Lewisham
Safeguarding Adults Board
A working partnership to prevent abuse

Safeguarding Adults Review Thematic Acute Hospital Discharge

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Contents

1. Introduction

1.1 On 1 May 2025, the Lewisham Safeguarding Adults Board [LSAB] Case Review Sub-Group agreed to commission a Thematic Safeguarding Adults Review [SAR].

1.2 The LSAB is a multiagency partnership that has representation from organisations that support adults who are residents of the London Borough of Lewisham.

1.3 This thematic SAR was commissioned to review the circumstances surrounding the care and support that was put in place for a small number of Lewisham citizens. Their care and support were arranged to enable their discharge from acute hospital care at the Lewisham and Greenwich NHS Trust (the Trust). The discharges took place between 2023 and 2025.

1.4 The themes distilled from the cases reviewed by the SAR author involved analysis of each set of circumstances based on case records provided by partners in Lewisham. (Please see Appendix 2 for a little more detail on the SAR methodology). As a thematic review, and in order to preserve the anonymity and confidentiality of the individuals involved, this public report does not focus on the personal detail of the care and support that was offered and received.

1.5 Sadly, each of the people whose care was reviewed in this SAR have now died.

1.6 Although each of the individuals whose care was reviewed in this thematic SAR did have hospital admissions and were discharged to their homes, their eventual deaths may not have been directly related to the circumstances of their hospital discharge.

1.7 Determining how, where and when the individuals died is the responsibility of the coroner through an Inquest.[1] This SAR will therefore make no comment about the circumstances of the deaths of any of the adults, as this is properly the coroner's responsibility to address.

1.8 This SAR does not cover any discharges or discharge arrangements from hospital-based mental health treatment in the local mental health hospitals.

1.9 The purpose of this SAR is not to re-investigate or to apportion blame. The purpose of the SAR is to:

- Establish whether there are cross-system lessons to be learned from the circumstances of the individual adults' care and support arrangements, considering the ways in which local professionals and agencies work together to safeguard adults.
- Inform and improve local interagency practice by acting on learning; and
- Make recommendations for future action based on the analysis of the reports submitted to the review by the agencies who had contact with the adults whose circumstances were considered as part of this SAR.

1.10 The Department of Health and Social Care's Care and Support Statutory Guidance (2014)[2] sets out six principles for how people with care and support needs are helped to remain safe in their lives. These six principles have informed the writing of this review as follows:

[1] More information about the role of the coroner and inquests can be found at: https://coronerscourtssupportservice.org.uk/
[2] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Empowerment	How each of the adults was involved in deciding how they managed their lives in the context of their needs when they were discharged from acute hospital care.
Prevention	The learning from this review will contribute to the prevention of harm to others.
Proportionality	Understanding whether in each of the adults' circumstances agencies responded in ways that were proportionate to their needs.
Protection	The learning from this review will contribute to the protection of others.
Partnership	Partners will reflect on how they worked together and use the learning from the review to improve partnership working.
Accountability	Assessment of the monitoring and quality assurance mechanisms that each agency had in place, and if these were implemented robustly. The LSAB governance will provide a framework for accountability ensuring that partners follow through on the learning from this review leading to demonstrable change.

1.11 More detail about the approach taken in the review can be found in **Appendix 2**.

2. Background Context to this SAR

2.1 A Previous Thematic SAR

2.2 In June 2020, the Lewisham SAB published a Thematic Safeguarding Adults Review relating to the care and support received by two adults in 2018 (Mrs A and Miss G). The published SAR and a summary 7-minute briefing can be found in the links at the footnote on this page.[3]

2.3 The LSAB June 2020 Thematic SAR found that discharge planning was not undertaken in line with the good practice standards as set out in the relevant guidelines. This led to risks for Mrs A and Miss G when they returned home from hospital.

2.4 The LSAB oversaw an action plan based on the recommendations from the SAR.

2.5 One of the questions that the LSAB Mrs A and Miss G Thematic SAR (June 2020) posed to local services was: "*Are these cases unusual, or do they reflect more widespread issues for adults being supported at home, with high and complex care needs?"* In view of the circumstances being reviewed in this new thematic SAR, answering this question remains an important issue to consider.

2.6 In view of a complex picture of concerns relating to arrangements for discharge from acute hospital for people with care and support needs, when reviewing the new cases, this SAR will also consider the recommendations from the previous Mrs A and Miss G SAR.

[3] Lewisham Safeguarding Adults Board - Thematic SAR Mrs A and Miss G
SAR Mrs A and Miss G - 7 Minute Briefing

3. The Wider Legal, Policy and Financial Context

3.1 There is a wide range of published national policy and practice guidance for the NHS, local authorities, and care providers. A summary of relevant guidance is listed at Appendix 3. Many of the guidance documents list the legislation that underpins hospital discharge arrangements.

3.2 Adults who are discharged from hospital may have no on-going needs for health and care support, other than remaining under the care of their General Practitioner or being reviewed in Outpatient Clinics. Others, such as the adults reviewed in this SAR, have much more complex needs.

