Essex Safeguarding Adults Board

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Safeguarding Adults Review

Lucy

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1. INTRODUCTION

This Safeguarding Adults Review (SAR) was commissioned by Essex Safeguarding Adults Board following the death of Lucy an 87-year-old lady at Basildon University Hospital NHS Trust on 28 April 2020. It considers the care provided to Lucy following a fall at home, in Essex on 21 February 2020, and the effectiveness of inter-agency collaboration, communication and information sharing throughout her care.

The responsibility of local authorities to commission a SAR is laid out in section 44 of the Care Act 2014. Safeguarding Adults Boards must arrange a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

The Board must also arrange a Safeguarding Adults Review where an adult is still alive but has experienced serious neglect or abuse, and there is concern that partner agencies could have worked more effectively to protect them. Safeguarding Adults Boards are free to arrange for a Safeguarding Adults Review in other situations where it feels there is a value in doing so, for example to prevent or reduce abuse or neglect or explore practice.

The purpose of the review is to determine what the relevant agencies and individuals involved in the case might have done differently in order to prevent harm or death. This is so that lessons can be learnt and applied to future cases to prevent similar harm occurring in future. It is not to hold any individual or organisation to account. (Reference: Essex Safeguarding Adults Board).

2. TERMS OF REFERENCE

2.1 To develop an understanding of Lucy's vulnerabilities, her health and care needs, capacity to care for herself and her level of independence and consider:

- How effective was inter-agency collaboration, communication and information sharing in providing treatment to Lucy, including during transfers of her care.
- Whether Lucy was considered at risk of further falls and the effectiveness of falls risk assessments.
- Whether preventative actions could have been taken by agencies that may have reduced the possibility of Lucy's circumstances escalating.

2.2 To what extent did the Covid-19 pandemic impact inpatient care, including reablement, hospital transfer and discharge decisions and domiciliary care provision?

2.3 To identity any difficulties agencies encountered when supporting Lucy that impacted on the case?

2.4 To what extent did practitioners listen to the voice of Lucy? Were her wishes and feelings heard and considered?

2.5 Whether assessments of Lucy's mental capacity were appropriately conducted?

2.6 To what extent were the concerns raised by Lucy's family regarding her health and discharge from hospital considered and responded to?

2.7 To identify whether agencies complied with any safeguarding protocols that have been agreed within and between agencies including protocols covering:

- Raising safeguarding concerns.
- Information sharing.
- Risk assessment, management and review

2.8 To identify any best practice that was in place.

2.9 To explore to what extent the care and treatment of Lucy offers an insight into health and social care professional practice during times of increased demand, such as the Covid-19 pandemic?

3. SCOPE

The aim of the investigation was to establish the facts surrounding the incident, aligning them to the policies and procedures of the various organisations involved in Lucy's care, taking into account changes implemented in respect of hospital discharges in response to the Government response to the COVID-19 Pandemic and to identify any learning from the incident that can be shared across organisations.

The investigation has considered the care and treatment provided by services as well as inter-agency collaboration, communication and information sharing from February 2020 following her fall at home, until her death in April 2020.

4. METHODOLOGY

This Safeguarding Adult overview report has been prepared following a review of clinical notes relating to Lucy's admissions to Mountnessing Court and the Mayfield Unit at Thurrock Hospital; review of all of the individual management reviews (IMRs) prepared by the organisations involved in Lucy's care and following three Safeguarding Adult Review Panel meetings. The aim of the panel meetings was to ensure appropriate challenge and scrutiny as well as proving an opportunity for all organisations to learn lessons from this incident. During a panel meeting held on

07 February 2022, it was agreed that due to the length of time it has taken to complete this review due to the COVID-19 pandemic that it would not be beneficial to hold separate learning events.

In addition to the above a meeting was held with Lucy's daughter in order to fully understand her concerns regarding the care provided to her mother and to gain an understanding of Lucy and her life, prior to her initial fall in February 2020. The author also had the opportunity to review the complaint made by Lucy's daughter and the response provided by Basildon and Brentwood CCG and also the outcome of the Section 42 Safeguarding investigation undertaken by Essex County Council.

5. CONTRIBUTORS

The following agencies were involved in Lucy's care and have submitted Individual Management Reviews (IMRs). Essex Safeguarding Adults Board's request for information (IMRs) falls under Section 45 of the Care Act 2014:

- East of England Ambulance Service NHS Trust
- Basildon University Hospital NHS Trust (BUHT)
- Essex Partnership University NHS Foundation Trust (EPUT)
- North-East London NHS Foundation Trust (NELFT)
- Basildon & Brentwood, Clinical Commissioning Group
- MercyLink Care Agency
- Nuffield Health Brentwood
- Essex County Council
- Essex Police

6. FAMILY INVOLVEMENT

Lucy's daughter raised a safeguarding referral on 08 April 2020, in respect of care provided by Mountnessing Court (EPUT), Mayfield Unit, Thurrock Community Hospital (NELFT) and Mercylink Care Agency. The points of concern included the following:

- The safety of Lucy's discharge from hospital (Mayfield Unit)
- The interaction with the family and a failure to act on a number of concerns raised
- Lucy's ability to understand the information given to her, retain information provided and consider the associated risks
- Poor communication from the clinical teams and a failure to listen and to take into account concerns raised by Lucy's family.

On 29 May 2020, a Multi-agency Safeguards meeting was held. This meeting was attended by Lucy's daughter and she was advised that the safeguarding allegations raised by her had been substantiated and an apology was offered to her.

A further meeting was held between Essex County Council in 2021 and Lucy's daughter. This provided the opportunity for ECC to set out the process for completion for the Safeguarding Adults Review (SAR) and also to advise Lucy's daughter of the details of the independent reviewer.

On 17 May 2021, a further meeting was held with Essex Council and the SAR Independent Reviewer at Ely House, Basildon. During this meeting Lucy's daughter shared information regarding her mother's life and also her concerns regarding the care provided to her mother. She expressed concern that despite a number of different organisations providing care to her mother she did not believe any of them were 'in her corner' and none of them were advocating for her to ensure her best interests. She shared her experience of trying to negotiate with staff who she felt had been rude and dismissive towards her and her concerns for her mother. She also stated that she believed staff had not always been truthful.

7. CASE REVIEW

Lucy was an Irish immigrant and one of eight children. She was a widow and mother of two daughters, one of whom lived in Essex and one who lived in Devon. Prior to this incident Lucy had lived independently in her own home, with support from her daughter, a neighbour and a befriending service who visited her twice weekly to provide her with company and support her with her shopping. Lucy was unable to drive and had not left her home very often during the 2 years prior to her death. She was described by her daughter as being stubborn and fiercely independent since the death of her husband 6-7 years ago from dementia.

