Havering Safeguarding Adult Board Themed SAR re Discharges from Hospitals and Care Homes 2024

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HSAB Independent Chair

Date 7th November 2024

Introduction

Havering
Safeguarding Adults Board

The Care Act 2014, sections 44 (1), (2) and (3), requires that a Safeguarding Adult Review (SAR) is undertaken where an adult with care and support needs has died or suffered serious harm,
and it is suspected or known that the cause was neglect or abuse, including self-neglect,
and there is concern that agencies could have worked better to protect the adult from harm.
Under **section 44(4) a SAR can be undertaken in other cases** concerning adults with care and support needs

Referrals are considered by the HSAB (Havering Safeguarding Adult Board) Case Review Working Group. They advise the SAB chair who makes the final decision.

In 2023 and 2024, 5 adults died in Havering and SAR (Safeguarding Adults' Review) Referrals were made for them; they had common concerns regarding **the discharge of these individuals from Hospital or Care Home to their own home**. Therefore, a Themed Review was commenced. The situations and the families' responses highlighted other additional issues; however, I have ensured that the focus should be on the priority issue of Discharge.
This is a **final report setting out findings to date**, and progress related to the SAB following a meeting on 18th September 2024.
In summary, this SAR report goes on to illustrate several issues:

- **a need to improve discharge planning as a system;**
- **delays in previous SAR actions being undertaken and learning from failed discharges making little difference to the system, perhaps due to pressure of demand;**
- **significant demographic challenges to the borough looking forward which will have an impact on discharges;**
- **and a need to involve families and community teams more in the discharge process, including sourcing advocacy for the individual involved.**

Background

SAB Case Review Working Group meetings were held in respect of three individuals

- **S** (meeting held 31st July 2023)
- **D** (meeting held 9th August 2023)
- **J** (meeting held 10th October 2023)

- Panel members agreed that the cases of **D** and **S** met the criteria to undertake a statutory SAR. In respect of the other case, **J**, the panel members were split. The meeting minutes evidenced that the group members had a detailed conversation about the circumstances of each case, supported by a detailed level of case information provided by separate agencies.
- Whilst the circumstances of each case were very different, there was one area highlighted by the review group to be a major factor that impacted on the individual's subsequent care. The **common theme was the handling of the individual's discharge from various health or care settings**. Hospital discharges have also been common themes for other local SARs and national SARs, and so this review draws upon national learning and actions, and local actions.
- As the HSAB Chair, I decided that a themed SAR was appropriate in respect of Hospital and Care Home Discharges after reviewing the minutes of the Havering SAB Case Reviews.

The brief circumstances for 3 individuals were as follows:

S was a 55 year old male. He became bed bound in November 2022 due to poor mobility and complications following previous hip injury. He also suffered from diabetes and schizophrenia. He was discharged to home from hospital.
"There was a very poor discharge from Hospital for S…… There was a lack of discharge planning and agencies working together."
"S's hospital discharge was not appropriate or successful."

D was a 92 year old female. She had a history of OCD and mental health issues. She was discharged from Hospital to a Care Home during the COVID-19 pandemic, and from the Care Home to her own property in 2020, on the assumption that she was going to be looked after by her granddaughter, who would be staying with her. This was not the case. Her health subsequently deteriorated over the coming years, with minimal intervention. When taken to hospital in 2023 she presented as emaciated and had multiple pressure ulcers due to a fall several days previously, with maggots found in the wounds.

J was a 76-year-old female, J was very ill and was fast tracked to end of life care. Several care homes were contacted but all declined to take her. She was discharged from an Essex hospital to be cared for at home. She died 12 hours later after difficulties with suction. DNACPR not available. *"NELFT described J's discharge as having been "unsafe." "The discharge was not thorough or robust."*

Methodology

The statutory guidance **Care and Support, issued under the Care Act 2014** states in para 14.135 that

"the SAB should be primarily concerned with weighing up what **type of review process** will **promote effective learning and improvement action to prevent future deaths and serious harm occurring again",**

and paragraph 14.141 "**No one model will be applicable for all cases**. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for family and friends of adults who have died or been seriously abused or neglected". The process therefore allows for a flexibility of options for reviewing such cases.

Safeguarding Adults Reviews should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children/adults;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed and
- Makes use of relevant research and case evidence to inform the findings.

This review report will include the following factors:

- Previous recommendations around Hospital discharge from other SARs in Havering and other national SARs;
- Scrutiny of the failed discharges reported back to BHRUT;
- Learning from Healthwatch Havering scrutiny;
- Oversight of the system;
- Demographic challenges in the borough.

Activity undertaken

- A meeting of senior leaders was held as part of this review on 5th February 2024, which I chaired. BHRUT, NELFT, Pharmacies, Adults' Social Care, Care Homes, St Francis Hospice, NEL ICB and Havering Housing were represented. Each agency presented the systemic issues as they saw them and discussed what steps could be taken to enable better discharges. It was acknowledged that need was increasing and becoming more complex. Many agencies were (and are) experiencing significant budget pressure, and all reported recruitment challenges. There were apologies from Public Health and Healthwatch, who have since had input into this report.
- I have since met separately with the Assistant Director for Adult Safeguarding, NEL ICB, Celia Jeffery, Gary Etheridge Director of Nursing, Patient Experience and Engagement & Safeguarding Director, BHRUT, MIND Advocacy, and Lucy Millard, Lead Patient Safety Specialist, Chair of the Mental Health Network, NELFT.
- A practitioners' event was held in June with 22 multi-agency practitioners. A follow up meeting with group who attended the February meeting took place in September 2024 to review actions identified.