3.3 There are several pathways that people can follow when they leave an acute hospital. The details of these can be found in Annex B of the government guidance found in the footnote below.[4]

3.4 Guidance requires NHS bodies and local authorities should agree the discharge models that best meet local needs and are effective and affordable within the budgets available to them. Partners in Lewisham have a range of operating procedures to support their agreed joint model.

3.5 In 2016, NHS England introduced as best practice the 'discharge to assess' (or D2A) model. This model is of relevance to this thematic SAR. This involves providing short-term care, rehabilitation and reablement, where needed, and then assessing people's longer-term needs for care and support once they have reached a point of optimal recovery. This may be in people's homes or using 'step-down' beds to support the transition from hospital to home. This means that people do not wait unnecessarily in hospital where there is a higher risk of acquiring infections or deconditioning. Assessing people out of hospital in the most appropriate setting and at the right time for them supports people's independence and long-term outcomes, reduces discharge delays, and improves patient flow.[5]

3.6 Health and social care partners in Lewisham work to this model, also known locally as Home First. The policy is supported by a detailed Standard Operating Procedure.

3.7 The services in Lewisham that are involved in assessing someone's needs for care at home and then for providing that care are provided or commissioned by the Council's Adult Social Care (ASC) services, the Trust's hospital and community services, the South East London Integrated Care Board's services[6], General Practice, and third sector and private home care providers.

3.8 There is some published evidence, which is detailed in the following sections, which suggests that at a *national* level there are reasons to be concerned about the experience of adults being discharged from hospital. Published SARs across England have also identified safeguarding concerns about practice.

3.9 The Care Quality Commission (CQC), the independent regulator of health and adult social care in England, publish an England-wide annual survey that looks at the experiences of people who stayed at least one night in hospital as an inpatient.

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[4] https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance#annex-b-discharge-pathways

[5] This description is taken from: https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance

[6] https://www.selodonics.org/icb/about-us/

3.10 In their most recent national survey[7] published in September 2025, they found the following as a key area for improvement:

a) “19.9% of respondents said that hospital staff did not discuss whether they would need any additional equipment or changes to their home after leaving the hospital but would have liked them to. Analysis also indicates a downward trend in most positive response option for this question since 2020.

b) Less than a half (47.5%) of respondents felt they ‘definitely’ got enough support from health or social care services to help them manage their condition after leaving hospital, and 23.1% said they did not receive enough support.”

3.11 The details for Lewisham and Greenwich NHS Trust can be found at the footnote below[8] and following through to patients’ responses to questions about their experience of leaving hospital. It should be noted, however, that not all patients being discharged from the Trust live in Lewisham. The Trust serves the residents of Bexley, Greenwich, and Lewisham, and will also receive a small number of patients from other areas. So, these data are about wider experience in the areas served by the Trust.

3.12 It should also be noted that many of the respondents to this national CQC survey may have been discharged in circumstances that are less complex than the adults reviewed in this thematic SAR. The same will be true for some of the National Voices research participants, the detail of which follows.

3.13 National Voices are a coalition of some 200 health and social care charities. In October 2025, jointly with the CQC they published a research report exploring peoples' experience of care after leaving hospital[9]. Findings from this work informed the CQC’s 2024/2025 annual State of Care report. While many of their respondents were happy with their discharge arrangements, some had less satisfactory experiences undermining their recovery.

3.14 Policy Partners Project are an organisation that “specialise in providing online policies, procedures and practice guidance sites for local authority adult social care, adult care providers, safeguarding adults boards and safeguarding children partnerships.”[10]

3.15 In August 2024 they published a briefing Hospital Discharge: Recommendations for Practice[11]. This briefing draws on analysis from the Second National Analysis of Safeguarding Adult Reviews: April 2019 - March 2023 (Local Government Association)[12]. The briefing summarises key points in relation to direct practice with adults with care and support needs in the context of discharge from hospital.

3.16 Only 3% of the SARs reviewed noted good practice during the hospital discharge process. 24% of the SARs reviewed noted practice shortcomings, which are provided in the published briefing.

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7 https://www.cqc.org.uk/publications/surveys/adult-inpatient-survey
8 https://www.cqc.org.uk/provider/RJ2/surveys/129
9 https://s42139.pcdn.co/wp-content/uploads/CQC-Final-report-Peoples-experience-of-care-after-hospital-discharge-.pdf
10 https://www.policypartnersproject.co.uk/about-us/
11 https://www.policypartnersproject.co.uk/wp-content/uploads/2015/02/Hospital-Discharge-Recommendations-for-Practice.pdf
12 https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023

4. Discharges of Lewisham Residents from the Lewisham and Greenwich NHS Trust

4.1 Lewisham and Greenwich NHS Trust manage a range of acute and community services including two hospitals, University Hospital Lewisham and Queen Elizabeth Hospital.

4.2 The Trust gathers, reviews, and analyses data on Emergency Department attendances, admissions to wards, all types of discharges and re-admissions. These data are part of a much larger suite of data that the Trust collects and reports.

4.3 The Trust and ASC receive reports that detail the hospital's discharge activity and performance as it relates to Lewisham residents.

4.4 Typically, the Trust averages some 10,000 discharges of Lewisham residents in a year. The small number of cases reviewed in this SAR occurred over three years. They therefore represent an extremely tiny proportion of the total number of discharges.