In the early hours of 22 February 2020, Lucy was admitted to Basildon University Hospital NHS Trust, following a fall at home on the night of 21 February 2020. She reported that she had been bending down in her living room, lost her balance and fallen. Unable to get up from the floor independently Lucy pressed her 'lifeline' for assistance. As there was no response to this call for assistance, she called emergency services, and an ambulance was despatched. On arrival at Lucy's home the ambulance crew were advised by her that she had fallen and was experiencing pain in her left leg and hip area and so she was conveyed to hospital by ambulance.

On arrival at the Accident and Emergency Department Lucy was examined by a doctor and an x-ray taken of her left hip, the x-ray demonstrated that she had sustained a fractured neck of femur (#NOF). On 24 February 2020, Lucy had surgery to repair her fracture by way of insertion of a dynamic hip screw. Although Lucy experienced intermittent confusion and an episode of chest pain and shortness of breath on 25 February 2020, her post-operative recovery was largely uneventful given her age and past medical history. On 11 March 2020, she was transferred to Mountnessing Court (MNC), an Intermediate Care Centre, in Billericay for rehabilitation, where she remained for approximately 3 weeks. The plan was for her to follow a 21-day pathway

to improve her physical mobility to enable her to return home, as at the time it was understood that she had no history of cognitive impairment.

During her admission to Mountnessing Court Lucy participated in both group and individual physiotherapy sessions and in between was supported by nursing and support staff to continue her physiotherapy and attend to her daily needs such as bathing and dressing. It is noted that she was improving physically and engaging well with staff, however, was reported to be sad at times and requested to talk to a priest and her family which is reported to have always lifted her mood. Following discussion at a weekly multidisciplinary team meeting it was agreed that a provisional date for her planned discharge would be 01 April 2020. However, on the morning of 01 April 2020, Lucy was noted to be unwell, she was also anxious and confused. Following examination by a doctor she was diagnosed with a chest infection for which she was prescribed oral antibiotics and as a result she was not well enough to be discharged home as planned.

On the evening of 03 April 2020, Lucy was reported to be more confused, she was observed to be wheezy and was complaining of pain when passing urine. A urine sample was collected and sent to the laboratory for analysis as it was thought her pain and intermittent confusion may be due to a urinary tract infection. Lucy was also observed to be low in mood, and so a telephone conversation was facilitated with her daughter after which she was noted to have improved.

On the same day Lucy's daughter was contacted by a nurse from the Continuing Health Care Team, from Basildon and Brentwood, CCG who had been relocated to support with hospital discharges. During this telephone conversation Lucy's daughter was advised that her mother's discharge was to be delayed because she was confused, low in mood and suspected of having a urinary tract infection. She was also advised that there was a problem with a profiling bed which had been ordered and a four-times a day care package for Lucy was still to be sourced. During this discussion Lucy's daughter expressed concern regarding her mother's discharge from hospital, she was concerned that her mother was not safe to manage at home independently and she herself would be unable to provide support because she was isolating due to COVID-19. In response to Lucy's daughter's concern a discussion took place regarding the possibility of Lucy being admitted to a residential care home and it was agreed that this may be a safer option.

In response to the increasing pressure of the COVID-19 pandemic a system decision was taken to close Mountnessing Court and to consolidate clinical services on fewer sites. It was hoped that by consolidating services this would mean the system could maintain safe staffing levels in the community hospitals and the community beds would continue to be made available to support the local acute trusts. This resulted in Lucy and other patients being moved from Mountnessing Court to the Mayfield Unit at Thurrock Hospital on 04 April 2020; staff from Mountnessing court did not transfer

with patients, however it is advised that a verbal handover between clinicians took place prior to staff transferring to Brentwood Community Hospital. In addition to the above a transfer handover sheet was completed indicating that Lucy could walk 3 metres with the assistance of 1 person and a walking frame. It was also documented that Lucy had an upper respiratory (chest) infection for which she was prescribed oral antibiotics. The transfer sheet made no mention of Lucy's confusion. Unfortunately, the speed of the decision to close Mountnessing court and transfer of patients (within 24 hours) made normal levels of communication and preparation with patients and their relatives challenging, and this resulted in Lucy's daughter not being advised of her transfer to the Mayfield Unit at Thurrock Hospital until the transfer had taken place.

On the morning of 06 April 2020, Lucy expressed a desire to go home. It is documented that although Lucy had stated that she was being 'held against her will', once offered an explanation regarding the need for her to become more mobile before she was discharged it is reported that she settled. There is an entry in Lucy's notes at 15.00 hours by a doctor, however, this entry is ambiguous and is later contradicted:

Plan

1. Complete antibiotics as commenced by previous team (this was a course of Amoxicillin for 7 days, started on the evening of 03 April 2020).
2. Medically stable to be discharged back to usual place of residence once therapist reviewed.
3. Senior review.

It is unclear from the note what is meant by 'senior review.' There is a further note which provides a summary of the reason for Lucy's admission and the treatment provided (surgical repair and rehabilitation) this entry stated, 'once medically stable to be transferred to our community care for further rehabilitation'. It is, therefore, unclear whether or not at the time of this entry Lucy was considered to be medically fit for discharge or whether this entry is meant to reflect that she would be discharged when medically fit. There is a further entry in the notes at 16.26 indicating that Lucy had been referred to the continuing health care team for assessment. It appears that there was no challenge from ward staff with regard to the fact that Lucy had not been reviewed by a therapist nor had she had a review by a Senior Doctor.

At 19.11, there is an entry in the notes indicating that Lucy had in the morning expressed a wish to go home and that the continuing care team had liaised with Lucy's family to arrange discharge. This entry implies that Lucy's family were in agreement with the discharge and this was not the case. A further entry noted that Lucy left the ward at 'around 18.00 hours'. This entry indicated that Lucy had been provided with 'sufficient medication to last until she receives her TTA's (drugs to take away) which should arrive on the ward tomorrow'. There is no indication in the notes as to how Lucy would obtain the remainder of her required medications or whether carers were aware of the need to administer her medication that evening.

It is of note that there are no entries in the clinical notes of an assessment made by the continuing healthcare team. Nor is there an entry relating to a discussion held between them and Lucy's daughter. However, despite a discussion between a nurse from the continuing healthcare team and Lucy's daughter, whereby she raised concerns regarding her mother's continued confusion. Lucy was discharged from Thurrock Community hospital on 6 April 2020. She was taken home by ambulance and a care package was arranged for a carer to visit her four times daily, commencing on the evening of her discharge.

