Central London
Community Healthcare
NHS Trust

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[redacted]
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Ms ME Hessel
HM Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London N1C 4PP

Dear Ms Hassell

I write to provide you with our response to the Regulation 28 report dated 5th December 2022 related to the sad death of Professor Richard Shannon on 19th February 2022.

We have worked together across the organisations involved in Professors Shannon's care to provide a response covering all nine areas of concern raised in your report, as relevant across the agencies. Subsequent to the safeguarding enquiry outcome meeting which was held on 16th June 2022, a number of changes to practice have taken place and we are committed to ensuring the improvements highlighted, both within our individual organisations and across our organisations are maintained moving forward.

We would like to take this opportunity to offer our sincere condolences to Professor Shannon's family, friends and those who knew him. We acknowledge and welcome the findings of the inquest and recognise that some of the care that Professor Shannon received fell below the standards we would expect, and for this we are sorry.

Regulation 28: Matters of Concern Actioned by Central London Community Healthcare NHS Trust

Concern 1: This concern related to discharge planning and the need for Central London Community Healthcare NHS Trust Community Nurses to be invited to discharge planning meetings.	Following the inquest, we have met with colleagues at University College Hospital NHS Trust and have agreed steps to improve our current working arrangements in relation to discharge planning. **Actions completed** • We have enhanced lines of communication between out teams, by setting up a specific phone number and time when the nurses will be able to discuss hospital discharges. • We have set up monthly review meetings with University College Hospital NHS Trust and partners to ensure the partnership working continues to develop and improve. • The District Nurses are now invited to meetings with University College Hospital NHS Trust for any complex discharges.

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Concern 2: Avoiding misunderstanding regarding care being provided by different providers could easily have been identified during discharge planning and the true position understood by all, if Central London Community Healthcare NHS Trust had been invited to the meeting.	We acknowledge that collaboration with partners during discharge planning would have ensured better continuity of care. The ability of Central London Community Healthcare NHS Trust's Community Nurses and staff from the Central North West London NHS Foundation Trust Community Independent Service to access and read each other's records when delivering care helped enhance communication between the two services; However, we have now taken further steps to strengthen communication across the system. **Actions completed** • All communications including care plans are now being shared with all providers involved in care at discharge to ensure consistency in care provision. • We are working with the Safeguarding Adults Executive Board to embed change and provide assurance regarding the safe discharge of adults at risk from all hospitals across the system.
Concern 3: The district nurses expected the carers employed by Kapital Care UK Limited to check the skin integrity every day. However, there is no record that they issued such an instruction.	**Action completed** • We have updated the care plans template for care plans that are held in the patients' home to ensure that they contain clear instructions for the carers where required. This documentation now also includes clear escalation criteria and contact details for the community nurses.
Concern 4. Upon discharge, a Discharge to Assess form was completed by therapists. The form raised a number of concerns but did not specifically instruct that carers should check skin integrity every day. That was an omission.	**Action completed** • The Central London Community Healthcare NHS Trust District Nursing Team has worked with University College Hospital NHS Trust and the City of Westminster to review and improve the quality of information we share with carers, prior to a vulnerable adult being discharged from hospital. This includes giving clear instructions regarding holistic care requirements and the equipment needed to reduce the risk of pressure damage.
Concerns 5: The City of Westminster social worker considering the Discharge to Assess form did not include in her thinking that Professor Shannon had a grade 2 pressure ulcer and was at high risk of developing pressure ulcers	Central London Community Healthcare NHS Trust continues to work with other organisations through the Safeguarding Adults Executive Board with its focus on the prevention of pressure ulcers. **Actions completed** • To further enhance the level of pressure ulcer prevention knowledge in the local system, we have shared our pressure ulcer care training proforma from the Central London Community Healthcare NHS Trust Academy with Westminster adult social care to assist in ensuring that there is a clear standard of training delivered by the different care organisations which will support carers to deliver effective care.

	• Central London Community Healthcare NHS Trust Academy will also offer further training where it is required to care organisations
Concern 6: When the District Nurse visited Professor Shannon the day after his discharge, his catheter bag was so full it had come detached, and he was demonstrably soiled.	Our Community Nurse did raise her concerns with the care agency and social worker about the soiled condition she found Professor Shannon. An internal incident report was completed by the Community Nurse. However, we acknowledge there was a missed opportunity to raise a safeguarding concern with the local authority. **Action completed** • We have shared learning from this with staff involved and across the organization to ensure that such an incident will automatically trigger an internal escalation to our safeguarding team in the Trust who will follow this up with the local authority.
Concern 9: Professor Shannon was not cared for as a whole person	**Action completed** • We have enhanced our overall communication with system partners and strengthened our discharge planning processes which has improved our overall planning and coordination of care needs, that will ensure all our patients receive holistic care.

Progress against all agreed and completed actions will be reviewed at our Divisional Quality forums on the 13th February and again on the 13th March 2023. Assurance will also be provided to our Patient Safety Risk group on 29th March 2023 to ensure all the agreed actions have been completed and improvements fully embedded.

We will continue to work collaboratively through the safeguarding processes to further embed improvements outlined above and agreed with our system partners to strengthen partnership working and discharge planning to enable holistic and personalized care to be delivered.

In addition, CLCH will ensure the changes to practice are embedded in operational procedures for all our community teams and this work will be completed by 31st March 2023.

Finally in my role as Chief Nursing Officer for the NW London ICB I will ensure their learning is shared with all providers of Community Nursing Services.

Yours sincerely

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Chief Nurse