Legal Frameworks

Guidance was published by the Government in January 2024 for discharging people at risk of or experiencing homelessness, and at risk of safeguarding concerns. This arose from multi-agency increased scrutiny of poor hospital discharge practices highlighted by Safeguarding Adult Reviews (SARs) into the deaths of people at risk of or experiencing homelessness.

It is **good practice for the NHS and local authority to establish referral pathways** and consider commissioning services to help patients access immigration and welfare rights advice prior to discharge or while being accommodated. Local authorities should establish protocols setting out who has responsibility for case management and strategic oversight.

Unsafe discharge can trigger a safeguarding concern linked to:

- ❖ neglect or self-neglect
- ❖ acts of omission (failure to provide access to appropriate health, care and support).

The new statutory GOV Hospital Discharge and Community Guidance, was introduced across England, in January 2024. https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance.

The statutory guidance provides a framework for discharge using the national pathways, that all England hospitals are to use. The statutory nature of these discharge pathways has been supported by the national NHSE team.

The **discharge guidance provides specific descriptions of each pathway**, which **related to** both **clinical need**, **risk**, **discharge goals** and **discharge venue**. **Using both** the national Pathways with the statutory guidance definitions, **standardises the discharge process across regional areas**, and **stops variation** from hospital to hospital across England. In addition, it **establishes a common understanding and application** of the pathways, which can be used by all professionals; hospital, discharge, community, GPs, thus reducing misunderstandings and assumptions about patient's needs, discharge plans, and **in turn, reduces patient risk when they are discharged.**

Family Voices

Each family spoke with the Partnership Manager, and the circumstances of the person's discharge had a considerable impact on their wellbeing and ultimate death.

D's family did not wish to take part but expressed their **hope that the review would make a difference.** Each family was offered the opportunity to comment on this report.

S's mother commented and she was **still waiting for feedback** regarding S's death from the Hospital and Housing.

The **family of S and J** provided family impact statements **see Appendix A.**

Demographics in Havering

It is important to place the impact of discharges in context with current and future demographics of the borough.

There are **no direct indicators**, but the **increase in the number of children and people living in poverty, or people with mental health concerns, learning disability or substance misuse concerns could raise the size of at-risk population with complex needs**, whose discharges and transitions could put them at more risk and take more resources, if there are complex needs and less prevention of difficulties.

The borough JSNA (**Joint Strategic Needs' Assessment) outlines that the largest increases in population by 2036 will be 31% for those aged 65-84 years and 36% for those aged 85+ years**. **Life expectancy** is **lower** than **the London average** for **males and females in Havering** and is over 7 years different for those living in the most deprived areas of the borough compared to those living in the most affluent areas.

Between **15-29 years of life for men and women are impaired by illness and disabilit**y, for those people. In 2021, 15% of residents disclosed that they had a disability, slightly lower than the London average.

- Havering is **expected** see an **increase in persons aged 65 and over with limiting long term illness** whose day-to-day activities are limited a lot from 12,081 in 2023 to 14,201 in 2035 (8.6%), a lower increase than London (13.2%) but higher than England (-10.4%);
- Pre-pandemic, neoplasms (cancers) and cardiovascular diseases (e.g. heart attack and stroke) caused the greatest loss of good health and premature mortality among Havering residents.

The most recent data available at borough level, aggregated **for** the **period 2018-2020**, shows that **life expectancy in Havering** actually **reduced for both men** (by 0.4yrs to 79.7yrs) **and women** (by 0.6yrs to 83.5yrs) **The pandemic** is also likely to leave **a legacy of persistent ill-health and disability**. This additional burden of ill-health will further emphasise the trend established before the pandemic whereby a significant proportion of life expectancy is impaired by ill health and disability resulting in poor quality of life and significant need for health and social care services.

In Havering, an **estimated 38,449** residents **reported having a disability in 2021**. This is an Age standardised proportion (ASP) of 15.3%, which is slightly lower than London (15.6%) and lower than England (17.7%). 6.6% of those people reported that their day-to-day activities were limited a lot and 8.7% reported their day-to-day activities were limited a little, due to a disability.

There are nearly three **(2.7) times more households with a disabled person in the highest ranked neighbourhood (Harold Hill East – 1,605) compared to the lowest (Emerson Park – 596**). According to projections, the estimated number of **people in Havering aged 18-64 with impaired mobility is 8,653, a rate of 5,463 per 100,000 population**. This rate is significantly higher than the London average (4,945), but similar to England's.

Havering is expected see an increase in people aged 18-64 with mobility problems of 1.6% by 2035, higher than London (0.9%) and England (-2.2%); an increase in people aged 18-64 with moderate or severe learning disability of 2.8% by 2035, higher than the London and England average changes. The estimated number of people in Havering aged 65 and over unable to manage at least one activity on their own is a rate of 19,478 per 100,000 population (equivalent to 1 in 5). This rate is the highest in London (alongside Bexley) and significantly higher than the London and England averages.

The estimated number of people in Havering aged 65 and over with a limiting long term illness whose day-to-day activities are limited a lot is 12,081, a rate of 25012 per 100,000 population (1 in 4). This rate is significantly higher than the England average but similar to the London average.