This discharge had been expedited in response to the Covid-19 Pandemic and changes to the way hospital discharges were managed. These changes introduced a 'discharge to assess' model of care across England and were set out in the Government's COVID-19 Hospital Discharge Service Requirement published in March 2020. This document set out the requirements for all NHS Trusts, Community Health Services and Social Care staff in England, specifying that unless required to be in hospital patients must not remain in an NHS bed. The expectation at this time was 95% of patients could go straight home on discharge. 50% could go home with minimal or no additional support (Pathway 0), 45% could go home with a short or longer-term support care package (Pathway 1). Of the remaining 5% it was anticipated that 4% of patients would require rehabilitation support (Pathway 2) and 1% would require nursing home care (Pathway 3).

This guidance also set out the Government's agreement that the NHS would fully fund the cost of new or extended out-of-hospital health and social care packages for people being discharged from hospital or those who would otherwise be admitted to hospital. The aim being to reduce the pressure on acute services. This meant that Care Act Assessments were no longer required prior to discharge from hospital.

At the time of the incident Lucy's nearest daughter was shielding due to COVID-19, as her own daughter (Lucy's granddaughter) was assessed as being extremely clinically vulnerable. As a result of the above Lucy's daughter was unable to visit her mother at home to provide support following her discharge from hospital.

Lucy arrived home on the evening of 06 April 2020. Shortly after her arrival home she contacted her daughter to say that she did not have any money to pay for her taxi home. This caused her daughter to be concerned as she believed her mother to be confused and therefore unsafe to be left on her own at home. So concerned was she that she called her sister in Devon, who in turn called her mum and found her to be very confused to the point where it was necessary to abandon the conversation.

On the arrival of a Carer from MercyLink Care Agency at around 9pm Lucy was found on the floor. She was alert and conscious, however, was complaining of pain in her hip. It is reported that she was attempting to stand but was unable to do so. As a result, the Carer called emergency services, however, was advised by a call handler that a Paramedic was unlikely to be able to attend for approximately 4 - 6 hours. Further

advice and assistance was sought from the Care Agency and a second Carer attended Lucy's home to provide assistance. Lucy was assisted from the floor to a commode where she remained supported by a neighbour until the arrival of an ambulance. Subsequently, Lucy was conveyed by ambulance to Basildon University Hospital, she arrived at 23.45 hours and she was found to have fractured her right neck of femur.

Lucy underwent further surgery to repair her fracture by way of insertion of a dynamic hip screw on 09 April 2020. On return from the operating theatre, she was in receipt of 3 litres of oxygen, intravenous fluids and antibiotics, she continued to have a urinary catheter in place and was nursed on a specialist air mattress in order to prevent pressure ulceration**.** It is reported that Lucy was intermittently confused and was refusing to take her oral medications. Lucy was assessed by a Physiotherapist and Occupational therapist and attempts were made to mobilise her with varying success. On occasions she declined therapy, however her mobility appeared to be improving and she was able to walk between 8 to 10 metres with the use of a Parapet frame and the assistance of two people.

Lucy continued to be intermittently confused and to refuse her medication, it is of note that she also complained of difficulty in swallowing, which appears to have been in part why she was refusing to take her medication. It was also noted that she needed encouragement and support to assist her with eating and drinking, she had been prescribed food supplements during her previous admission. Despite this, Lucy was not referred to a dietician and or speech and language therapist to assess her swallowing (until she returned from the Nuffield Hospital).

On 20 April 2020, Lucy refused any input from staff and was reported to have developed a cough. It was noted that a repeat COVID-swab would be taken in order to exclude COVID-19. The following day she was reviewed by a Consultant Physician who noted that she was subdued, it was thought this was likely to be as a result of depression and so a trial Sertraline 25mg (a medication used to treat depression and anxiety disorders) was agreed. Lucy continued to intermittently decline her oral medication and therapy input and it was agreed that she would require rehabilitation prior to her discharge and so plans were made to transfer her to a rehabilitation centre, however, no beds were available at Thurrock or Brentwood hospitals at this time.

Lucy was transferred to Nuffield Hospital in Brentwood on 25 April 2020. On arrival at the hospital, staff were concerned as she appeared to be unwell and was coughing. Basildon Hospital were contacted, however, were unable to confirm whether or not COVID-19 had been excluded via a Polymerase chain reaction (PCR) test, a laboratory test for COVID-19 or a CT scan and so the team at Nuffield requested a CT scan which demonstrated signs of possible COVID-19 and so Lucy was transferred back to Basildon University Hospital where she continued to decline her medication and therapy input and subsequently died on 28 April 2020. The cause of death was noted

to be 'aspiration pneumonia; contributing factors were severe clinical frailty, ischaemic heart disease and hip fracture followed by surgery'.

8. CONTEXTUAL INFORMATION / SAFEGUARDING CONCERNS

On 08 April 2020, Lucy's daughter raised an adult safeguarding concern with Essex County Council in respect of her mother's discharge from Thurrock Community Hospital and also in respect of manual handling practises by staff working in the care agency MercyLink Care Services. Although not included directly in the safeguarding concern Lucy's daughter also noted that staff working for the care agency had not administered Lucy's medication on the night of 06 April 2020, this included medication to manage her epilepsy.

This referral was reviewed by an Adult Social Care Team Manager, also on 08 April 2020, who considered that the information provided met the threshold criteria under the three-stage test under the Care Act 2014 and that this should progress to a section 42 enquiry. The three-stage test criteria were as follows:

- having care and support needs.
- experiencing (or being at risk of) abuse or neglect.
- being unable to protect themselves because of those needs.

The Safeguards enquiry commenced on 17 April 2020, and information was requested from the relevant agencies regarding their internal investigations (IMRs). Lucy's daughter was also contacted to inform her of the name of the professional leading the safeguarding enquiry.

On 29 May 2020, a Strategy Meeting was held in accordance with Safeguards Principles: in particular, accountability and transparency in delivering safeguarding. Lucy's daughter was in attendance at this meeting where it was confirmed that the two safeguarding concerns were substantiated. It is of note that this meeting took place prior to Lucy's funeral.

The enquiry carried out by Essex Social Care was based on review of clinical documentation, discussion with representatives for North-East London Foundation Trust and Basildon and Brentwood CCG representatives, as well information provided by Lucy's daughters. This enquiry concluded that the safeguard concerns raised were valid. In respect of the concern regarding an unsafe discharge the enquiry concluded that there appeared to be a lack of clarity regarding the source of Lucy's infection, her confusion and capacity at the time of her discharge and there had been a failure to ensure a reassessment of her needs following her transfer from Mountnessing Court to the Mayfield Unit at Thurrock Hospital. It further concluded that there had been no consideration given to concerns raised by Lucy's daughter that they had found her to be confused during discussion with her on the telephone.