4.5 That said, in commissioning this thematic SAR, the LSAB has rightly taken the view that further investigation and reflection is needed in relation to the very serious events that befell a handful of people from 2023 to early 2025.

4.6 Paragraphs 9.23-9.25 below outline the intensifying financial pressures experienced by the NHS and Local Authorities nationally, regionally and locally. As people live longer with complex health needs, there are also increasing demographic pressures. These factors undoubtedly have an impact on the planning and delivery of services that support people when they leave hospital. This issue is addressed in recommendation 10.6 below.

5. Governance Arrangements that Oversee Lewisham's Joint Working on Acute Hospital Discharge

5.1 Health and social care partners in Lewisham work to a D2A model, also known locally as Home First.

5.2 In May 2024, the Home First Executive Team commissioned a borough-wide review of community therapy services and enablement services, to better understand the rehabilitation capacity available in the system and provide recommendations regarding what was needed to make the most effective use of the collective resource.

5.3 Based on the outcomes of the work, a key recommendation included the creation of a Transfer of Care Hub service (TOCH), whose function is to coordinate and manage all Lewisham residents transitioning from Lewisham and Greenwich NHS Trust to home who require a period of enablement.

5.4 Enablement is a process aimed at helping individuals regain independence after a hospital stay or illness.

5.5 The aim of the TOCH was to bring together health and social care practitioners involved in supporting people when they are discharged from hospital.

5.6 This service has been in place since 1 September 2025.

5.7 The governance for this service includes a governance board with senior representation from the Trust and Adult Social Care. As of January 2026, the governance structure is being reviewed.

5.8 The Board met regularly. The work of the Board includes reviewing a range of performance information. This includes incident review, compliments, and complaints.

5.9 This Board was set up for a specific purpose, namely, to oversee the implementation, development, and review of the TOCH.

5.10 As the majority of Trust discharges are managed with a simple discharge home, they do not come into contact with the TOCH. Consequently, the services involved in simple discharges back home are not represented in the current governance arrangements.

6. Case Studies Reviewed for this Safeguarding Adults Review

6.1 This is a high-level summary of the case studies covered by this thematic SAR.

6.2 The cases involved both men and women. The ethnicities of each individual were recorded in the documents provided to the SAR. Their ages ranged from 66 to 90 at the time of their death.

6.3 In the small sample of cases reviewed, and in the context of the local demographic profile, no issues or trends relating to gender or ethnicity emerged in the analysis. It should not, however, be assumed that this may not be a relevant issue, and this is discussed further in the analysis that follows.

6.4 All had been living with very significant health problems which resulted in hospital admission, sometimes several admissions.

6.5 Each adult had a range of services being provided at home in various combinations from the NHS, Adult Social Care, Home Care agencies and local Third Sector organisations. All were registered with General Practice.

6.6 Some of the adults developed new pressure ulcers. For others, their existing risk of pressure damage worsened.

6.7 Support at home with equipment and Linkline Telecare (the quick response phone service) were common features, as was consideration of the use of a key safe.

6.8 All lived alone. Some had family members who were able to offer some support, including for some involvement at a distance. Some had some support from neighbours.

6.9 The records provided to the review are silent on whether any of the adults were or had been part of a faith community.

6.10 For some of the adults, when their discharge from hospital was being planned, options for a short stay residential placement was discussed with them and/or their family. All opted to return to be cared for at home. Whether these decisions were taken with full understanding by the adult is not clear in several cases.

6.11 Some of the adults were unhappy with their care arrangements at home and from time-to-time, or for periods of time they declined care. The records provided to the review are not

always clear about how the individuals' mental capacity to make this decision were assessed; nor how the risks that arose were evaluated.

6.12 There were background Safeguarding Concerns for several of the adults, but the records provided to the review were often incomplete as to how Safeguarding Enquiries were raised and followed through in line with Lewisham's Adult Safeguarding Pathway.[13]

6.13 For some of the adults, their hospital stays, and discharge took place during the winter months. This is often one of the busiest times for hospital and the community services. It is not possible to discern from the records provided to the review whether the health and social care system's experience of "winter pressures" adversely affected the care arrangements for these adults.

7. Recommendations from the June 2020 SAR

7.1 The LSAB June 2020 Thematic SAR found areas of health and social care practice which offer an explanation as to why professional practice was not more effective in protecting two adults from failures in their care arrangements.

7.2 This June 2020 SAR made the following findings:

7.2.1 Problems may arise in the re-assessment of the needs for social and health care when older adults are admitted to hospital. Where mobility has decreased due to an infection or other illness this should inform a full re-assessment when patients return home.

7.2.2 Discharge from hospital may result in the restart of previous levels of care, which are no longer appropriate to meet an increase in care needs.

7.2.3 Discharge planning is not undertaken in line with the good practice standards, as set out in the NICE Guidelines, which led to subsequent risks for both adults when they returned home from hospital.

7.2.4 Home carers continue to attempt to meet clients' needs rather than escalate either difficulties with the delivery of effective care, or the impact on clients' health where needs are not met.

7.2.5 District Nursing Services do not always respond appropriately or in a timely manner to referrals made by hospital or community services.