According to the Census 2021, 12.7% (12,838) of the population aged 66 years and above are living in one-person households. This is the second highest proportion after Bexley in London . Older people living alone can be an indicator of social isolation and may require more support from health and social care services.

Review of identified issues in respect of discharges for previous SARs

	Actions	
VS and JS SAR & DHR (2019)	NELFT must review the partnership arrangements with Queen's Hospital & between substance misuse services & the NELFT inpatient & community services. This is to ensure that discharges are coordinated appropriately with Queen's Hospital where there are mental health concerns, & with regards to substance misuse services that risks associated with co-morbidity are recognised & responded to as an area for joint working. LBH must seek assurance that the policy requirements for assessing capacity,	
	LBH must seek assurance that the policy requirements for assessing capacity, DoLS, safeguarding, care support planning & carers' assessments are in place & meet the quality standards set.	there are policies BL
	Carewatch must ensure that an appropriate operating & escalation procedure is in place for adult support initial and risk assessments & that assurance systems are in place to demonstrate that this is embedded in practice.	
Mr C (2022)	Is there an up-to-date & functional housing/hospital discharge protocol that covers housing demand, supported housing & housing management?	Amanda hsr[[e/ Sophie webseter
	Should Housing and the Hospital be asked to report back to the Board the outcomes of evaluations of new roles such as Housing's In-reach housing worker & the hospital's housing discharge coordinator?	
	Is there a role for the SAB in facilitating relations between Hospital Discharge Teams & the housing safeguarding lead on the MASH?	
	What assurances does the SAB seek about hospital discharge processes locally?	A fortnightly working group is held which reports into the UEC to ensure continuous improvement
	How can better familiarity be enabled between Housing & Hospital Discharge Teams as regards the assessment & support provided to newly housed tenants?	
	Has the SAB recently asked Havering Adult Social Care to share updates about arrangements for processing referrals & insights about strengths & vulnerabilities & drivers of any identified work- arounds?	
HM (2017) & CM (2017)	Actions for HM & CM Co-ordinate & facilitate a programme of work shadowing opportunities between peers from different agencies across the multi-agency partnership. Co-ordinate & facilitate a forum for direct practitioners & managers from across the multi-agency partnership & reflect together on anonymised case examples	

Practitioner Voice

- On 5th June, 22 practitioners met in two workshops, which I led, to consider systems' issues around discharges from Hospitals and Care Homes.
- Frontline practitioners attended from BHRUT Emergency Department (ED) and the Discharge Team, NELFT District Nursing and Speech and Language Therapy, Little Gaynes Care Home, MIND Advocacy and Havering Council Adults' Social Care.

There were some **common themes-**

- ❖ communication between agencies
- ❖ understanding of each other's roles
- ❖ working pressures;
- ❖ the role of the ED in discharging patients and BHRUT Discharge Team's capacity to support them;
- ❖ sharing learning from discharge alerts;
- ❖ patients and families being encouraged to be more independent in the community;
- ❖ Mental Health support only being provided when the patient is medically fit for discharge from Hospital;
- ❖ End of Life care could be better supported in the community;
- ❖ Care Home capacity was low for those with complex needs and they weren't always aware of patients' needs when people were discharged to them.

Improvements already noted :

- ❖ The BHRUT Discharge Team was becoming well established;
- ❖ Multi-Disciplinary Team Meetings (MDTs) were taking place more frequently with complex cases;
- ❖ MDT ward rounds were taking place twice daily

Additional information supplied by Healthwatch, NEL ICB and BHRUT.

Healthwatch Havering is meeting with BHRUT following a recent Enter and View to the LAS (London Ambulance Service) at the Emergency Department, which was undertaken to review how the LAS new arrangements for handover of patients within 45 minutes was operating. The new arrangements are working well for the LAS.

The Visiting team wanted to understand what impact the new LAS service had on patients in the ED. The Visiting team reported that they had a great concern regarding the number of elderly patients and vulnerable patients, now waiting on trolleys and beds throughout the adjoining corridors and particularly the nurse/patient ratio. Healthwatch recommended we also consider patients who should not be in Hospital in the first place.

NEL ICB The Designated Nurse for Safeguarding Adults is leading a working group to develop the actions from this SAR. The local hospital discharge process in this area is not currently using these statutory national discharge pathways – **Pathway 0,1,2,3,** as laid out within the national discharge guidance. The guidance states that each patient is to be specifically assessed and identified against the Pathway Framework, prior to discharge from hospital.

Havering uses of '**Trusted Assessors' in our area hospitals**, who work in collaboration with local nursing homes. These staff members assess patients who are medically fit for discharge from hospital and recommend discharge destinations. The Trusted Assessor role is not qualified regulated professional; therefore, they have reduced ability to accurately identify a patient clinical need and risk, whilst identifying a discharge destination. This **assessment of the correct discharge destination must be especially challenging for these Trusted Assessors**, when the statutory national pathways outlined in the Hospital Discharge guidance have not been effectively implemented in our area hospitals

BHRUT held a successful Discharge Event with NELFT and other agencies in April 2024. There was very positive feedback. BHRUT also carried out a comprehensive audit of reported failed discharges. 219 failed discharges were reported to BHRUT in the 2023 calendar year. BHRUT know some agencies say they receive no feedback and therefore do not always make the alerts they should. We have considered the 47 alerts from January and February. They show some common themes- there was a **lack of contact from the Hospital to District Nursing to arrange treatment in the community** for 14 **patients** (January 8, February 6); a **lack of thorough assessment prior to discharge for 6 people**; and **no medication review prior to discharge for 3.** Concerns were much the same for 40 alerts received November-December 2023.

