Manchester University
NHS Foundation Trust

Joint Group Medical Directors' Office
Trust Headquarters
Room 218, Cobbett House
Oxford Road
M13 9WL

Tel: [redacted]

5th August 2024

HM Assistant Coroner Ms L Costello
HM Coroner's Office - Manchester South
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Costello

**Re. Mr John Francis Howe. Regulation 28: Prevention of Future Deaths**

Thank you for highlighting your concerns in respect of this case, which I have now had the opportunity to look into. The response required from Manchester University NHS Foundation Trust (MFT) is in relation to the following:

- Timing of discharges for patients from the Manchester Royal Infirmary (MRI)

MFT was notified of the second concern outlined within the Regulation 28 report issued following the inquest, we understand that this relates to Manchester City Council and therefore no response is required from MFT on this matter.

With regard to the timing of discharges from the MRI, as advised during the inquest there had been a locally implemented discharge process which should prevent vulnerable patients being discharged home after 21:00 hours. Since the inquest, I can confirm that actions have been taken to strengthen this process, which I have explained below.

Across all adult services within MFT the group wide Discharge Policy (reviewed January 2024) is utlised which outlines that "*where possible discharges from a ward area should be avoided after 20:00 hours".* Within the MRI, the Transfer and Discharge Unit (TDU) is utlised which operates until 21:00 hours, Monday – Friday and supports the safe discharge of patients from within the hospital. During weekends, patients are discharged directly from ward areas.

In Mr Howe's case, he had been transferred to the TDU within the MRI, however the booked transport (via East Midlands Ambulance Service) had not arrived by 21:00 hours and therefore Mr Howe was transferred to the Ambulatory Care Unit to await transport. It is acknowledged that the continuation of Mr Howe's discharge out of hours took place in the absence of any formal guidance relating to delayed transport.

I am aware that during the inquest, a narrative update was provided to you which described the informal arrangements the MRI team had taken to support the management of late discharges, in line with the Discharge Policy. This included the requirement for TDU staff to undertake an assessment at 20:00 hours to consider any remaining patients awaiting discharge. Any such patient would then be escalated to the MRI Hospital Site Management team to enable appropriate bed allocation back within the hospital bed base, if was felt that transport would not arrive in a timely manner.

I acknowledge that whilst the inquest heard about this process, there was a lack of evidence provided to the hearing demonstrating how this had been formally implemented across the hospital site which could provide you with sufficient assurance regarding the robustness of these arrangements.

The MRI team have confirmed that a formal process for managing delayed discharges has now been developed via an “Out of Hours Discharge Avoidance” Standard Operating Procedure (SOP), which will be utlised as part of the operational application of the MFT Discharge Policy. Whilst this SOP is still in draft, it is due to be presented for ratification at the MRI Quality and Safety Committee on Tuesday 13th August 2024. For completeness a copy of the draft SOP has been enclosed within this correspondence.

MFT comprises of several adult hospital sites, and ambulance transport services are utilized across the organisation. The draft SOP has therefore also been shared with the teams at Wythenshawe Hospital and North Manchester General Hospital who have confirmed their intention to take it through their relevant governance structures to ratify and implement. I anticipate that this will prevent inconsistencies in discharge practices across the organisation, which could have led to challenges for external providers.

I also note within the Regulation 28 report that the Inquest heard that the East Midlands Ambulance Service were unaware of the change in discharge timings. I hope that this correspondence assures you of the steps taken to implement a formal and robust process that supports decision making when discharges have been delayed. I can confirm that once the draft SOP is formally ratified across the relevant sites, MFT intends to formally communicate this to the external transport providers that support in the discharges of our patients.

Please accept my assurances that lessons have been learned from this case and appropriate actions have been put in place to address the issues raised. If you require anything further then please do not hesitate to contact me.

Yours sincerely

[redacted]

[redacted]

**Joint Group Chief Medical Officer / Responsible Officer**

[redacted]

Enclosed. Draft Out of Hours Discharge Avoidance SOP