St George's, Epsom and St Helier
University Hospitals and Health Group

Epsom and St Helier University Hospitals NHS Trust
Wrythe Lane
Carshalton, Surrey
SM5 1AA

[redacted]

Ms Caroline Topping
Assistant Coroner, HM Coroner's Court
Station Approach,
Woking,Surrey, GU22 7AP

11 June 2024

Dear Ms Topping,

Mr Timothy Clayton (Deceased)
Response to Regulation 28 Report to Prevent Future Deaths

This letter comprises the formal response of Epsom and St Helier University Hospitals NHS Trust 'the Trust' to the issues raised in the Regulation 28 Report to Prevent Future Deaths, dated 17 April 2024 'the Report', made after the inquest into the death of Timothy Clayton which was opened on 29 December 2022 and resumed on 16 January 2024 and concluded on 12 March 2024. The Trust would like to again express our deepest sympathy and condolences towards the family.

Background

The findings from the Inquest were that *"Mr Timothy Clayton was suffering from alcohol related brain damage and malnutrition result of chronic alcohol use. His mobility was impacted and he had fluctuating confusion. He was found hypothermic at his home on 27 October 2022, taken to hospital and discharged. On 20 November 2022, he was again hypothermic and was admitted to hospital. He was discharged on 24 November 2022, to be cared for by a family member. On 29 November 2022, he was admitted to hospital and transferred to Epsom General Hospital suffering with reduced mobility, slurred speech and confusion. The underlying cause of his condition was not diagnosed. He was found to be medically fit for discharge. The discharge planning was not undertaken in accordance with the hospital policy. No heed was paid to his family's concerns that he was not well enough to care for himself. He was discharged on the 5 December 2022 to live at his own flat. The heating was inadequate and he self-neglected in relation to eating. He was found profoundly hypothermic on the 11 December 2022 and admitted to Epsom General Hospital.*

He died from the effects of hypothermia on the 12 December 2022. Pressure on staff to vacate hospital bed spaces led to inadequate discharge planning and more than minimally contributed to the death."

A narrative conclusion was delivered at the inquest as follows:

"There was a lack of information sharing and investigation in relation to the discharge planning for Mr Clayton. Contrary to the Trust's policy he was not identified as a vulnerable patient. His family was not involved in the discharge planning. On a number of occasions, they raised their concerns as to his ability to live independently and were ignored. Staff were unaware of the discharge planning policy. The underlying cause for his presentation was not diagnosed. Discharge decisions were taken in a vacuum without understanding the recent history of frequent admission, his diagnosis and without sufficient investigation of his home circumstances.

An assumption that Mr Clayton had capacity was made and used to justify his discharge without considering whether he could make informed decisions about his ability to live alone without knowing what underlay his deterioration and how his ability to self-care was impacted.

It was accepted that pressure to vacate hospital bed spaces played a part in the inadequacy of discharge planning. The imperative to free up a bed space led to a rushed discharge on 5 December 2022 without an adequate care plan being in place."

The medical cause of death was found to be:

1a) Hypothermia
1b) Self neglect and Chronic Alcohol Excess

The Report raises the following concerns:

1. The policy in relation to discharge planning remains under review, including how families are to be involved, so it has not been possible to assess the adequacy of the new policy.

2. There was a misunderstanding by a clinician in relation to whether capacity to make a decision can be relied on to justify actions taken when the requisite information which needed to be considered by Mr Clayton in relation to that decision, and its consequences, had not been provided to him. Mr Clayton's expressed wish to go home alone, without any care plan in place, was relied on, erroneously, to justify an unsafe discharge on the bases that he had capacity.

In relation to both Epsom General Hospital and NHS England

3. The pressure to vacate bed spaces impacted on clinicians' ability to prepare a properly considered discharge plan and led to rushed under-informed decision making.

First Concern

The first concern set out in the Report is as follows:

> *'The policy in relation to discharge planning remains under review, including how families are to be involved, so it has not been possible to assess the adequacy of the new policy'.*

Trust response:

The Root Cause Analysis undertaken following this incident identified the fact that Mr Clayton was a vulnerable adult and so a complex discharge pathway should have been triggered as required within the Trust's discharge policy. As a result of this investigation, the principles of effective discharge processes were reviewed, safe check lists embedded into practice and clinical practice reviewed. Subsequent to the Inquest the Hospital Discharge and Criteria to Reside Policy (ESTH/POL/64521) has been reviewed, updated and approved and shared with staff in the organisation. This policy provides clarity on the identification of vulnerable patients for discharge and outlines the responsibilities of patients, family and carers to be in included in the discharge planning. The policy encourages families to raise concerns and, where concerns are raised, supports how these are managed. The effectiveness of the new policy will be reviewed through a planned Trust-wide audit in November 2024 which will be presented and any actions resulting from this monitored by the Patient Safety and Quality Group.