2 people were discharged back into their homes, which were found to be uninhabitable when they arrived home, due to hoarding. One concern, raised by District Nursing was regarding a patient, who spoke no English- there were no details of this on his discharge notes and Language-line had been used to communicate with him in Hospital. One Care Home did not provide up to date information regarding the patient's complex feeding needs in the Care Passport, on admission to Hospital. On Hospital discharge, 3 Care Homes, did not have sufficient information in the discharge summary. This included details about a wound for one patient and scabies for another.

Gary Etheridge has established a short-lived **Discharge Group**, which focused on the following:

Discharge Alerts: The group produced a **revised flowchart**. Key staff now receive **a weekly discharge alert** report. Gary Etheridge personally **chases the Clinical Groups** to ensure that an **investigation has taken place**. The number of **alerts** has **reduced from 49 to 14.**

Section 42s: The group has developed a **revised Sect 42 flowchart** to **review the progress** of any Section 42's that have been received by safeguarding. They have a system in place whereby the Clinical Groups are responsible for investigating and they are then processed by the Safeguarding Team. **Themes from Section 42**s are included in a safeguarding report that is **presented at the Trust's Safeguarding Operational and Safeguarding Strategic & Assurance Groups**.

SARs, CSPRs and DHRs: The group developed a **revised flowchart about SARs, CSPRs and DHRs.** The reviews are **shared at the quarterly Trust Safeguarding Operational and Safeguarding Strategic & Assurance Groups.** At the Safeguarding Operational Group, they **also share a safeguarding case and talk though the learning**. Cases and safeguarding **themes are also shared via a weekly safeguarding bulletin.** **Members of the Trust Group were coming together in June to review how the above actions** are being progressed and the group is looking at discharges from a system wide approach

Oversight

- **Oversight of health discharges across the system** (including acute health, community health and social care) **occurs at Place level**, and sits within the portfolio of the **Director for Ageing Well, and the Joint Director, Partnerships, Impact and Delivery (Integrated Commissioning**). The Ageing Well Team lead on the operational discharge issues resulting from the daily calls from the Royal London Hospital and would seek to resolve issues causing delayed discharges that are escalated to them throughout the week.
- This **integrated team also oversees a local urgent care working group**, a local systems' group with membership across the system (including Primary Care, London Ambulance Service, ELFT, Barts and commissioning teams) that **analyses information relating to the working of discharges** as part of its functions.
- **Within the ICB, discharge information is sent by Provider Trusts to the ICB data warehouse**. This information is used within the system command centre (SCC), **identifying several discharge metrics measured comparatively across all acute provider trusts in North East London**. This can be used to identify issues and improve patient flow, and would be used more for supporting operational pressure and decision making, linking in with the work carried out at place previously outlined, rather than for analysis of qualitative data.
- Furthermore**, discharge information is collated across seven domains** and is overseen through the performance team and reported back to the NHS NEL ICB Board. These include: **Planned Care Recovery** and Transformation; Outpatient Transformation; Diagnostics; Cancer; Urgent and Emergency Care; Health Services in the Community; and Mental Health.
- The **focus on the ICB discharge performance monitoring is across North East London** and is by Trust rather than place specific, and includes feedback on discharge performance, including detail on delayed discharges and discharge destinations and pathways.
- The **safeguarding team at the ICB** are sighted on all incidents that occur within provider organisations, which would include any incidents related to discharge, through a weekly summary. Final reports are again sent through to the safeguarding for comment as to whether it is felt the report provides the necessary information and learning required for closure.
- **Lucy Millard, and colleagues at NELFT have undertaken an audit of NELFT discharges** and found some **common themes** and is developing **a bi-monthly learning forum, which in time is planned to include care homes and families.** This should help to support the system and professional relationships.

Questions set for this SAR in agreement with the Case Review Working Group.

1) Hospital discharges of adults with care and support needs require careful planning and co- ordination between key professionals, and follow-up in the community afterwards, including the GP, and all require a contingency plan. What are the multi-agency systemic issues which mean that hospital discharges are still placing vulnerable adults at considerable risk in Havering? How can we ensure assessments are effective?

2) What are the achievable actions to bring rapid sustained improvements?

3) How can we seek assurance that multi-agency hospital discharge processes have improved and are fit for purpose?

4) Looking at the predicted demographic changes to the population in Havering provided by the JSNA (Joint Strategic Needs' Assessment), what do we need to do to have a discharge system which will prove to be effective in 5-10 years' time?

Findings

Discharges are potentially placing residents at risk in Havering, because the need to ensure well-planned discharges with contingency planning where the home environment has been visited and is prepared and families and carers are well prepared is not always being met. Some of these requirements are hard to ensure, because of the pressure of discharges, changes in, and lack of staffing, confusions about discharge pathways, methods of communication and ways to escalate concerns. Availability of medication can also delay discharge as well as families living at a distance from their loved one. Advice and advocacy do not appear to be readily available. I visited the local MIND advocacy service during the summer to find out more.

The demographic projections show that health needs will rise in future in Havering for those aged over 65, a proportion of whom have disabilities - a significant group involved in BHRUT failed discharges. It is important that care pathways are as effective as possible.

NICE guidelines state that the family or carers, where there is consent, should be included in the discharge plan and receive a copy of it. We know that families were not appropriately involved in the cases reviewed as part of this SAR, or in some of the BHRUT failed discharges in 2023.