7.2.6 Equipment that is required to assist in delivery of care may not be ordered, delivered, or set up, due to logistical and practical difficulties.

7.2.7 Access arrangements to enable carers or DN's to visit clients are not included when referrals are made to these services, which causes delays in responding to referrals.

7.2.8 Delays in practical aspects of setting up changes to care cause needs to remain unmet and this leads to serious health consequences for clients.

7.2.9 Decision making for older adults is not always assessed even when poor physical health can lead to concerns about their mental capacity and associated risks in the community.

[13] https://www.safeguardinglewisham.org.uk/lsab/lsab/lewisham-adult-safeguarding-pathway/safeguarding-pathway

7.3 Each of these findings had recommendations to address the issues identified. The LSAB oversaw the delivery of an inter-agency action plan to address the recommendations.

7.4 Recommendations From other Incident Analyses and Complaints

7.5 As part of this SAR, the author reviewed a small sample of complaints and the management of learning from one set of circumstances that received important external scrutiny.

7.6 An internal TOCH monthly quality and performance meeting reviews complaints and compliments that relate to their services.

7.7 The Trust and ASC have established a governance group that is overseeing improvement actions relating to one set of case circumstances. This governance group provides a possible framework for future governance arrangements to oversee how partners address service improvement arising from individual case circumstances

8. Analysis and Findings

8.1 Lewisham's Discharge to Assess Home First Strategy

8.2 As outlined above, health and social care partners in Lewisham work to the national D2A model, also known locally as Home First. This framework model is supported by a detailed Standard Operating Procedure.

8.3 With the benefit of the hindsight this SAR provides, given the complexity and intensity of each individual's needs, it is not clear that returning home was always the safest option for several of the adults reviewed as part of this thematic SAR.

8.4 Options for residential care placements, including short term placements, were discussed professionally and with some of the adults and/or their families. In the event, these options were not followed through with the adults for whom this might have been an option and the adults returned home.

8.5 Making decisions about the discharge destination will be discussed further in the section that follows.

8.6 Mental Capacity and Discharge Planning

8.7 In October 2023, an independent social worker was commissioned to carry out an audit of local practice in relation to assessing Mental Capacity. The audit reviewed a sample of records from the previous eighteen months.

8.8 More detail about what it means to assess Mental Capacity, and the underpinning law can be found in the footnote below.[14]

8.9 The cases reviewed in the audit cover a wider range of ages and circumstances than those of the adults whose care was reviewed in this SAR. However, the most common decision that was reviewed in the audit related to hospital discharge destination. The audit identified some of the practice challenges which can arise when discussing discharge destinations with people whose ability to make that decision may be in question or who might need extra help and support.

[14] https://www.nhs.uk/social-care-and-support/making-decisions-for-someone-else/mental-capacity-act/

8.10 The audit identified that the Local Authority and two local NHS Trusts had not kept up to date with changes in Mental Capacity related case law.

8.11 In view of the issues that have been identified in this thematic SAR, the implementation of the findings of the October 2023 audit need review.

8.12 The audit that Lewisham carried out provides some important context to this SAR.

8.13 Each of the adults reviewed in this SAR had very significant health problems. These included Arthritis and other joint conditions, Cancer, Chronic Obstructive Pulmonary Disease, Diabetes, various skin conditions, and sight related conditions. Some individuals had complications including kidney and urinary conditions. As will be addressed later, most had pressure ulcers.

8.14 At times, either because of their ill health including active infections or because of diagnosed dementia, records show that their cognitive functioning was in question. Most of the records do not clarify how important care and support decisions were reached taking this into account.

8.15 In addition to following the requirements of the Mental Capacity Act (2005)[15] and its associated Code of Practice[16] and local guidance, services needed to have built up individual pictures of how care and support was experienced by each of the adults and how best to support their needs in the context of what was important to them. The records provided to the review do not give a clear picture of how each individual was supported to make decisions about their care arrangements in order to maximise their safety in circumstances that were clearly challenging for them.

8.16 Some of the adults were not content with their care and support arrangements, to the extent that they declined some of their care. It is quite clear from their records that their decisions had a detrimental impact on their wellbeing.

8.17 What is also not always clear in the records is how efforts were made to encourage and support the person to clarify what was important to them and how this could be built into care arrangements that were safer.

8.18 The link provided in footnote 13 explains some of the ways in which people can be helped to make complex decisions.

8.19 The records provided to the review also do not evidence work with the individuals to weigh up the consequences of their decisions to decline care. Of course, each such decision made by those individuals who declined care might have been a carefully considered decision. However, it is also not clear in the records how services then mitigated the risks that might have arisen from declining what professionals had determined was life sustaining and essential care. The records provided to the review do not evidence any consideration of whether the individual's decisions to decline care were leading to self-neglect.

8.20 This would suggest that staff may lack expertise and/or confidence in assessing mental capacity, documenting both the process and the outcomes of their deliberations, putting risk

[15] Mental Capacity Act 2005 - https://www.legislation.gov.uk/ukpga/2005/9/contents
[16] Mental Capacity Act 2005 Code of Practice (London 2007) - https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

mitigation strategies in place, and escalating concerns if safeguarding strategies are not successful.

