



39 Victoria Street London SW1H 0EU



Mr Christopher Morris HM Area Coroner, Manchester South HM Coroner's Court 1 Mount Tabor Street Stockport SK1 3AG

08 June 2021

Dear Mr Morris,

Thank you for your letter of 15 April 2021 about the death of Ailsa Stewart. I am replying as the Minister with responsibility for adult social care.

Firstly, I wish to offer my condolences to Ms Stewart's family and loved ones. High quality, safe care is a priority for all and I was extremely saddened to learn of the circumstances surrounding Ms Stewart's death.

I have noted carefully your concerns about the roles and responsibilities of health and care agencies in conveying information when a vulnerable patient is sent home from an urgent care setting; and the circumstances in which a domiciliary care package can be suspended.

In preparing this response, my officials have made enquiries with NHS England and NHS Improvement (NHSE and NHSI) and their regional and local partners.

Safeguarding is everyone's business and it is of concern that there was an insufficient multi-agency approach in place to safeguard Ms Stewart.

The Care Act 2014¹ specifies that local authorities and their relevant partners have a reciprocal responsibility to cooperate to promote the wellbeing of adults with care and support needs.

All involved parties across health and social care should work together to agree whether it is appropriate to suspend care. Home care providers need to assess the risks posed by a reduction or suspension of visits and take prompt reparative action, recognising that people living alone may be particularly vulnerable if care visits are missed or suspended.

¹ Care Act 2014 (legislation.gov.uk)

During the pandemic the Government published guidance² for home care providers which covers hospital discharge and other matters. We aim to continue to provide guidance to the sector post-pandemic.

As mentioned earlier, my officials have also sought information from NHS England and NHS Improvement (NHSE and NHSI) with regards to the circumstances surrounding Ms Stewart's care.

NHSE and NHSI has assured my officials that it is extremely rare for a care package to be automatically stopped by the care provider.

The Care Act statutory guidance highlights the importance of partnership and cooperation in the prevention of abuse or neglect. The Act requires a local authority to set up a Safeguarding Adults Board, with authority to carry out a Safeguarding Adult Review (SAR) when serious harm or a fatality has occurred.

The aim of the SAR should be to promote effective learning and improvement action across all relevant organisations, to prevent future deaths or serious harm occurring again.

NHSE and NHSI have informed my department that it is conventional operational practice in Stockport that when a person in receipt of a community care package attends the hospital Emergency Department for assessment, that this package remains in place.

The care provider has given assurances that this had been the case on previous occasions, consistent with local agreements. My officials have been informed that the care provider accepted that, on this occasion, it was a breach of the agreed plan and contractual arrangements for Stockport Adult Social Services.

NHSE and NHSI have informed my officials that technically Ms Stewart had not been admitted to hospital and it was therefore not necessary for the Trust to invoke their discharge process.

My officials have been informed that Stockport NHS Trust will continue to work as part of shared care arrangements in line with national standards and the protection of vulnerable people. This will ensure when a patient attends for an assessment, a care package in the community will remain in place until notification that the patient requires admission into an inpatient provision.

Following Ms Stewart's death the Trust shared an additional safety alert on 9th May 2019 to alert practitioners to this potential risk and give due consideration to the vulnerability of the patient, their medical presentation and what should happen when returning home. The Safety Alert states "it is the responsibility of the nursing staff to take reasonable steps to ensure the carers are aware of the discharge. This must be documented in the patient's medical records".

² Coronavirus (COVID-19): provision of home care - GOV.UK (www.gov.uk).

North West Ambulance Services (NWAS) has since introduced an additional question to prevent a journey from proceeding until confirmation is received, at the point of discharge booking, that a care package is either not required or is in place.

In addition, communications have been sent to all NWAS and third-party resources reminding them of their obligation to ensure patients are taken to their destination and left with access to a communication device or an alarm raising facility.

Promoting integrated care is a priority for this Government. There is a traditional divide between primary care, community services and hospitals, and social care services. The differences in commissioning, incentives and accountability have all contributed to creating barriers to seamless delivery of person-centred care.

Our aim is to join up care around a person's needs so that, from their perspective, the experience of care is seamless. We want everyone to be supported to live their best lives. We are confident that our proposals in the Health and Care White Paper³, such as Integrated Care Systems, will help to address the barriers which prevent effective join-up between health and social care services and support local systems to implement solutions that work best for them.

This integrated approach to person-centred care will bring together actors in health and social care, alongside local and voluntary partners, to support people to retain their independence, health and wellbeing for longer.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

HELEN WHATELY

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