the following themes identified from the 88 concluded inquests conducted into unexpected deaths held during the reporting period as follows:

- Lack of/failure to update care plans/risk assessments
- Lack of appropriate follow up (following referrals and ward discharge)
- Lack of Communication between Trust Drug and Alcohol ;Psychiatric Liaison and Community Mental Health Services
- Multi-agency communication (probation/housing)
- Delay in allocation of care co-ordinator
- Poor communication between teams /clinicians
- Actions not being discussed and actions not being carried out following MDT meetings.
- Key individuals not being invited to meetings
- Opiate guidelines not followed correctly
- Poor management of MEWS (Modified Early Warning Score) scores
- Inadequate resuscitation process
- Failure to inform family that patient died on the ward
- Lack of understanding of the observation policy / Physical Health not monitored
- Poor documentation on RiO (the Trust's electronic patient record database).
- Procedure/ protocol not followed (referrals);
- Poor record keeping;
- Delay/ Lack of communication between CMHT and GP;
- Lack of assessment/ assessments not being undertaken in a timely manner;

All of the above issues were identified in SI reviews, conducted into these deaths heard at Inquest. Associated recommendations and action plans have been developed to address these findings.

## 9.8 Last contact with ELFT Services

During the reporting period a total of 88 Coroner's Inquest were held and concluded.

## **10.00 Themes from Expected Deaths**

### 1011 Themes & Trends

The review looked at themes and trends from both expected and unexpected deaths across the Trust. The highest number of overall mortalities related to patients under Community Health Services.

There were more expected deaths than unexpected deaths. Unexpected deaths were higher in the Inpatient and Community Mental Health Services, where suicide was the highest figure. Outside of the higher numbers of reported deaths these findings are not unusual when compared to previous years' figures.

### End of Life Pathway (ELP) and Preferred Plan of Care (PPC)

Over the period 1 April 2020 and 31 March 2021 there has continued to be a steady increase in the number of patients with an End of Life Plan (ELP) in place. Patients that did not have an ELP in place and available for review had either; deteriorated unexpectedly requiring an emergent hospital or hospice admission or the patient was referred to ELFT and died before being seen or they were patients who had contracted and died from COVID 19.

### Age

The highest mortality rate was observed in the 76 – 100-year-old age group. Unsurprisingly, the highest number of deaths occurred with patients under Community Health Services. Deaths that occurred in patients' under the age of 18 were all under Specialist Children's Services and all had life limiting conditions.

### Gender

Differences in the numbers of deaths in males and females were noted monthly throughout the reporting period. Variations in gender were minimal and when observed as a collective showed that overall 34 more females died than males.

### Standard of care

Care of the dying person was reviewed using the East London Foundation Trust (ELFT) Dignity in Care at the End of Life Practice Guidance and the Gold Standard Framework (GSF) Guidance.

Dignity in Care at the End of Life Practice Guidelines enables teams to develop a person centred holistic plan of care enabling patients to make their own choices on where they wished to be cared for and their preferred place to die.

The Risk and Governance team also review the quality of information being reported on the daily DATIX incident report including: missing information, missing patient details and any other required information.

The GSF sets out 7 domains of guidance including; communication; co-ordination; control of symptoms; continuity of care; continued learning; care support and care in the dying phase. These domains are reviewed under the SJR process.



Between April 2020 and March 2021 the case notes reviewed under the SJR process showed that in general the care delivered across the Trust met the requirements expected when caring for a dying person and that had a GSF in place.

### Diagnosis and Cause of Death

The highest number of deaths was amongst cancer patients. Deaths from organ and respiratory failure saw an increase in the number of deaths especially between December 2020 and March 2021, this coincides with the second wave of COVID 19.

## **10.0 Conclusion**

The Covid-19 Pandemic which resulted in the first national lockdown on 23 March 2020, coincided with the start of the reporting period for this report. Sadly, the almost 50% increase in deaths during this reporting period can be directly correlated with the pandemic.

The highest number of deaths during this period also occurred during the peaks of the Covid-19 pandemic in April 2020 and again in February 2021. Indicating, the voracity of the disease on patients with co-morbidities which placed them at greater risk from the pandemic.

Some patients were symptomatic of COVID 19 but were never swabbed as they were receiving end of life care. They were not for resuscitation or for ventilation and had no wish to be admitted to a care home or hospice choosing to die at home.

Palliative patients at home who suddenly deteriorated with symptoms of or similar to COVID 19 were treated as such and assumptions were made that they had died because of COVID 19 despite not being swabbed.

Sadly, the high number of deaths in our patients'/service users with learning disabilities is yet another fall out from the pandemic. The effects on staff / carers responsible for the long term care of our Learning Disabled users should not be underestimated. These carer / staff groups had often developed long term supportive relationships and the loss of these patients'/ service users have had profound effects on those left behind.

Altogether, the highest proportion of deaths at ELFT occur within Community Health Services where the morbidity rate of patients is highest and where the number of patients in receipt of palliative care is greatest.

During the reporting period there, sadly, have been a total of 20 deaths which were concluded at Inquest as being due to suicide. These incidents of death by suicide are a matter that the Trust is resolved to work toward preventing and reducing. The use of the National Confidential Enquiry into Deaths Toolkit is one of several mechanisms the Trust has adopted to support initiatives in this area.

During the course of the year the group identified repetitions in themes arising following mortality reviews and moved to focus in greater depth on learning and driving improvements to end of life care planning and the revision of services where necessary.

Going forward, The Learning from Deaths Group 2021- 2022 plan is to focus on;

- I. Reviewing and evaluating End of Life Pathways to determine whether patients' preferences, including their wishes related to where they wish to die, have been met or not.
- II. Engaging in Partnership Learning from Deaths together with ELFTs partner healthcare providers including; GPs and Hospices.
- III. Reviewing, with the aid of the Structured Review of Deaths Toolkit;
  - deaths on the national personal demographics spine against those reported on the Trust's incident reporting database (Datix)
  - individual case reviews
  - Themes and trends identified from the process of care
- IV. Conducting High Level Strategic Reviews of all deaths to inform systems and planning processes.
- V. Embracing learning from PFD reports issued to other organisations where the patient safety of ELFT patients can be further enhanced.
- VI. Consider ways of providing enhanced support to ELFT staff emotionally affected by the death of long term patients'/service users.