8.21 These findings are especially significant in the wider context of Safeguarding Adults Review that the LSAB has commissioned in recent years. Since 2019 most of these have found that despite often being indicated, mental capacity assessments were not carried out in line with the requirements of the Mental Capacity Act (2005) and its associated Code of Practice[17] and local guidance.

8.22 Discharge Passports

8.23 A discharge passport is a document outlining the care that is needed in someone's home upon when they are discharged from hospital.

8.24 Some of the individuals reviewed in this SAR received discharge passports that did not adequately address their needs. This created a situation where some returned home with an incomplete plan, and gaps in the services that were needed from day one.

8.25 Skin Integrity Management

8.26 Tissue viability services support people with assessment, drawing up care plans to prevent pressure ulcers including advising on and arranging pressure relieving equipment, treating pressure ulcer wounds, and providing care plans for ongoing treatment by district nurses or home carers.

8.27 Most of the adults in this SAR experienced pressures ulcers.

8.28 Until all the inquests are held for those adults who developed pressures ulcers, it is not possible to say whether their pressure ulcers contributed to their deaths. However, it is possible to say that for the adults reviewed in this SAR, their pressure ulcers either developed or deteriorated while they were being cared for at home.

8.29 In the case of some of these adults their developing pressure ulcers may not have been detected quickly because of their unwillingness to receive personal care from home carers. This is despite of the evident risks because of their overall health conditions and lack of mobility.

8.30 This illustrates the importance of home care staff and district nurses responding rapidly by escalating concerns. The records for several of the people in this SAR do not evidence a clear focus on the risks of pressure ulcers that the individuals were facing.

8.31 Provision of Equipment, Assistive Technology, and Key Safes

8.32 Linkline Telecare, the quick response community alarm phone service, was either already in place or put in place for several of the adults. Installing key safes to enable ease of access by care and support staff is often useful and sometimes essential if for whatever reason, including emergencies, the adult is unable to open their own front door.

[17] Mental Capacity Act 2005 Code of Practice (London 2007) - https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

8.33 When adults sign up for Lewisham's Linkline Telecare community alarm service[18], the service hold a set of keys for the adult's home. If the alarm is activated in the person's home, the service will call them via the monitor, and if help is needed, or if no contact can be made with the adult, they will visit the home.

8.34 If in addition, the adult has a key safe, the Linkeline Telecare community alarm service will hold the code for the key safe which can be shared with emergency services if this is required.

8.35 How this works in practice was an issue addressed in the earlier June 2020 Thematic SAR.

8.36 In some of the circumstances reviewed in this thematic SAR, the code for the key safe was not available in a timely way to key personnel, potentially leaving the adults concerned without care for short periods of time.

8.37 In the context of this thematic SAR, it can be the case that adults are not content to have a community alarm system or a key safe installed.

8.38 When this happened in the cases reviewed, the records are largely silent on how the risks associated with the absence of a key safe were weighed up and discussed fully with the individuals and/or their friends and/or family.

8.39 This finding most probably links to the issue of assessing Mental Capacity referenced above. Where a service offer is being declined, it was not clear in the records provided to the SAR how staff weighed up whether this a decision made with good understanding of the possible consequences.

8.40 The provision of equipment to support people's mobility, safety when moving, skin integrity and general comfort is essential to enabling people to remain safe and comfortable in the environment where they live and receive care. More than one of the adults experienced significant delays in the necessary equipment being delivered. In each case this compromised their wellbeing.

8.41 The timely and appropriate provision of equipment was also an issue identified in the LSAB June 2020 Thematic SAR as it affected Miss G.

8.42 Support from Family and Friends

8.43 As mentioned above, all the adults reviewed in this thematic SAR lived alone. Some had family members who were able to offer some support, including, for some, involvement at a distance. Some of the adults reviewed had some support from neighbours.

8.44 The records provided to the review reveal that professionals made some assumptions about the roles that neighbours provided to some of the adults. In some cases, records show that professionals seem to have assumed that neighbours were designated as an adult's next of kin, without of course any lawful basis for that designation.

8.45 There seems to have been a lack of diligence in mapping out individual's circle of support and being clear about their roles and responsibilities. Furthermore, with some adults whose families lived at some distance, the records are silent as to how their potential involvement

[18] https://lewisham.gov.uk/myservices/socialcare/adult/myhome/help-at-home/community-alarm-system--linkline-telecare

in the adult's care was being considered and discussed with the adult in the context of end-of-life care planning.

8.46 "One Team" Approach

8.47 Enabling someone to leave hospital safely with appropriate care arrangements in place involves coordination between a wide range of health and social care services. This can be challenging when multiple services are involved.

8.48 Each person's circumstances are unique, and discharge staff must put together a personalised and bespoke jigsaw of services that will hold together safely.

8.49 Sometimes this jigsaw can feel more like a kaleidoscope, with relationships between different services changing when needs change. Some services necessarily need to stop and start. This is a challenge for people receiving care, their friends, and families and indeed for services themselves.

8.50 Ensuring that this all is done in a safe and timely way is referenced in detail in Lewisham's operational procedures for hospital discharge.