In respect of the concerns raised regarding poor manual handling practices by the Carers from MercyLink Care Agency, when they attended and found Lucy on the floor in her home, the enquiry concluded that whilst Carers may have believed they were acting in Lucy's best interests, correct procedures were not followed and therefore this aspect of the safeguarding concern was also substantiated.

9. THEMATIC ANALYSIS OF CASE AND FINDINGS

9.1 Basildon Hospital (1st admission)

As previously indicated, Lucy was admitted to Basildon University Hospital on 21 February 2020, following a fall at home. She was subsequently diagnosed with a fractured neck of her left femur for which she underwent surgery on 24 February 2020. Lucy complained of chest pain and shortness of breath on the morning of 25 February 2020, she was also noted to be confused. An echocardiogram was conducted and no changes were noted.

The following day Lucy continued to be confused but was able to mobilise with the supervision of a physiotherapist, a support worker and the assistance of a gutter frame. The following day, whilst still confused Lucy was able to mobilise to the toilet (30 metres) with the same assistance. The plan was for her to be discharged to a rehabilitation centre once she was assessed to be medically fit to do so.

On 28 February 2020, Lucy experienced a seizure lasting approximately one minute. She was made comfortable and was monitored throughout the day without any further seizures. She was again able to mobilise 30 metres with the assistance of 2 people and a rotunda frame. Lucy was however noted to have developed a pressure ulcer on her buttocks.

On 01 March 2020, Lucy was reviewed by a doctor and was assessed as medically fit for discharge to a rehabilitation centre. A referral was made however there were no beds available. Lucy continued to received physiotherapy and assistance with her personal hygiene. She complained of pain in her left hip and pain relief was provided. She was also treated for constipation.

On 06 March 2020, Lucy complained of difficulty in swallowing her medication, advice was sought from a speech and language therapist, who advised that her medication should be reviewed by a doctor to see whether this could be administered in an alternative form that she was able to swallow. No formal assessment was undertaken by the speech and language therapist at this time. Otherwise, Lucy continued to mobilise in line with the prescribed plan.

On 08 March, Lucy was prescribed antibiotics as she was thought to have developed a urinary tract infection. The remainder of her stay in Basildon hospital was uneventful and she was transferred to Mountnessing Court for rehabilitation.

There were no concerns raised by Lucy's family and or service delivery problems identified with regard to this episode of care.

9.2 Mountnessing Court, Essex Partnership Trust

Lucy was admitted to Mountnessing Court for a period of rehabilitation following her surgery to repair her fractured neck of femur. Despite some challenges with staffing associated with COVID-19, it appears Lucy received appropriate physiotherapy, both group and individual sessions, and she made significant progress in terms of her mobility. Her discharge was planned for 01 April 2020, however, this was delayed initially as staff shortages had meant that a planned home visit on 31 March 2020, to review her equipment needs in order to support her discharge home could not take place. Furthermore, on the morning of 01 April 2020, Lucy complained of feeling unwell. She complained of a headache and was noted to be pale, confused and anxious and she had developed a cough. She was subsequently reviewed by a doctor and was diagnosed with a chest infection for which she was prescribed antibiotics. The records state that Lucy's daughter was notified that her mother was unwell and therefore would not be discharged, however her daughter stated that this was not correct and that she had been advised that Lucy would be discharged the following day, Thursday 2nd April 2020.

On 03 April 2020, Lucy continued to feel unwell. She was reported to be 'wheezy' and had complained of pain whilst passing urine. She was again reviewed by a doctor and was thought that she may have developed a urinary tract infection associated with an indwelling urinary catheter. A urine sample was collected and sent to the laboratory for analysis.

On the same day Lucy's daughter was contacted by a member of the Continuing Healthcare Team (CHC) who had been relocated to support hospital discharges. This nurse advised her that Lucy continued to be unwell and remained confused, therefore her discharge would be delayed until after the weekend. During this discussion Lucy's daughter expressed her concern that her mother would not be able to manage independently at home and she would not be able to visit her because she was isolating as her daughter, Lucy's granddaughter, was considered to be critically vulnerable and therefore the family was isolating. The CHC nurse appeared to take on board Lucy's daughter's concerns and suggested that it may be preferable for Lucy to be discharged to a residential care home on a short-term basis. Lucy's daughter was reassured by this suggestion and understood that her mother would be reassessed after the weekend due to her on-going concerns regarding her safety.

On 04 April 2020, a system decision was taken to close Mountnessing Court and to consolidate services on fewer sites, those sites being the Mayfield Unit at Thurrock Hospital and Brentwood Community Hospital. As a result, Lucy was transferred to the Mayfield Unit. A clinician-to-clinician handover took place via telephone and information was recorded on a patient transfer handover form. Whilst it is reported that during the verbal handover it was made clear to staff at the Mayfield Unit that Lucy was suffering from a chest infection, a possible urinary tract infection and was also confused; it is of note that there was no reference to Lucy's confusion or a urinary tract infection documented on the transfer form. It was, however, recorded that she was suffering from upper respiratory infection (chest infection) and had been commenced on oral antibiotics on 03 April 2020. There was no information recorded to indicate that Lucy had refused her antibiotics and so at the time of her transfer had received only 2 doses.

During the meeting held with Lucy's daughter on 17 May 2021, no care and/or service delivery problems were identified in respect of Mountnessing Court, except for the fact that she was not notified of Lucy's transfer to Mayfield Unit until after the transfer had taken place. It is, however, of concern that there appears to have been a failure by staff at Mountnessing Court to clearly document the full extent of Lucy's health concerns in particular her confusion.

The following recommendations were made by EPUT in the individual management review:

1. To review and improve the referral form used by acute wards and other primary care refers via the Bed Bureau to improve the exchange of information providing a seamless pathway for the patient – This has now been implemented and one referral form is now used by all three acute trusts for requests for any of the community beds.

2. If visiting is prohibited in an in-patient unit in the future a more formal communication channel needs to be established with families to ensure they continue to actively involved and informed regarding the care of their relatives.

3. Where possible if a number of patients are going to be moved from one clinical area to another and the clinical team looking after them do not transfer with the patient, then time is set aside for communication between the two teams following transfer. This will allow any queries to be answered and any patient plans to be fully understood by the receiving team.

9.3 Mayfield Unit, Thurrock Hospital, North-East London Trust and Basildon and Brentwood Clinical Commissioning Group (CCG)

Lucy was transferred to the Mayfield Unit, Thurrock Hospital on 04 April 2020 following the closure of Mountnessing Court. On admission to the unit, Lucy was noted to be confused and was also thought to be suffering from a chest infection. Antibiotics had been prescribed on 03 April, however only 2 doses had been administered at the time of her transfer as Lucy had declined to take them. No further doses were administered on the day of her transfer. The following day Lucy was noted to have developed a cough.