The process for identifying vulnerable patients has been strengthened and is defined in section 7.2:

Across both simple and complex discharges, particular attention will be paid to patients considered as vulnerable, who may not be coping with living in the community (i.e. lack of utilities) and/or have multiple needs or a high level of dependency. This could include, but is not limited to, patients with the following features:

- *Are elderly and live alone.*
- *Are terminally ill or have a rapidly deteriorating condition.*
- *Have functional disabilities in self-care or have a history of self-neglect or hoarding.*
- *Are confused or have a cognitive impairment or memory loss.*
- *Are nutritionally compromised.*
- *Have any form of communication difficulties.*
- *Have mental health problems or a history of self-harm.*
- *Have a learning disability.*

- *Are homeless and have 'no fixed abode' or those patients in temporary accommodation. The Trust has a duty to refer any adult who is declaring themselves to be homeless, or at risk of becoming homeless under the Homelessness Reduction Act (2017).*
- *Have specialised medical/nursing needs, e.g. patients on home non-invasive ventilation, tracheostomies, enteral feeding, Hickman lines, continuous ambulatory peritoneal dialysis (CAPD) or home dialysis.*
- *Are prisoners.*
- *Asylum seekers.*
- *Overseas visitors, or those not entitled to NHS care.*

The process for ensuring families are involved when patients are discharged from hospital are embedded within the policy. See below:

Section 6

- *Risks associated with discharge will be promptly identified through discussion with the patient, relatives, and carers. Other personnel will be involved according to the needs of the individual.*

- *Patients, relatives, and carers will be central to the planning of care and the successful discharge.*

- *Prior to discharge, patients, relatives, or carers are given details of arrangements; contact details; support; and any relevant information regarding their future treatment and care. Discharge medication information and counselling will be given by the Registered Nurse discharging the patient and the ward pharmacist.*

Section 17 Patient/carer (or relative/family member) Involvement

It is essential that the patient and, with permission, their carer, relative or family member are included in the ongoing assessment and care planning in relation to discharge planning, and that information is provided in a way that helps them to make decisions about their treatment and care, along with plans for discharge.

During their stay in hospital a patient, and, if appropriate, their carer or family member should be provided with verbal/written information which will include:

- *Treatment plan and expected discharge date;*
- *Reason for admission and what the diagnosis is;*
- *Investigations carried out, what the results were and what does that mean;*
- *Treatment received and relevant information i.e. what treatment to continue and for how long;*
- *What side effects the patient might expect and what they should do if they experience them;*
- *What are the follow-up arrangements, including the needs for any further investigations;*

- *What is likely to happen in the future and does the patient have to change anything;*
- *Arrangements, contact details and any relevant information regarding the patient's future treatment and care;*
- *Full information on the assessment of their health and/or social needs;*
- *Information regarding their medication;*
- *Discharge arrangements and expectations;*
- *Where patients have undergone a surgical procedure, they will be given written / verbal information which must include post-discharge advice.*

If and when a patient's care needs are complex, there is a difference of opinion between the patient/carer/relative and the MDT, or there have been concerns raised either by the patient and/or their carer or relative in relation to the discharge plan, an MDT meeting should be held to collectively discuss the concerns and work through any mitigations or further action required. The Patient Advice and Liaison (PALS) team can support the patient, relative or carer with further negotiation with the MDT if required.

If a patient lacks capacity and has no one appointed to act in their best interests relating to health and wellbeing (or finances), an Independent Mental Capacity Advocate (IMCA) will be required. This will be a joint decision between the Consultant (or GP in community settings), the discharge team (acute hospital), nursing teams and the relevant social care team i.e. allocated social worker.

18.Carer's Assessment

A carer is a person who provides or intends to provide care for another adult. It is either a relative or a friend who assists another person in their day-to-day life. This is different from someone who offers care professionally or through a voluntary organisation. This could include helping with personal care, washing, and dressing, nutritional needs, escorting them to appointments, or keeping them company when the cared person is lonely or anxious.

A carers needs must be considered during the discharge planning process, and a carers assessment may need to be undertaken by the appropriate social work team, as per the Care Act (2014) and the Health and Care Act (2022). Factors that need consideration include: the carers role, breaks and social life, physical and mental wellbeing, finance, work responsibilities, education and training, future caring role, practical and emotional support, emergencies and alternative care arrangements, access to information and advocacy, personal safety, and risk management.

All staff have been informed of the updated policy through the staff bulletin which is sent out to all staff and the importance of safe discharge including the new policy through learning bulletin for patient safety "Topic of the Week" which provides information on Trust patient safety priorities. Departmental leads are required to provide evidence to the senior leadership team that the clinical staff in their areas have read and understood the policy by 1st July 2024.

To monitor the effectiveness of these changes, discharge process has been registered for the 2024-2025 clinical audit plan for trust wide audit. There has been additional focus in the area where Mr Clayton was cared for with a baseline audit in May 2024 prior to the policy and weekly audits led by the senior nursing staff.