8.51 Lewisham's approach to hospital discharge includes the aim of teams working as one team. This includes

- Clear structures and processes in place so that staff have the skills,
- Confidence and support to manage higher levels of risk and safety.
- Strengthened interface between community partners and discharge processes.

8.52 Regrettably this One Team approach was not always evident in some of the circumstances surrounding the individuals concerned.

8.53 Some of the case study material supplied to the SAR has significant inconsistencies between accounts given by different teams who should be aiming for a One Team approach.

8.54 Safeguarding Interventions

8.55 The case study records supplied to this review include various professional concerns about the safety of individuals.

8.56 Some of those concerns result in Safeguarding Concerns being notified to the Lewisham Adult Gateway.[19]

8.57 It is very difficult to understand from the documentation provided to the SAR what was reported as a concern, what resulted in formal enquiry and whether several of the enquiries that were made were fully followed through in line with Lewisham's Adult Safeguarding Pathway. [20]

8.58 Furthermore, the language that is used in the records is not consistent with the agreed national terminology as reflected in the Lewisham Adult Safeguarding Pathway. This comment may seem fastidious, but in the reviewer's view, it reflects a lack of understanding

[19] https://lewisham.gov.uk/organizations/adult-social-care-enquiries
[20] https://www.safeguardinglewisham.org.uk/lsab/lsab/lewisham-adult-safeguarding-pathway/safeguarding-pathway

by front line staff and perhaps in some local policies as to the agreed pathway for following through on adult Safeguarding Concerns in Lewisham. This confused used of terminology and lack of clarity about expected outcomes when concerns are raised has the potential to place adults who may be unsafe at further risk.

8.59 Some of these Safeguarding Concerns can also with hindsight be understood to be warnings of disruption in the care arrangements; disruptions that needed attention, perhaps early indications of the significant events that were unfolding. It may have been the case that some of the concerns did not meet safeguarding thresholds, but nevertheless they were indications that all was not well with the individuals concerned. Greater professional curiosity might have opened up different conversations with the adults who were at some risk, leading potentially to different outcomes.

8.60 Monitoring and Quality Assurance

8.61 This SAR did not seek evidence on the supervision arrangements or training resources that are in place for front line staff.

8.62 Implementation of Previous Action Plans

8.63 Partners in Lewisham have a significant dossier of information about care and support failures in recent years as they relate to older adults whose discharge home after a hospital admission have been very problematic.

8.64 In the cases covered in this SAR, the two cases in the June 2020 SAR and complaints that services have received[21], there are some recurring themes.

8.65 While this SAR recognises that these represent a small proportion of overall hospital discharges during the relevant years, the outcomes for the adults and for their families raise many concerns. It is therefore imperative that services establish cross system governance arrangements to enable them to identify and track quality and performance issues as they arise in order to intervene and implement change where needed.

8.66 Equalities Issues

8.67 As indicated above no issues or trends relating to gender or ethnicity emerged in the analysis of the handful of cases in this thematic SAR. However, as there is no single cross-service and cross-agency governance group that reviews all acute hospital discharge activity and outcomes as they impact on Lewisham residents, is essential that there is proper scrutiny of how the Equality Act 2010 protected characteristic may be impacting on people's discharge experience and outcomes.

9. Conclusions

9.1 This thematic SAR has aimed to set a framework for important and urgent work that must be followed through locally.

9.2 It is the SAR author's view that the cases reviewed should be regarded as "sentinel" cases. They involved unplanned events that resulted in serious physical and/or psychological outcomes. What happened to each of the individuals concerned was not related simply to the natural course of their health and care needs. Services did not respond adequately to

[21] The SAR only reviewed a very small sample of complaints.

the health and care challenges as they evolved. This was to the serious detriment of each of the individuals concerned, and by extension to their families and networks.

9.3 Such events require a strong leadership response to help the organisations involved reduce risk and improve quality for all.

9.4 The third report from the second national analysis of safeguarding adult reviews outline five key domains for SARs.[22] In drawing conclusions about what this SAR has been able to review, conclusions are set out under these headings.

- Direct practice.
- Interagency practice.
- Organisational support.
- Governance.
- National context.

9.5 **Direct Practice**

9.6 In the cases reviewed in this SAR, there were multiple examples of direct practice concerns.

9.7 Of note was the approach to assessing mental capacity in relation to hospital discharge destination and refusals of care and support.

9.8 Another important issue was the lack of accuracy in describing safeguarding actions and following through on outcomes in line with Lewisham's Adult Safeguarding Pathway.[23]

9.9 **Interagency Practice**

9.10 As mentioned in the analysis, Lewisham's approach to hospital discharge includes the aim of teams working as One Team. This includes:

- Clear structures and processes in place so that staff have the skills.
- Confidence and support to manage higher levels of risk and safety.
- Strengthened interface between community partners and discharge processes.

9.11 Each set of discharge arrangements must be highly personalised to an individual's needs and wishes.

9.12 In some of the cases reviewed in the SAR, agencies and services did not pull together as "One Team" to provide care that was experienced as seamless by the individual and others involved in their family and informal care.