On the morning of 06 April 2020, Lucy was noted to be agitated and expressed a desire to go home, however once staff had explained that she was not well enough to go home and needed further rehabilitation she appeared to settle. She was reviewed by a doctor at 14.27 hrs who noted that Lucy appeared to be alert and sitting comfortably in a chair. It is also noted that Lucy was 'keen on going home'. The plan documented indicated that Lucy should continue with her antibiotics and stated 'medically stable to be discharged back to her usual place of residence once therapy reviewed'. Later in the same entry the doctor noted 'once medically stable to transfer in to our community care for further rehabilitation'. It is therefore unclear from this entry whether the doctor believed that Lucy was medically fit for discharge or not as the two entries appear to be contradictory. The next entry in the clinical notes (16.26) indicates that Lucy had been referred to the Continuing Healthcare Team and was awaiting assessment. It is worthy of noting that Lucy had not been assessed by a therapist during her admission to the Mayfield Unit.

In response to increasing pressures associated with COVID-19, staff from the Continuing Healthcare Team from the Basildon and Brentwood CCG were relocated to Mountnessing Court and Thurrock Hospital to help support patient discharges. It appears that the purpose of this relocation of staff was to form a virtual discharge hub in line with best practice. These staff worked alongside established teams as trusted assessors to expedite and co-ordinate discharge plans. However, there were a number of problems associated with this relocation of staff. It appears that ward-based nursing staff became disempowered in respect of discharge planning, as responsibility for this reverted to the continuing health care nurses, who were fulfilling the role of discharge coordinators. It appears that there was a lack of clarity regarding who was ultimately accountable for the decision to discharge Lucy, and the documented clinical plan was not followed. The continuing health care nurses were not provided with access to SystmOne, the electronic patient record used in these units. This meant that they did not have direct access to information recorded in Lucy's notes, nor were they able to record their assessments and or details of their communication with Lucy and her family in the clinical records.

It remains unclear why the CHC nurses were not provided with access to SystmOne as this is not complex. All that would have been required was for a 'sponsor' within NELFT to authorise access to the module in use at Thurrock Hospital, issuing of smartcards to the relevant nursing staff, if they did not already have one and this could easily have been achieved within 24 hours had this been requested.

On the morning of 6 April 2020, the CHC nurses did not attend the handover meeting (board round) held on the Mayfield Unit as they had been directed to another ward in error. However, it is reported that during the afternoon meeting they were advised that Lucy was 'medically optimised' and therefore ready for discharge home. Information provided by Basildon and Brentwood CCG stated that the CHC nurses 'did not make this determination' and stated their role was to broker the care package to meet the needs as identified by the MDT. If indeed the role of the CHC nurse was merely to broker the care package this calls into question the rationale for Lucy being assessed by a CHC nurse on 03 April 2020, why this nurse contacted Lucy's daughter to advise that her mother was not well enough to be discharged and why this nurse provided assurance that a residential care home would be considered, if it was not within her remit to do so.

It remains unclear whether Lucy had the mental capacity to make the decision to go home, as conflicting information has been provided. It is reported that on the day of her discharge the CHC nurse did not have any reason to question her capacity, however, there is no clinical documentation to evidence that a risk assessment was undertaken; this is of concern given the following:

- Lucy had been diagnosed with a chest infection and only commenced treatment with antibiotics on 03 April 2020.
- At the time of her discharge from Mayfield Unit Lucy had received only 7 doses of the prescribed antibiotics (7-day course, 3 times daily). She was, therefore, unlikely to have recovered from her chest infection and was also thought to have a concurrent urinary tract infection.
- Lucy had been reported to be confused.
- Lucy had not been reassessed by a therapist at all since her transfer to the Mayfield Unit. Documentation in her notes stated, 'to be discharged back to usual place of residence once therapist reviewed'.
- Lucy's capacity to make a decision regarding her discharge and her understanding of the associated risks had not been formally assessed.
- Lucy's daughter had raised concerns regarding her mother's ability to cope alone at home.

It is apparent that the concerns raised by Lucy's daughter were not taken into account.

There were no recommendations identified by NELFT in their individual management review. However, Basildon and Brentwood CCG, have undertaken reflection with regard to the care provided by the CHC nurses and have identified the following learning:

- There was a missed opportunity to engage Lucy's daughters more proactively in a conversation with her regarding the wisdom and safety of her being discharged home.
- Clinical documentation completed by the CHC nurses should have been uploaded to SystmOne.
- A falls risk assessment should have been requested; particularly given Lucy had been admitted following a fall.
- A medication review should have been requested to assess the benefits of medication which are known to increase the likelihood of a falls.
- Evidence should have been sought that Lucy had been assessed by a doctor and was medically optimised.

A safeguarding concern was raised by Lucy's daughter on 08 April 2020 in respect of the discharge from the Mayfield Unit as she believed that this was unsafe and that her concerns regarding her mother's safety had been ignored. This concern was investigated by Essex County Council under Section 42 of the Care Act 2014 and these allegations were substantiated.

9.5 MercyLink Care Agency

MercyLink Care agency were commissioned by Basildon & Brentwood CCG to provide a package of care for Lucy following her discharge from hospital. The plan was for one carer to visit her four times a day to provide assistance with personal care, including bathing and oral hygiene, assistance to the toilet, routine repositioning to avoid pressure ulceration and promote comfort, administration of medications from a blister pack, meal preparation and laundry. Assistance with shopping was to be provided twice weekly by another organisation (Home Instead).

It is understood that on the evening of 06 April 2020 a Carer attended Lucy's home at tea time (shortly after 17.00hrs), to assist Lucy with her evening meal, however, Lucy had not arrived home. Advice was sought from the Care Coordinator on duty who advised the Carer to return later to help Lucy into bed.

It is reported that Carers attending Lucy were aware that she had previously fallen at home and she had received treatment in hospital prior to a period of rehabilitation in Mountnessing Court.

A Carer attended Lucy's home again at around 21:00, and on their arrival found Lucy on the floor. The Carer called emergency services from Lucy's telephone, however, was advised that a paramedic would not be able to attend for a minimum of 4 - 6 hours

and was also advised not to move her. In response to this, the Carer once again called the on-call Care Coordinator to inform her of the situation and to seek advice. She reported that Lucy had fallen and was struggling to get up. A second Carer was despatched to provide support and to attempt to make Lucy comfortable.

In the meantime, the Care Coordinator attempted to contact Lucy's daughter to advise her of the above incident, however she was not available and her husband advised that they would not be able to attend Lucy's home due to COVID-19 restrictions.