Not all previous recommendations from SARs in Havering regarding discharges have been progressed. The findings from failed discharges in early 2023 were fed back to appropriate staff in BHRUT, but seemed to have made minimal difference to later concerns. This is in some ways understandable considering the pressured working conditions they have been engaged in. Strategic oversight has not brought about improvement to the system. I am hopeful that there is now a commitment to improve this issue in Havering.

Our meeting in February 2024 identified that care plans should be strengths' based, have review dates, lead officers, and consider all aspects of a person's life, the discharge planning process should promote multi-disciplinary information sharing, including regarding changing or ending care packages, meetings, and risk assessments. Discharge should be planned from the patient's admission to Hospital.

Meeting in June with frontline practitioners, it is clear that there is support in place but the whole system did not communicate what was available and how it worked as well as it could. I am pleased that BHRUT and NELFT are looking at learning and bringing practitioners together.

Actions for the Havering Partnership are outlined in Appendix 2.

The Integrated Commissioning Team and the ICB have a strong role in monitoring themes and holding the system to account. I will be asking them to report to the SAB going forward as we look for safety and improvement in Havering.

I held a review meeting to consider actions from the February SAR meeting and feedback from the June 2024 Practitioners' event on 18th September. This meeting was attended by most key agencies, with the exception of Pharmacies, ICB Continuing Health Care, Care Home and Day Care Providers, and Saint Francis Hospice.

The meeting heard about the local actions that had been undertaken to strengthen discharge processes, the development of new BHRUT flowcharts and analysis of failed discharges. I was heartened that information sharing has been strengthened and there has been some professional exchanges between disciplines.

Pharmacies reported afterwards.

Summary of actions taken across agencies:

- In terms of the East London patient record, all pharmacies are encouraged to use this as a system of reference. Use of this record is becoming more important, with the increasing number of clinical services being delivered from community pharmacies. We have pharmacy services managers who visit pharmacies to deliver training sessions and part of their visits involve discussing use of the record;
- In community pharmacy, we have the essential service of the Discharge medicine service (DMS). This service involves hospitals sending through discharge summaries to pharmacies, who will then follow a three stage process to ensure that patients are receiving the correct medication, where there have been changes. Community pharmacists will also ensure that patients are aware of how to take their medication, this is vital where there have been changes to medicines and dosing regimens;
- The use of DMS has been limited and there is work ongoing with the trusts to increase referral numbers.
- NELFT and BHRUT have developed a bi-monthly Peer Review schedule to build relationships from September 2024.
- NELFT has a Trust-wide Carer Strategy in place, which promotes the identification and assessment of carers. In Havering, they are in a unique position as we have carer leads that support all operational teams to ensure professionals are facilitating carer assessments and training staff to identify who the carer is in that patient's network. The training and support also includes, prompt carer conversation, recording of any identified carers on the patient's electronic record (RIO) and developing robust care plan and crisis planning to support the carer, caring for the patient.
- There is a monthly NELFT carer and patient engagement forum. This involved monthly drop-ins and an opportunity to gain feedback and look at potential gaps in service provision.
- All advocacy service are listed on the Joy app, which connects local residents with services within the borough. This will promote wider uptake of patient access to advocacy. NELFT leads have promoted the Joy App in all operational services in Havering. Those patients and carers without internet access, the team promotes advocacy through organisations, such a Mind.
- NELFT are participants in the monthly Integrated Discharge Hub meeting. This group reviews and looks at the discharge pathways, processes and community assessments for patients being discharged from cute inpatient settings into the community. The group also use some of the previous learning to identify gaps, improve and develop the discharge pathways furthers.
- Lucy Milliard - Lead Patient Safety Specialist is leading on the engagement between BHRUT and NELFT to build mutually beneficial, long-term and strong professional working relationships between frontline NELFT community service staff and BHRUT ward staff.
- Havering MASH team has access to NELFT records, and this pathway is frequently utilised to ensure referral and action to correct services health service within the Trust. NELFT has also recently funded a position within that service.

Next Steps

- I have resolved to review progress with senior leaders in September 2025, with a focus in the meantime on the Discharge Process to Care Homes, the use of Advocacy, GPs, Voluntary Sector agencies and Continuing Health Care in the ICB.
- LB Sutton has undertaken considerable work relating to Hospital Discharge. Sutton Council, for example, has set up a spreadsheet to ensure that within 24 hours of discharge, checks are made to confirm whether an individual has returned home and has received appropriate care and support. Staff responsible for commissioning care and support now have clear communication channels with provider agencies and the Hospital Pathway Social Worker. The social worker is also required to communicate with the adult or their family / advocate.
- I am heartened that there has been such strong senior leadership support from the key agencies involved in undertaking this themed SAR and I wish to thank everyone involved, and most especially the families of S, J and D. I was encouraged that everyone agreed to work together to improve discharge pathways in Havering, when we met in February