9.13 This was further exacerbated by a few significant inconsistencies between accounts given to the SAR process by different teams. This suggests that differences of professional opinion may not have been worked through fully to safeguard individuals. It reveals potential weaknesses in the One Team approach.

9.14 The issues arising will be addressed in the governance section below.

[22] https://www.local.gov.uk/sites/default/files/documents/NationalSARAnalysis
[23] https://www.safeguardinglewisham.org.uk/lsab/lsab/lewisham-adult-safeguarding-pathway/safeguarding-pathway

9.15 **Organisational Support**

9.16 This SAR did not seek evidence on the supervision arrangements or training resources that are in place for front line staff.

9.17 The issues arising will be addressed in the governance section below.

9.18 **Governance**

9.19 The current governance arrangements that support health and social care partners to steer the quality of the hospital discharge services needs development.

9.20 There are two key issues that require urgent attention.

9.21 The first is that there are key players who need to be included in the governance and quality assurance oversight arrangements. The TOCH Board does not include all the services that are dealing day to day with hospital discharges. This means that there is no one governance group that has oversight of the whole picture of current Lewisham acute hospital discharge. This is a very serious governance gap.

9.22 The second issue: Health and care partners do not have a current mechanism for joint review of individual cases causing significant concern. The question that the LSAB Mrs A and Miss G Thematic SAR (June 2020) posed to local services was: “Are these cases unusual, or do they reflect more widespread issues for adults being supported at home, with high and complex care needs?”

9.23 The cases reviewed in this SAR suggest that there is good reason to be concerned about the lack of safety and comfort that some people have experienced when returning home after acute hospital admission. As possible “sentinel” cases, the small number of cases of concern suggest that there may be wider systemic issues.

9.24 Health and social care services need to implement a joint approach to review serious cases in depth. Learning can then be drawn out and changes implemented across the system. The reviewer understands that there is not a well-developed local framework to support this vital work. Approaches were developed in relation to the June 2020 Thematic SAR, and in relation to one recent case. These approaches can and should be built on.

9.25 **National Context**

9.26 In November 2025, the Association of Directors of Adult Social Services (ADASS) published the results of their survey of Directors.[24] Several of the key findings from this survey are relevant to the circumstances reviewed in this thematic SAR.

9.27 Adult social care pressures are intensifying, and Directors are estimating the largest overspend at this point in the year in the post Covid-19 era.

9.28 Significant savings will be required from next year’s adult social care budgets to enable councils to deliver legally required balanced budgets.

9.29 The ability of councils to influence NHS partners is diminishing at a time when Government priorities on neighbourhood health and shifting activity from hospital to community require a strong adult social care voice.

[24] https://www.adass.org.uk/documents/adass-autumn-survey-2025/

9.30 Government's ambition to deliver a shift to neighbourhood health and care is likely to be jeopardised by an absence of funded agreements between health and councils to delegate healthcare activities to frontline adult social care staff.

9.31 Adopting the recommendations of this thematic SAR, will need to be cross-referenced with the challenging financial and policy context that all health and social care organisations face at this time.

10. Recommendations

10.1 Senior Leaders to commission and implement a new Lewisham interagency structure to oversee acute hospital discharge policy and practice. While it is for Lewisham partners to design the appropriate structures, the following issues should be addressed:

a) Very rapidly establish a set of outline arrangements in order to progress the findings of this SAR. This should not be delayed while fine detail of future arrangements is designed, agreed, and implemented.

b) New governance arrangements should build on existing successful local cross-service and cross-agency governance models and integrated with existing governance structures.

c) Inclusion of the services that are not represented in the current arrangements in order to strengthen the One Team approach across **all** relevant services.

d) Establish appropriate sub-groups which may be task and finish groups, to focus on the actions needed in relation to the cases covered by this SAR, and any other subsequent cases.

e) Develop an agreed work plan based on the case for change. This work plan should build on existing work plans and on the findings of this SAR. It should include a timetabled plan of key audits. The case studies in this SAR suggest that the management of pressure ulcer risk, especially in people who decline personal care is an area for urgent audit.

f) Commitment from the various agency data and performance teams to provide the necessary data suites to enable governance partners to see the whole picture of discharge activity as it relates to Lewisham citizens. The agreed data suites should include full breakdown by the Equality Act 2010 protected characteristics.

g) Engagement with people who use services and their families.

h) Workforce development planning based on the direct practice issues identified in this SAR, and other local intelligence about training and workforce needs.

10.2 **Trust, ICB and Adult Social Care services working with Lewisham people who are discharged from acute hospitals:** Progress rapidly the reviews of individual cases which formed part of this SAR in order to implement service and workforce development changes. Prepare as One Team with candour to any outstanding complaints, liaison and communication with families, and submissions to the Coroner's Office.

10.3 **Lewisham and Greenwich NHS Trust, London Borough of Lewisham Adult Social Care and South London and the Maudsley NHS Trust:** Review the recommendations of the October 2023 Audit of mental capacity practice in Lewisham and cross reference with findings of this SAR and action 10.2. Design and implement a cross-agency service

improvement plan. Design and deliver a plan of regular audits to gauge progress. Report the audit outcomes and the actions being undertaken.