The Carer contacted the neighbour and advised them of the incident and that an ambulance had been called. It is reported that at this time Lucy stated that she did not want to go to hospital and asked staff to help her get up. During the section 42 investigation staff confirmed that they assisted Lucy onto the commode by using a 'drag lift'. This was against the advice of the Essex Ambulance Service who had advised to leave Lucy in situ until an ambulance crew arrived and was also contrary to good manual handling practice and MercyLink's own Manual Handling Policy. Prior to leaving Lucy's home Carers observed her for signs of 'bleeding and dampness' neither of which were noted. The Carers subsequently left Lucy in the care of her neighbour whilst waiting for the ambulance to attend, it is of note that during their visit the Carers did not administer Lucy's evening medication in line with her care plan.

A safeguarding concern was raised by Lucy's daughter in respect of the inappropriate and or unsafe manual handling practices. This concern was investigated by Essex County Council under Section 42 of the Care Act 2014 and these allegations were substantiated. In line with good practice the Care Quality Commission were informed of this incident.

There were no recommendations identified by MercyLink in their individual management review.

9.6 Basildon Hospital (2nd admission)

Following her readmission to Basildon Hospital, Lucy was diagnosed with a fracture of her right hip and she underwent further surgery for repair of this fracture by way of insertion of a dynamic hip screw on 09 April 2020. Her immediate post-operative recovery was uneventful. However, although she appeared to be recovering well from the surgery, in that her wounds healed appropriately and she was able to commence mobilisation, her overall health appeared to be deteriorating. She complained of difficulty in swallowing, she developed a cough and was becoming increasingly subdued. She began to disengage with staff, declining their assistance to meet her personal hygiene needs, she declined her oral medication, intermittently declined therapy input and was eating and drinking only minimal amounts.

Lucy was seen and assessed appropriately by a Consultant Physician, who considered that she was depressed and may benefit from Sertraline, however, it is unclear whether

Lucy continued to be intermittently confused. She was refusing her medication, and had complained of difficulty in swallowing. It was also noted that she needed encouragement and support to assist her with eating and drinking, she had been prescribed food supplement during her previous admission. Despite this Lucy was not referred to a dietician and or speech and language therapist to assess her swallowing.

On 20 April 2020, Lucy refused any input from staff and is reported to have developed a cough. It was noted that a repeat COVID-swab would be taken in order to exclude COVID-19. It is also noted that she had developed a grade 2 pressure ulcer. The following day she was reviewed by a Consultant Physician who noted that she was subdued, likely to be as a result of depression and a trial sertraline 25mg was agreed. It was also noted that she may be suffering from a chest infection. Lucy continued to decline oral medication and therapy input and following an MDT review it was agreed that she would require rehabilitation prior to her discharge and so plans were made to transfer her to a rehabilitation centre.

Although, no concerns were raised by Lucy's family in respect of this admission to Basildon hospital, there were some care and service delivery concerns identified. Despite Lucy's reported difficulty in swallowing and her reluctance to eat and drink it appears that she was not referred to a speech and language therapist for assessment of her swallow reflex. It is also unclear what action, if any, was taken at Basildon hospital in respect of concerns regarding her cough and or chest infection prior to her transfer to the Nuffield Hospital for rehabilitation. This should have been explored by the Trust to rule out COVID-19 prior to transferring Lucy. (Ref: HM Government Hospital Discharge and Community Support Staff Action Card)

9.7 Nuffield Hospital, Brentwood

Lucy was assessed by staff at Basildon Hospital to be safe to transfer from an acute NHS Trust to a step-down placement at a third-party healthcare facility at the Nuffield Hospital in Brentwood. This agreement was under the nationwide contract that the NHS held with all Independent Hospitals during the coronavirus pandemic, to assist the NHS with acute Covid-19 patient admission capacity.

Lucy had only a very brief admission to the Nuffield Hospital as on her arrival on the afternoon of 25 April 2020, staff were concerned that Lucy appeared to be unwell and ambulance staff had reported that she had been coughing continuously during her journey from Basildon Hospital.

In response to these concerns the admitting team escalated their concerns promptly to the Matron, who advised that Lucy should be admitted to a single room to ensure stringent infection control measures were in place as a precaution, as Lucy may be suffering from Covid-19. Her notes were reviewed and there was no evidence to

indicate that a PCR swab or CT scan had been taken within 72 hours of Lucy's transfer which at the time was the protocol for all transfers /discharges of patients from red zones to residential/nursing homes or other healthcare providers. Lucy was seen promptly by an Orthopaedic Consultant Surgeon who advised that in view of the above Lucy should be transferred back to Basildon Hospital as soon as a bed was available. In the meantime, he requested a CT scan in order to exclude a diagnosis of Covid-19.

A CT scan was carried out at the Nuffield Hospital where Lucy remained overnight. She was subsequently transferred back to Basildon Hospital on the afternoon of 26 April 2020.

Lucy's family did not raise any concerns regarding the care and treatment provided at the Nuffield Hospital and there were no care or service delivery concerns identified. On the contrary, staff acted promptly and decisively to ensure that Lucy was comfortable and isolated in single room to reduce the possibility of transmitting infection to others. They also undertook appropriate diagnostic procedures prior to her return to Basildon Hospital.

There were no recommendations identified by the Nuffield Hospital during the individual management review.

9.8 Basildon Hospital (3rd admission)

On her return to Basildon hospital on 26 April 2020, Lucy continued to decline her medication and oral diet and fluids. She was noted to be fatigued and also refused therapy input and so remained in bed. Her urine output was noted to be poor and so IV frusemide (a diuretic) was administered. Lucy was reviewed on the daily ward round on 27 April 2020, where she was observed to have deteriorated. Her CT scan (taken at the Nuffield Hospital the previous day) showed findings consistent with aspiration pneumonia. Intravenous fluids and antibiotics were prescribed and administered and a referral was made to a speech and language therapist to assess her swallowing and a referral was also made to a dietician. Despite this it was agreed that Lucy's prognosis was poor and she was likely to require 24-hour care in future. It was agreed that a discussion would be held with her daughter to advise her of the above.

On the morning of 28 April 2020, Lucy's daughter was contacted and advised of her mother's deterioration and poor prognosis, doctors were explicit that Lucy was unlikely to live beyond a few weeks. It was agreed that arrangements would be made promptly for her to receive palliative care and to ensure she would remain comfortable.

Sadly, Lucy died on the evening of the same day. Despite Lucy's deterioration being more rapid than anticipated there were no apparent care or service delivery problems identified for this episode of care.

There were no recommendations made by Basildon Hospital following their individual management review.