Appendix A   Impact statement for S

- *S's mother Lilian told us the following, and let us use his photograph for our Senior Leaders' Meeting in February 2024.*
- *"S was happy in Hospital. His last words by phone were about going upstairs in the Hospital and he said he would call later. I called him an hour or two later and there was no answer.   I tried to contact him many times after the operation, but there was no answer.. Then I got a text 3 days later saying call the Hospital immediately. This was on S's mobile. I phoned back and the man said "Oh yes, he's passed". This was a terrible shock and I screamed. I was in a state.   I was his next of kin so they had my details and they had S's mobile. There was no excuse for this disgraceful way of telling me my son had died. There was an autopsy, as they could not release his body. On the death certificate it said a heart attack. This is not good enough. Did he die on the operating table or in his bed? What was the problem? He was not an emergency because he had been put back for more urgent cases. At a time when the doctors were on strike. We do not know what went wrong. Every death is a heart attack at the end. He was a young man. Somebody has to answer for my son's death.   You are trying to put things right in the future, but no consolation to us.*
- *"Firstly, S had MRSA the last time he was in hospital and the nurse called late in the evening with the news as they did not know outcome. She was a good and sympathetic nurse. He was bi-polar and a lady called Lynn came to him every 2 weeks to give him his injection. She is the person who gets our respect.*
- *When we buried S we went to his flat but the keys were not where they should be. Spoke to lady next door who had helped him and she said they had been taken by council. Whether or not truth we will never know. Could not get into his flat so everything was left for whomever.*
- *He was looked after by an Agency with two young gentlemen helping him at home- they spoke no English. They didn't know how to use the microwave or the toaster. They didn't know how to put the butter on the toast. They only stayed 20 mins or a little more.   I complained to the Agency and she said she would sort it. She never did. A neighbour helped S, called Faye she cooked meals for him. The bi-polar nurse visited every two weeks. I said he should move downstairs and I said I would get him a motorised scooter or wheelchair.*
- *"S was mistreated and ignored. I kept the food deliveries for him- the delivery people brought the food in and put it away for him. He was treated very badly. The people who looked after him were useless. Someone needs to pay for this".*
- *This has opened a can of worms for me and I want answers. I know too late for my son but it might give our family some rest, because we feel we should have done more, and he was left".* **Lilian, S's mother, January 2024**

Appendix A Impact statement for J

- *J's family agreed to let us use this family impact statement at our review meeting, which is planned for September 2024. "Mum was fast-tracked to discharge on a trial scheme. We did not know that care homes had declined her care. We were aware of a care home in Ilford- but we had hoped she would not have gone there due to the geography. We knew a Hospital in Maldon and Brentwood were being considered for rehabilitation. We were told Mum was not ready; then she went to the bottom of the list. We knew the treatment was then palliative- and the decision was for Mum to go home as she wanted that- it was her goal. We were waiting and waiting constantly. Then there was short notice for the actual discharge- 24-36 hours. We needed to clear the furniture. The ambulance and staff were booked.*

- *On the day, Mum arrived at 4pm. The ambulance had to stop half way and Mark had to help with the laritube and Mark had to put it in. The paramedics had struggled and Mark had been taught how to do this. Ian was at home to meet the ambulance and met the Team caring for Mum. They had to get equipment- wipes, plastic bags, and basins- they had thought that care staff would provide this. The bed needed more sheets and they bought things from Amazon, (trolley, wardrobe). They had to buy a nebuliser- the ward showed them what to buy and then agreed it was fine afterwards. Food was delivered but it was the wrong type. They were not sure who had ordered it.*

- *Initially, it was planned for Mum to stay in Hospital for 6 weeks after her surgery but her blood was sticky and there were difficulties in healing.*

- *Mum's desire was to get home and have the last week of her life if possible in St Francis Hospice. Her wishes were observed and she had "accepted" the fact that her cancer was terminal. All they did was geared around this wish and the Hospital staff had really tried to help.*

- *The fast track was a success. They thought she had 2-3 months left to live. On the Thursday evening they left Mum at home in reasonable spirits and on Friday morning they were told by the care staff she was unresponsive and had not made it. They had thought she had died peacefully in her sleep- the death certificate said cancer. It was a big shock to find out about the SAR, equipment and DNR documentation not being available and for CPR to have started. It was a shock and a surprise.. she was smiling, laughing and joking. They had a photo. They thought she had had a peaceful and quiet death. There was no Post Mortem. If they had known there were issues, they might have asked for a PM. They were now imagining her state of panic as her suction did not work. They had to come to terms with this new information as they were processing their parents' deaths. It had been hard to sleep. The meeting had been in October and why were they being told now? There were implications about defective equipment- can the cause of death be established? Would the SAR lead to a Coroner's Inquest? 6 months on, this was hard to take. They would have liked to have known about the circumstances of Mum's death immediately, as difficult as it would have been.*

They had lost both parents over 6 months and were processing their deaths all the time. They were sorting out the property and had to go there. They had adapted and took some comfort in their mother dying in her sleep. They had been moving on, on that basis. The new information had undone everything. They had spent the last 6 months coming to terms with things. They had been robbed of more time, some weeks with their mother. They had not finished discussing things, like Mum's funeral- they had just started that and were going to talk to Mum on Saturday- her grandchildren were going to visit as they worked during the week. It was hard to accept, so quick, so suddenly. It was a shock and surprise. Mum had been smiling at staff and dancing. They did not know it had changed so quickly.
Ian did not want to tell the family- 2 of Mum's sisters had died of cancer and for one there had been an Inquest due to failings in her medical care. They felt frustration and anger. They would feel under pressure to do something about their Mum.