10.4 **The new acute hospital discharge governance group** – Convene during the first half of 2026-2027.

10.5 **Lewisham Safeguarding Adults Board** – Instruct all agencies to revise their safeguarding documentation so that it is consistent with the Lewisham's Adult Safeguarding Pathway[25] and train staff accordingly. Design and commission an audit during 2026 of the enquiries being received by the Lewisham Adult Gateway to gauge progress towards compliance with the agreed framework for progressing concerns to enquiries through to plans. Report the audit outcomes and the actions being undertaken.

10.6 **Lewisham Joint Commissioning and Public Health** – Consider whether in view of demographic and funding pressures, the findings of this thematic SAR, and the findings of the June 2020 Thematic SAR, whether the work of Joint Strategic Needs Assessment should address the context in which hospital discharge services are commissioned and delivered. Of particular concern in this thematic SAR is a recurring theme from the previous June 2020 Thematic SAR of problems in the delivery of assistive equipment.

[25] https://www.safeguardinglewisham.org.uk/lsab/lsab/lewisham-adult-safeguarding-pathway/safeguarding-pathway

Appendix 1 – Safeguarding Adults Reviews

The purpose and underpinning principles of this SAR are set out in section 2.7 of the London Multi-Agency Adult Safeguarding Policy, Practice Guidance and Procedures. All Lewisham Safeguarding Adults Board (SAB) members and organisations involved in this SAR, and all SAR panel members, agree to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation, and will reflect the current realities of practice ("tell it like it is")

Section 44 of the Care Act 2014 places a statutory requirement on the Lewisham Safeguarding Adults Board (LSAB) to commission and learn from SARs in specific circumstances, as laid out below, and confers on Lewisham SAB the power to commission a SAR into any other case:

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect, or

c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –

a) identifying the lessons to be learnt from the adult's case, and

b) applying those lessons to future cases.

This SAR was conducted in accordance with requirements set out in:

- Care Act 2014 (https://www.legislation.gov.uk/ukpga/2014/23/contents) and statutory guidance https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance)
- Safeguarding Adults Reviews under the Care Act: implementation support (SCIE 2015) https://www.scie.org.uk/safeguarding/adults/reviews/care-act/).
- Lewisham and London safeguarding policies and procedures (https://www.safeguardinglewisham.org.uk/lsab/lsab/publications/policies-and-procedures-library)

Appendix 2 – Scope of the Review and Methodology Used

The purpose of this thematic SAR is to:

- Establish whether there are cross-system lessons to be learned from the circumstances of the individual adults' care and support arrangements, considering the ways in which local professionals and agencies work together to safeguard adults.
- Inform and improve local interagency practice by acting on learning; and
- Make recommendations for future action based on the analysis of the reports submitted to the review by the agencies who had contact with the adults whose circumstances were considered as part of this SAR.

The author of this SAR was provided with case study documents for each of the adults whose cases were reviewed.

In addition, the author of this SAR reviewed some key documents relating to the historical cases.

The following agencies and organisations were invited to contribute to the SAR and how they were involved with the governance of local discharge arrangements and the care and support of the adults whose care and support was reviewed.

- London Borough of Lewisham Adult Social Care
- Lewisham and Greenwich NHS Trust
- General Practice (where relevant to the case)
- Home Care Providers

Thanks to each of them for the work they have undertaken to reflect on the circumstances of this thematic SAR.

The reviewer and author of this report is a retired adult social services and NHS manager with previous experience of Safeguarding Adults Reviews. She had no previous involvement in the care and support offered to the adults and no connection with the agencies who worked with them.

Appendix 3 - The Legislative and Evidence Base for the Review

In addition to the legislation, guidance and policy documents referenced in Appendix 1, the following document are pertinent to the topic of this thematic Review

- The National Institute for Health and Care Excellence Guideline Transition between inpatient hospital settings and community or care home settings for adults with social care needs - https://www.nice.org.uk/guidance/ng27
- The Department of Health's statutory guidance on Statutory Hospital discharge and community support guidance - https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance
- NHS England's guidance on Improving Hospital Discharge https://www.england.nhs.uk/urgent-emergency-care/improving-hospital-discharge/
- The Social Care Institute for Excellence's guidance on Hospital discharge and preventing unnecessary hospital admissions **-** https://www.scie.org.uk/providing-care/commissioning/hospital-discharge-admissions/ This guidance was issue during the height of the Covid-19 pandemic, and should therefore be read in that context
- The results of the Care Quality Commission Adult inpatient survey 2024 - https://www.cqc.org.uk/publications/surveys/adult-inpatient-survey
- The findings of the National Voices and Care Quality Commission's research into people's experience of care after hospital discharge - https://s42139.pcdn.co/wp-content/uploads/CQC-Final-report-Peoples-experience-of-care-after-hospital-discharge-.pdf
- The Local Government Association and Association of Directors of Adults Social Services publication of the Second National Analysis of SARS (April 2019-March 2023). Four documents can be found at https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023
- The Policy Partners Project briefing on Hospital Discharge Recommendations for Practice - https://www.policypartnersproject.co.uk/wp-content/uploads/2015/02/Hospital-Discharge-Recommendations-for-Practice.pdf