9.9 Essex County Council

A referral to Essex County Council was made by staff at Basildon on 02 March 2020, indicating that Lucy may require an additional care package to support her on discharge. This referral gave no indication of Lucy's expected date of discharge. However, in any event this was not pursued as Lucy was transferred to Mountnessing Court for rehabilitation. No further referrals were made to Essex County Council and therefore no social care input was provided by them for Lucy. Essex County Council were not informed of Lucy discharge on 06 April 2020 and so were not involved in the decision to discharge Lucy from hospital or the care package to be provided by MercyLink. This care package was commissioned by Basildon and Brentwood CCG.

On 08 April 2020, Essex County Council received a Safeguarding concern from Lucy's daughter. There were two aspects of this concern firstly that Lucy's discharge from hospital was unsafe and without due regard for the concerns raised by Lucy's family and secondly that Carers from MercyLink had used inappropriate manual handling procedures by 'drag lifting' Lucy from the floor to a commode.

These concerns raised by Lucy's daughter were reviewed on the same day by an Adult Social Care Team Manager, who determined that the allegations met the criteria for further investigation under section 42 of the Care Act 2014.

These concerns were investigated promptly by an appropriately trained and experienced social worker and the allegations were substantiated.

No concerns were raised by Lucy's family in respect of Essex County Council and no service delivery concern were identified.

Although ECC were not involved in planning Lucy's discharges the following recommendations were made during the individual management review and have been implemented:

1. At the time Lucy was discharged from Mayfield Unit there was not a daily Microsoft Teams or telephone conference call with all allied professionals including social care. These changes have evolved with the community rehabilitation discharge process whereby there is an MDT daily conference call; including therapy, ward nurse, discharge facilitator, social care and a lead from the integrated discharge team (IDT) to chair the meeting to discuss the upcoming discharges. This call is specifically to discuss patients ready to be discharged and views are shared with all allied professionals to assist with the co-ordination of the upcoming planned discharge.

2. A medically optimised notification was not in progress from Mayfield Unit at the time of Lucy's discharge from the Community Hospital to alert Adult Social Care, this is now sent to the integrated discharge team (IDT) who disseminate this document to social care and have oversight of the daily discharges to increase communication effectiveness and multi-agency perspectives of what could be offered such as Assistive Technology.

3. There is now a link worker and secondary link worker in place who have built up relationships with the IDT. There is a handover sent to a central inbox overseeing all community in-patient wards in the South-West and the IDT escalate patients who require Social Care involvement.

4. The IDT complete discharge to assess tools to determine pathway 2 & 3 and share the assessment with social care for either a Care Act 2014 Assessment in the community or a joint NHS Continuing Healthcare Assessment within a 6-week timeline.

5. There is a Monthly meeting with the CCG and Social Care to specifically focus on patients who are on a Continuing HealthCare Pathway to enable a Joint Assessment Approach when a person is discharged from either a community or acute hospital setting.

6. The Red Cross have been commissioned to support discharges from hospital where the adult lives alone and can be referred to by Health or Social Care, Monday to Friday to enable a link between the discharge and the first care call for people who need a supported discharge from either the community or acute hospital.

7. The Bridging Service was not utilised to support Lucy, this service can complete a home visit until the Care Provider is due to start, bringing forward a discharge, in this case the benefit would have been an earlier discharge at Lunchtime with Bridging Support in a shorter timeline between the discharge and the care call than MercyLink afforded at the time.

8. The in-patient Occupational Therapists could complete home visits either independently or with Social Care to check the environment for any barriers to reduce risk of a failed discharge and aid any equipment, inclusive of assistive technology that would be required prior to discharge.

9.10 East of England Ambulance Service

On 06 April 2020, the East of England Ambulance service were call by Carer's from MercyLink at 21.54 and the Carer was advised that there would be a delay of circa 4-6 hours before a paramedic would be available to attend. The call to the ambulance services was triaged as a category 3 call, this category is for patients who have potentially urgent conditions that are not life-threatening but require treatment

and/or transport. In these circumstances the regional target aims to respond to 9 out of 10 patients with an appropriate resource within 120 minutes. At the time of this incident there were a high number of calls for patients in this category and some with a higher priority status resulting in some delay. Despite this the ambulance service responded with an appropriate resource within 98 minutes which was within the agreed target response time.

There were no concerns raised by Lucy's family and no service delivery problems identified in respect of the East of England Ambulance service.

10. CONCLUSION

It must be recognised that the COVID-19 pandemic significantly impacted on the care provided to Lucy in 2020, and on the staff aiming to provide care. Staff in the NHS were working in extremely difficult circumstances, with staff shortages due to sickness absences and staff shielding. This resulted in staff being redeployed to areas at short notice, with minimal induction and often areas outside of their usual expertise. Decisions were made nationally, rather than locally and there was pressure on them to discharge patients as quickly as possible in order to free up capacity for acutely unwell patients requiring beds urgently. That said, despite pressure to expedite discharges, staff had a responsibility to Lucy and her family to ensure that her discharge from hospital was appropriately planned and was safe. Sadly, this was not the case. Following Lucy's discharge from Thurrock hospital, against the wishes of her family Lucy suffered another fall resulting in a fractured femur and HM Coroner confirmed that this fall contributed to her death.

It is evident that the discharging team had attempted to take into account Lucy's wishes to return home, however, it seems doubtful that she had the capacity to make this decision, given that she had been reported to be confused, had been diagnosed with a chest infection and a possible concurrent urinary tract infection. No formal mental capacity assessment was undertaken prior to her discharge. It is of note that on the day prior to her discharge Lucy was assessed by a registered nurse and although broadly orientated to time, when asked to recall an address with five components she was unable to do so. This clearly calls into question her ability to process information and weigh up the risks and benefits of her decision. There is no evidence to suggest that advice was sought from the Trust's Safeguarding team in respect of her capacity or a best interest's assessment. Furthermore, Lucy's family had raised concerns regarding her safety, particularly as they were shielding and unable to provide her with support.

On 03 April 2020, following a discussion with Lucy's daughter it was agreed that a short-term placement in a residential home would be considered, however, this decision was not pursued, more likely than not this was because this decision was not effectively communicated to the clinical team on the ward or to the CHC nurse who

ultimately arranged Lucy's discharge. This issue was compounded by the fact that CHC staff did not have access to SystmOne and therefore did not have access to read or update Lucy's clinical records and therefore were not up to date with contemporaneous information regarding her clinical presentation.

Lucy had experienced 2 significant falls within a period of 3 months, she was noted to score 7 out of 9 on the Rockford clinical frailty score. In addition to this she had become unwell due to infection and had struggled to comply with her medication (antibiotics) due to her confusion and difficulty in swallowing, she was therefore at an increased risk of falls and should have undergone an assessment with a physiotherapist to assess her suitability for discharge. This assessment did not take place despite this being clearly documented in her care plan.