Staff should have told us- they knew people reacted to news in different ways- it was quite traumatic but they were not violent people. It had destroyed the whole concept of how their Mum had passed. Maybe there was panic and she was choking. Had she been drowning? It was not definitive- it was going through their minds. They thought they had closure. It appeared not. They needed to find out more and ensure lessons were learned. Others might benefit.
Did communication break down? What information was passed to staff? They did not know homes had refused to accept Mum- they were not told the process and thought they were looking for more local homes.
The goalposts had changed. Mum had many pre-op blood tests and only after some operations not succeeding did she have a more full test, which showed the clotting problems. She had 7 operations in 3 weeks. Everything was on hold every couple of weeks and she had so many months in Hospital. She had surprised staff that her recovery was so slow. Could this have been avoided? She had hell and torment.
It was the worse case scenario- their father died whilst their Mum was in Hospital. Mum had a slow demise. Their father deteriorated. If the blood tests had been undertaken, maybe her surgery would not have been attempted.
The meetings in the background should have been communicated quicker.
The equipment was returned- staff should have said there was a problem. Was this defective equipment going constantly back into service?
The District Nurse arrived after Ian arrived. Later in the day, they visited the ward to let them know their Mum had died. Many staff attended her funeral.
It was strange the carers did not have the DNR. They were aware of it at the Hospital and they had spoken to Hospital staff about it. They had had conversations with their Mum about it and had also had to organise it for their father. They had had to tell their mother that their father had died. They had not been able to see each other for some months.
Mum had been perfectly fine- what had changed overnight? The circumstances of their Mum's death was not communicated to them. The care staff had left. Perhaps they were upset. It had flipped everything on its head. They (Commissioners) had tried to find a place where staff were suitably trained and they knew it had proved difficult.
When Mark went in, there was lots on the floor- medication- it seemed very unorganised. It had been a hard year. At the time, our father had been in Hospital – he had Parkinson's and Mum had cared for him. He died on 7th May. In early July, Ian had a heart attack.
They were concerned about accountability - did equipment fail? If you have equipment you should have a back-up plan and more equipment, in case it failed. They wanted to see change to avoid death so quickly after discharge. To ensure this did not happen again". **Mark and Ian the sons of JD,. January 2024**

Appendix B - Action Plan 5th February 2024

	Action	Outcome
1	JG to convene a Task & Finish Group, making sure to include AK, DJ, MA, IH, JT, JM, JB & GE to: • Explore MDTs taking place in Hospitals, prescriptions being ready when required, good information sharing & planning, involvement of families & Advocates if required; • Develop a BHRUT Hospital discharge policy, pathway and procedure, which clarifies communication pathways and accountability to support safe effective discharge plus developing a contingency plan; • Explore Workforce shadowing- Discharge Professionals, home care staff, Commissioners; • Ensure the principle of End of Life Care- working to get home as the best option- is prioritised; • Develop a Health Action Plan for the GP, which gives an overview of the individual's health needs; appointments and screenings; • Develop a Hospital & GP Summary Care Record which can be accessed by Out of Hours Services to assist in the ongoing management of treatment and care planning; • Clarify Sect 42 v other referrals; These documents may prove useful https://www.suttonsab.org.uk/static/practitioners_files/Grab%20guide%20Safe%20Discharge%20Planning%20When%20an%20Individual%20Lives%20alone%20July%202022.pptx https://www.ms-solicitors.co.uk/community-care-law/hospital-discharge/factsheet-safe-discharge-from-hospital/	To see admissions & discharges correct, information sharing, bed management meetings, involvement of Medics, prescriptions available at discharge where appropriate To develop crib sheets for admissions, transitions to other wards & discharges to and from Hospitals, care homes, own homes Awareness raising for patients / residents and their families of their rights and expectations, and ability to raise concerns Families & patients know advocacy support routes & what they can expect
2	St Francis Hospice to support HSP/ all agencies in providing training re talking about dying;	WA JN EM
3	Work to go on to improve Hospital referrals so that they are robust and accurate;	JM GE
4	All to explore sharing information via East London Health Record;	JG / All Sept 2024
5	Pharmacies to report back to the group on their development work;	DJ ongoing
6	All agencies to give SAB assurance that they have disseminated the processes and learning re discharges & admissions to all their staff and to give the SAB evidence that improvements are forthcoming;	All Sept 2024
7	All relevant agencies to give SAB assurance that Health Passports for those with Learning Disabilities are in place	All Sept 2024
8	Advocacy to be promoted for patients / residents and families and its availability to be scrutinised by the SAB;	All Sept 2024
9	Assurance and evidence to be provided to the SAB that Continuing Health Care (CHC) needs assessments are being applied within the expected threshold; and Carers' Assessments are taking place as required;	John Tengende Sept 2024
10	Each GP practice to plan to hold weekly complex case meetings with the multi-disciplinary team to ensure that adults and children with complex needs are reviewed on a regular basis to avoid issues such as treatment delay, no response to missed appointments;	JM
11	Brian Boxall to chair a meeting with frontline staff to gain views- Hospital, Housing, Care Homes, Domiciliary Care;	May / June 2024
12	The Integrated Commissioning Team and NEL ICB to report regularly to the SAB re their oversight of discharges, any significant issues and evidence of improvement	Integrated Commissioning Team NEL ICB

Appendix C Literature Review

Previous Havering SARs.