Second Concern

The second concern is as follows:

> *'There was a misunderstanding by a clinician in relation to whether capacity to make a decision can be relied on to justify actions taken when the requisite information which needed to be considered by Mr Clayton in relation to that decision, and its consequences had not been provided to him. Mr Clayton's expressed wish to go home alone, without any care plan in place, was relied on, erroneously, to justify an unsafe discharge on the bases that he had capacity'.*

Trust response

Following the investigation, the safeguarding training at the Trust has been reviewed and training has been updated include Mr Claytons case anonymised to support training. Following the inquest, further actions have been taken to strengthen the training. Whilst currently Mental Capacity Act training is included as part of Safeguarding Training, the Trust has reviewed the safeguarding training, and will deliver the training in 2 separate sessions with eLearning modules which are being imported from St George's Hospital to support the face-to-face offering. This will further allow staff to have further developed their understanding and responsibilities and duties under the Mental Capacity Act than currently in one single session. The specific Mental Capacity Act training objectives are;

- Understand the 5 principles of the Mental Capacity Act (MCA);
- Understand the stages of decision-making outlined by the MCA;
- Knowledge of the key steps to assist people to make moderately complex decisions;
- Understand the two-stage test of capacity;
- Understand what a comprehensive capacity assessment looks like;
- Knowledge of when and how to make a "best interests" decision;
- Understand how to document both the capacity assessment and the "best interests" decision making process.

This will go live on 1 August 2024.

As well as the existing scheduled safeguarding training sessions during 2024/2025, an additional member of the Safeguarding team has been employed to facilitate increased training sessions to provide additional training within areas where there are high numbers of medical discharges including Buckley Ward and provide additional sessions above previously scheduled sessions. The discharge coordinators across the Trust will additionally receive individualised training on safeguarding and mental capacity assessments. Compliance with safeguarding and mental capacity assessment training will be monitored through the statutory and mandatory training dash boards for each division in the Senior Leadership Team Meetings.

Third Concern

The concern in relation to both Epsom General Hospital and NHS England set out in the Report is as follows:

> *'The pressure to vacate bed spaces impacted on clinicians' ability to prepare a properly considered discharge plan and led to rushed under-informed decision making'*

Trust Response:

As a result of the Inquest and the concerns raised, the Trust has revised the discharge policy to ensures that the processes to gather the information required, the responsibilities of clinicians and the escalation processes for safe, timely and appropriate discharge of patients are clear. Staff have been encouraged to escalate to their senior managers when they have concerns regarding discharge through the Topic of the Week. The Site Chief Medical Officer and Site Chief Nursing Officer has presented this at key senior leadership meetings including the Clinical Leads meeting, Divisional Senior Leadership Team meeting and Divisional Medical Directors meetings. Escalation processes have been strengthened to ensure that there is a clear pathway for escalating concerns for clinical and clinical operational teams within working hours and out of hours.

Conclusion

As a result of the inquest and the concerns raised

1. The Trust has reviewed, updated and approved the Hospital Discharge and Criteria to Reside Policy. This has highlighted:
   a) The process for identifying vulnerable patients under the care of the Trust is emphasised including the importance of considering these patients in the context of complex discharge processes.
   b) The importance of family involvement in decision making in patients when planning to discharge including the safety of the discharge.
   c) The policy is now being shared across the trust and the effectiveness of the policy will be monitored to provide assurance of compliance with the standards within the policy. The effectiveness of the new policy will be reviewed through planned audits which will be presented and monitored by the Patient Safety and Quality Group.

2. The Trust has reviewed and refreshed the safeguarding and mental capacity staff training with:

   a) An immediate focus for improving the skills for staff working in high discharge departments by completing any outstanding aspects of safeguarding training, including mental capacity assessment and providing additional bespoke sessions for staff in these areas.

   b) As well as existing scheduled safeguarding training sessions during 2024/25 which includes anonymised information in relation to Mr Clayton's case, a member of the Safeguarding team has been employed to facilitate further training in departments and other sessional opportunities, to ensure training completion across professional groups. This includes discharge coordinators who support the discharge processes in the Trust. Compliance with safeguarding training by divisions is monitored through the divisional score card at the monthly Finance and Performance meeting chaired by the Managing Director of the Trust.

   c) Communication has been sent across the Epsom & St Helier University Hospitals Trust site and Group which provides anonymised learning and actions taken in relation to Mr Clayton's case.

3. Concern in relation to both Epsom General Hospital and NHS England:

   a) The Trust has emphasised that safe discharge is a key priority through communications with staff particularly highlighting the expectations of safe discharge encompassed within the policy including escalation processes where required.

I hope that this letter has provided you with assurance that your concerns have been taken very seriously by the Trust and that our procedures and processes have been revised to address those concerns.

We will share this letter with the family of Mr Clayton and hope that it provides them with some reassurance that the Trust now has safeguards in place to ensure patients, their families and carers are actively involved in discharge processes to ensure safety.

Yours sincerely,

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Group Chief Executive