Furthermore, Lucy had not completed her course of antibiotics and therefore it was unlikely that she had recovered sufficiently to manage at home independently. Whilst discussion had taken place regarding a short-term residential placement, this was not communicated effectively and was not pursued. There was also a missed opportunity whilst at Mayfield Unit to submit a Medically Optimised referral form to social care. This prevented social care from making a further referral for additional assistive technology / equipment which may have reduced the risk of falls. The above combined with the total disregard of Lucy's daughter's concerns about her mother's ability to cope demonstrated poor interagency collaboration.

Responding to the COVID-19 pandemic meant that services had to be more flexible in order to meet the increasing demands on the service. This resulted in decisions being made quickly and often outside of the local health and social care system. It is understood that the system response was to have daily system calls to monitor the response. It appears that these systems failed to identify a significant risk to patients as staff redeployed across the system did not have access to all of the information required to safely care for their patients e.g., they did not have access to the electronic patient record.

The findings of this report appear to demonstrate that changes made in respect of discharge planning in the context COVID-19 significantly impacted on the care provided to Lucy and her family. The predominant focus appears to have been on expediting discharge from hospital rather than person centred care and as a result services appear to have lost sight of Lucy's vulnerability and her associated care needs. Transfer of responsibility for discharge from hospital transferred from social care to health without robust governance arrangements being in place to provide appropriate care co-ordination and clarity as to who was ultimately accountable for decision making. No evidence was seen to indicate that a robust risk assessment was carried out to assess the risks associated with the closure of facilities and transferring patients' alternative facilities.

It is acknowledged that there have been significant changes to the way discharges are planned since this incident and there is a greater focus on Home First – Discharge to Assess models which involve better interagency collaboration through establishing transfer of care hubs, with dedicated care co-ordination and clear lines of accountability (ref: Home first /discharge to assess: A practical guide to for achieving good outcomes for people leaving hospital, November 2021).

11. RECOMMENDATIONS

It is acknowledged that this incident occurred in unprecedented times, however, despite this staff had a responsibility to ensure that it was appropriate and safe for Lucy to be discharged from hospital. The following recommendations should be considered:

NB: please also refer to the document explaining the identified themes for the 6 x SARs published in November 2022.

1. NELFT & Basildon and Brentwood Integrated Care Board (ICB) [1] to share the findings from this safeguarding overview report with all working at the Mayfield Unit at Thurrock hospital and the Continuing Care Nurses who were redeployed to facilitate discharges from the community hospitals to ensure learning from this incident. Staff have a professional responsibility to liaise with family members to ensure that they are acting in the best interest of the patient. This did not happen to a standard that should be expected and this led to Lucy's family believing that 'there was no-one in her corner'.

   (Links to Theme 2: Improving Making Safeguarding Personal (MSP) and hearing the voice of the adult at risk)

2. Decisions to discharge patients should not be made in isolation and without reference to the clinical notes and robust interagency communication. All organisations to review their Business Continuity plans in place to ensure there are clear lines of accountability with regard to discharge planning should similar circumstances arise in the future. This should include the arrangements for appropriate senior managerial oversight of the operational delivery and risk and responsibility for escalating matters of concern to the system leaders. (ALL)

   (Links to Theme 5: Improving interagency communications between Health and Social Care)

[1] Integrated Care Boards were established as part of the Health & Care Act and replaced CCGs in July 2022

3. NELFT to review their discharge policy to ensure that in circumstances whereby a patient's who are experiencing episodes of confusion and are expressing a wish to be discharged from hospital advice is sought from the Trust's Safeguarding Team and a formal mental capacity assessment must be undertaken to ensure that they are able understand the consequences of their decision and the potential associated risks.

   (Links to Theme 1: Challenges when working with those who experience Complex Needs)

4. NELFT to ensure that where a patient's lacks capacity a best interest assessment should be undertaken and this must include the views of family members. (ALL)

   (Links to Theme 1: Challenges when working with those who experience Complex Needs)

5. NELFT to ensure that where there are documented plans in place these should be reviewed on the day of discharge during the Ward / Board Meeting to ensure the plans are up to date and remain relevant. Further, the patient should be assessed by a registered health professional immediately prior to leaving the ward to ensure that they are fit for discharge at the point they are discharged (ALL).

   (Links to Theme 1: Challenges when working with those who experience Complex Needs)

6. All health organisations to review and update their Business continuity plans to ensure arrangements are in place to enable prompt access to IT clinical systems e.g., the electronic patient record is accessible to clinical staff redeployed in emergency situations OR a decision made to revert to hard copy paper notes. Where there is a decision to revert to paper notes, arrangements must be instigated to ensure that these notes are upload onto the relevant clinical record system at the point of discharge to ensure records are complete.

   (Links to Theme 5: Improving interagency communications between Health and Social Care)

7. MercyLink to ensure that all staff are provided with further training in respect of manual handling procedures and in respect of actions to be taken on discovery of a patient on the floor with a possible hip fracture.

   (Links to Theme 4: ESAB's oversight of outcomes from partner's quality assurance of safeguarding systems)

8. Integrated Care Boards and Local authority to consider arrangements in place in discharge hubs to monitor discharges and to provide an urgent response in the event of failed discharges.

   (Links to Theme 2: Improving Making Safeguarding Personal (MSP) and hearing the voice of the adult at risk & Theme 4: ESAB's oversight of outcomes from partner's quality assurance of safeguarding systems & Theme 5: Improving interagency communications between Health and Social Care)

9. All organisations in future to submit Individual Management Reviews using the Essex County Council Standard format and ensure that recommendations for their organisations are set out within the IMR.

   (Links to Theme 3: The importance of a shared approach to setting high standards in safeguarding practice and oversight from ESAB)

12. GLOSSARY OF TERMS

SAR	Safeguarding Adults Review
ESAB	Essex Safeguarding Adults Board
BUHFT	Basildon University Hospitals NHS Trust
EPUT	Essex Partnership Trust
NELFT	North East London NHS Foundation Trust
ECC	Essex County Council
CHC	Continuing Health Care (CCG)
CCG	Clinical Commissioning Group
#NOF	Fractured Neck of Femur
IMC	Intermediate Care
MNC	Mountnessing Court Rehabilitation Centre (EPUT)
UTI	Urinary Tract Infection
RN	Registered Nurse

URTI	Upper Respiratory Tract Infection (Chest Infection)
IMR	Individual Management Report
IDT	Integrated Discharge Team

13. APPENDICES

1. Government's COVID-19 Hospital Discharge Service Requirement published in March 2020:

https://www.gov.uk/government/publications/coronavirus-covid-19-hospital-discharge-service-requirements

2. Hospital Discharge and Community Support: Staff Action Cards:

https://www.gov.uk/government/publications/hospital-discharge-service-action-cards