Mr C 2022- housing difficulties following discharge from Hospital- areas of home not accessible- he died. summary here

HM 2017 -Older woman, whose health deteriorated at home with pressure ulcers. Her daughter declined repair of the hoist at home. summary here

CM 2017-An older man who took his own life shortly after hospital discharge. His wife remained in hospital. He had a history of mental health concerns. summary here

National Safeguarding Adults Reviews (SARs)

Sutton Thematic SAR into care homes 2021 This review considered two cases. The death of a woman discharged from hospital into a care home and abuse experienced by residents at a different residential home for adults with learning difficulties run by a large national provider with homes in Sutton.
There are a number of clear themes arising from this review, some of which emerged strongly in all the interviews, and which together provide considerable learning for the multi-agency safeguarding system in Sutton. **Theme 1 : Safeguarding Practice** a locality restructure in adult social care had undermined confidence in safeguarding practice with inconsistencies in social work expertise in safeguarding practice, also disruption of links & communication processes
Theme 2 Relationships the importance of strong relationships between professionals.
Theme 3 Family and Friends the central importance of the voice of residents, and the role of their family and friends.
See summary here for detailed learning points

Appendix C Literature Review contd.

- **Newham 2019 thematic review** 4 vulnerable men who died 2017-18. See summary here
- **Findings:**

❖ Use of Mental Capacity Act (taking legal advice when adults make "unwise decisions")

❖ Carers' Assessments offer

❖ Multi-disciplinary communication and holistic risk assessments

❖ Development of a hospital discharge policy and procedure, which clarifies communication pathways and accountability to support safe effective discharge plus developing a contingency plan

❖ Safeguarding is everyone's business- Local Authority has a duty to undertake the Sect 42 or ensure this is being done

Appendix C Literature Review contd.

Adult B 2021 Cumbria

This concerns a 52 year old White British woman with learning disabilities and limited ability to communicate with others following a significant brain injury during an accident as a child. She had health problems including low body weight and oesophageal reflux, and died after declining health and considerable treatment, which sometimes was delayed. She was living in a supported living facility.

Themes identified: **Mental Capacity & Best Interest Decision Making**; **Patient Pathway for underweight adults who lack capacity; Management of Difference of opinions**; **Continuity, Co-ordination of Care and Hospital Discharge Planning**; **Assessment and Funding of Care Needs; Supporting Staff ,** which are outlined in a learning brief here. The full report is here Adult B SAR Report

Appendix C Literature Review contd.

Brent Safeguarding Adult Review Sean 2019

- Irish man, in his 70s, who was isolated, mental health and substance use problems, living in a neglected environment. He was assessed as high risk by the hospital on discharge, after 3 weeks' admission for physical concerns. Mental capacity was assumed.
- **Findings:**
- Response to missed appointments and non-engagement and responding to repeated risks of self-neglect
- Care plans should be strengths' based, have review dates, lead officers, and consider all aspects of a person's life
- Multi-disciplinary information sharing, including regarding changing or ending care packages, meetings, and risk assessments
- Role of commissioning and work with providers

Appendix C Literature Review contd.

- **Sutton SAR LB 2019 :a** 90 year old living alone; he was taken to A&E as unwell, but was swiftly discharged; however, his care package was suspended and he was found dead at home a week later. 7 Step Briefing

Learning:

- **Clarity of process regarding suspension of care package on hospital attendance**
- **Action taken:** LBS have set up a spreadsheet to ensure that within 24 hours of discharge, checks are made to confirm whether an individual has returned home and has received appropriate care and support. Staff responsible for commissioning care and support now have clear communication channels with provider agencies and the Hospital Pathway Social Worker. The social worker is also required to communicate with the adult or their family/ representative.
- **Communication between partners:** A number of assumptions were made as to whether LB was admitted onto a hospital ward and insufficient checks were made to understand what this would mean in terms of the processes for restarting suspended care packages.
- **Action taken:** Work is being undertaken to complete localised, multi-agency protocol, with provider, service user and family member input into this. This has a clear pathway and links to the statutory obligations for safe hospital discharge. This clearly sets out communication, risk processes and assurance with expected outcomes and how we can measure that these have been achieved.
- **Understanding the Duty of Care**: The local authority, care providers, brokers, hospitals must when fulfilling their functions, ensure they have met their duties to adults at risk. This includes being familiar with the statutory duties, standards and protocols related to hospital admissions, attendance at A&E and discharge planning obligations. It is crucial that staff working across health and social care find common language so that handovers between different agencies don't inadvertently become 'hand offs'.

Appendix C Literature Review contd.

Trafford Strategic Safeguarding Partnership SAR John 2019

John had significant learning disabilities and mental health concerns and lived in supported living. He had a number of serious falls, necessitating several hospital admissions and injuries.

Learning

- That Trafford Strategic Safeguarding Board obtains an enhanced appreciation of the nature and extent of unsafe hospital discharges by monitoring safeguarding referrals arising from them.
- That Trafford Strategic Safeguarding Board obtains assurance that the commissioners of placements for people at risk of falls include the effectiveness of falls policies in placement commissioning and monitoring.
- That Trafford Strategic Safeguarding Board obtains assurance that providers of placements for people at risk of falls have robust falls policies in place supported by appropriate staff training.
- It may be necessary to clarify where responsibility for preparing patient passports lies. The NHS guidance on 'going into hospital' (https://www.nhs.uk/conditions/learningdisabilities/going-into-hospital/) indicates that responsibility for 'healthcare passports' resides with the community learning disability team, GP or hospital, with no mention of the provider of care and support (13).
- That Trafford Strategic Safeguarding Board obtains assurance that patient passports are initiated and maintained in respect of all adults with learning disabilities

Briefing for Partners SAR John   SAR John Final report