Lewisham and Greenwich NHS Trust
University Hospital Lewisham
Lewisham High Street
London
SE13 6LH

Ms Liliane Field
Assistant Coroner for London Inner South
1 Tennis Street
Southwark
London SE1 1 YD

26th March 2025

Dear Ms Field

RESPONSE TO REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
Re: Ms Naomi Suleyman

Dear Ms Field

We are writing in response to your prevention of future death report dated 29th January 2025, concerning the care provided to Ms Naomi Suleyman.

Your report highlighted in total six matters of concern.

In respect of the D2A service which is an integrated multidisciplinary team of Health and Social Care professionals employed by both (Lewisham and Greenwich NHS Trust (LGT) and London Borough of Lewisham (LBL), the Coroner raised four concerns.

All four of these concerns have been considered both jointly and separately by the D2A service, Concern 1-2 is responded to by LGT, and concern 3-4 is a joint response by LGT and LBL.

The coroner raised 2 further concerns relating to the district nursing team only which has also been addressed in this response by LGT.

- Concern 1 (response from LGT)

  The 'discharge passport' completed by the UHL in-patient team was inaccurate, failing to record Ms Suleyman's vulnerability to pressure ulcers, the need for therapies input from day 1, the equipment she required and that her home environment had not been optimised to meet her needs both in terms of equipment and layout. Whilst I heard that scrutiny of the discharge passport had improved at ward level, deficient discharge passports were still filtering through to the D2A team.

- Each member of the ward-based team, who is involved in the patient care, now provides input into the centrally located (and saved) discharge passports.
- The nurse in charge of the shift holds overall responsibility for checking the information contained, prior to sending the document to the hospital discharge teams.
- Once checked and approved, the hospital discharge team will ensure the passports are uploaded to the electronic patient record
- The confirmed discharge plan and date is confirmed daily multidisciplinary ward review meetings which comprise of the lead Doctor and Nurse, therapists, relevant nurse specialists, pharmacist and other specialists where appropriate. The discharge plan is then updated in the electronic patient record. A new electronic bed management system will be going live in the trust in June 2025, which will facilitate the sharing of information regarding the planned discharge date.
- The nurse in charge will again review the information submitted on the discharge passport. This review will ensure that the data contained remains valid and that it is a true reflection of the patient's actual need at the proposed discharge date.
- A multidisciplinary task and finish group has commenced work to outline standards of practice, and to define roles and responsibilities relating to prescription of pressure care equipment and hospital beds. The project will be undertaken using Quality improvement methodology and will produce guidance materials and teaching for staff by end of April 2025.
- A multi-agency discharge event was carried out on 05/03/2025 which tests the systematic approach to discharge processes and further events are planned to improve multi agency communication and ways of working.
- An Occupational Therapy Policy has been developed which outlines roles, responsibilities and processes relating to therapy practice for environmental assessments and equipment provision. This is currently being agreed through the Trusts governance procedures.

<u>Concern 2 (response from LGT)</u>

- **The deficiencies in the discharge passport were not identified when it was screened by the LGT Hospital Flow Centre.**
    - The discharge team now perform additional checks on the patient electronic care record to ensure there have been no last-minute changes in the patient's condition or discharge support needs. This is underpinned by a new protocol which has been shared with the team and operationally embedded into working practices.

<u>Concern 3 and 4 - Joint response from LGT and LBL</u>

- **On the day of discharge, Ms Suleyman should have received a welfare check from the LBL out of hours social worker which did not happen. Due to lack of capacity, Ms Suleyman's interim care needs pending assessment were brokered to a care**

provider. As a result, she did not receive a visit from a social worker, and/or Occupational Therapist within 24 hours of discharge as she would have done if her care needs had been provided by the in-house Enablement team.

- Any client in receipt of Enablement or brokered out care provision now receives a visit from an Enablement Care Officer, this visit happens the same day that the patient is discharged from hospital and reviews the suitability of care provision once the patient is in their own environment. Any changes are fed back to the Discharge to Assess Team (occupational therapist, physiotherapist or social worker) and patient, carer or other family members.
- For those patients discharged out of hours between 5pm-8pm) the out of hours social worker ensures that a welfare call is carried out the next day.by a therapist and/or social worker
- There is now an established pathway, for escalation of concerns and information sharing between community services (Podiatry, District nursing and Community therapies/Enablement). This information has been shared across the services and embedded at all levels and will be monitored and audited moving forward.
- Escalation processes between care agencies and community services has been established for some time. This has also been reshared with community care providers.
- Escalation processes for GP services are well established and in good use.
- Community leads across therapies, district nursing, podiatry and enablement services; have systems in place to action urgent reviews by the most appropriate person, should it be required.

In respect of the involvement of the District Nursing Service (LGT)

Concern 1

- **The referral to the District Nursing team was incorrect in that it wrongly referred to Ms Suleyman having a sacral DTI on discharge. This led the District Nursing team to believe that she was already on the caseload of the community TVN team. This resulted in a delay in her being assessed by them.**
    - On further investigation the District Nursing referral was done in a timely way from the ward on the day of discharge and received and actioned by the DN team. The referral noted both the foot ulcers and the sacral ulcer correctly.
    - In order to ensure that the DN team identify complex wounds in future and refer to the TVN, a new process has been implemented during the first assessment, if there is any uncertainty about TVN involvement in complex wounds, the DN team will confirm this directly and ensure a referral is made if required

Concern 2

- **There was little communication between the therapists from the D2A team and the District Nurses.**

- An established pathway for the escalation of urgent concerns between community services (Podiatry, District Nursing, and Community Therapies/Enablement) is in place. All staff have been reminded of the process.
- Additionally, training sessions will be initiated for community therapy services and district nurses and delivered between April and June 2025 to enhance awareness of available services and referral procedures.
- In response to the report highlighting limited communication between the Discharge to Assess team and District Nurses, regular meetings have already been established between the teams to ensure consistent exchange of patient information. A staff member, or communication champion, has been appointed to oversee this process and ensure that care plans are followed. These communication efforts are being actively monitored and evaluated to confirm their effectiveness in preventing any future issues.

In conclusion ensuring compliance and the effectiveness of new processes will be overseen and monitored in a joint Lewisham and Greenwich NHS Trust (LGT) and London Borough of Lewisham (LBL) oversight meeting. This group will meet monthly and commences in April 2025.

I would like to assure you that Lewisham and Greenwich NHS Trust and London Borough of Lewisham have taken the concerns raised seriously and learning from this incident will be shared and overseen by the Divisional Governance Meeting.

Should you have any further questions regarding any of the information provided in this letter or require any further information please do not hesitate to contact us.

Yours sincerely

[redacted]

[redacted]

Chief Medical Officer
Lewisham and Greenwich NHS Trust

[redacted]

Interim Executive Director
Adult Social Care & Health
London Borough of Lewisham