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Nottinghamshire County Council

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Michael Wall
HM Assistant Coroner
For Nottingham City and
Nottinghamshire

28 November 2023

Dear Michael

RE: [redacted] - Janet Irene SPENCER - Regulation 28 Prevention of Future Deaths

Please see below our response to the matters of concerns as set out in section 5 of the report:

"The MATTERS OF CONCERN are as follows:
(brief summary of matters of concern)

The systems in place in respect of discharge to assess patients do not appear to ensure patients are discharged or transferred between care facilities with an adequate and up to date risk assessment and care plan in place.

1. Nottinghamshire County Council has a joint strategy and policy with partners in the Nottingham and Nottinghamshire Integrated Care System (ICS) in line with national NHS England Discharge to Assess (D2A) Policy and Guidance.

2. Under this model there are four routes out of hospital for people as follows:

   - P0 – No additional support required on discharge at home from Adult Social Care but could include District Nursing input
   - P1- Reablement or rehabilitation at home- in Nottinghamshire this is provided by the Local Authority (LA) and NHS Community Health Provider
   - P2- Residential rehabilitation or further assessment- this is provided by the NHS.
   - P3- Complex discharge planning, often including assessment for Funded Nursing Care or NHS Continuing Healthcare – this is also an NHS provision on discharge from hospital.

3. The Nottingham and Nottinghamshire ICS D2A policy and procedure has been agreed between NHS and Local Authority partners and is as follows:

   A 'Discharge to Assess' referral form is completed by the NHS ward staff caring for the person, this details their care and support needs, risk assessment and where appropriate consideration of Mental Capacity and Best Interests relating to further care/rehabilitation/reablement required for hospital discharge.

4. The Discharge to Assess form is sent to the 'Transfer of Care Hub' - which is a multi-disciplinary Team sited within the hospital. Each referral to the Hub is discussed by the team which includes NHS and LA Social Care professionals, also linking with District Council and Community & Voluntary Sector staff as required. The Multi- Disciplinary Team make a joint decision regarding which pathway the person requires to ensure a safe discharge from hospital with appropriate care, support and reablement to promote their wellbeing and independence.

5. The Pathway decision and referral forms are shared with the care provider, for example for people leaving hospital to return home on Pathway 1 (social care supported discharge) this information is shared with the LA Services, and for those being supported via Pathway 1 by Community Health Provision- information is shared accordingly. This information pack also includes a discharge summary and medication list / arrangements.

6. In Mrs Spencer's case she was assessed to require a Pathway 1 discharge (Social Care Supported Discharge), the Multi- Disciplinary Team identified that she would benefit from further assessment and reablement in an Assessment Flat- which in her local area are situated at Gladstone Court. However, as there was not an Assessment Flat available when she was ready to leave hospital, interim care arrangements were made at a local Residential Care Home and she was discharged safely to that location, the Nightingale Care Home manager was sent the D2A Form information as part of the preliminary discharge planning and agreed that they could meet her needs, discharge went smoothly.

7. The transfer from Nightingale Care Home to the Assessment Flat was not satisfactory as highlighted in HM Coroner's report, the Local Authority policy and guidance was not followed in terms of ensuring that arrangements were in place for Mrs Spencer's medication, and recording of information regarding the care arrangements required This has been addressed via a Safeguarding Adults Enquiry (Sec. 42, Care Act 2014), with recommendations and action plan implemented (please see para.11).

Partnership working and Service Improvements

8. To ensure continued quality assurance and service improvements there are weekly Multi-Disciplinary Workshops as part of the Integrated Care System Discharge to Assess Planning and Service Provision. This includes a regular review of Transfer of Care Hubs and Multi-Disciplinary Team working practices. Each month there is a focussed workshop on each Pathway 1-3 and then a more strategic workshop as part of this agreed work plan for the Integrated Care System. These workshops include senior operational and strategic representatives from all key partner agencies and is key to partnership working and collaborative culture to improving hospital discharge for people and their carers/families.

9. At a more operational level, the Transfer of Care Hubs hold weekly audits and reflective discussions of hospital discharges that have gone well or where improvements are required.

10. Another key improvement for Hospital Discharge planning across the Integrated Care System been the implementation of a shared dataset which tracks people through their hospital admission and pathway out of hospital. This dataset and dashboard is used by NHS and LA partners to ensure that all people leaving hospital are supported to do so in as timely and safe a manner as possible.

Nottinghamshire County Council Service Improvements

11. The LA recognises that improvements have been required in the clear and accurate sharing of up-to-date information for admission to the Assessment Flats, as illustrated by Mrs Spencer's situation. To ensure that the risk of any future breakdown in communication is mitigated, a new process and referral / assessment form has been implemented for all people moving into Assessment Flat accommodation. This process is for hospital and community admissions into

the service. The assessment form outlines the person's care and support needs, any risks and updated medical information including medication. This is recorded on the Social Care Electronic Record and shared with the care provider at Gladstone Court which is Fosse Healthcare.

12. There are also weekly meetings for the Discharge to Assessment Team Managers from the Local Authority where practice is reviewed, and improvements discussed and shared across the service.

The systems in place in respect of discharge to assess patients do not appear to ensure a smooth transition between care facilities, especially when transfers are arranged at pace. In particular, they do not appear to ensure that all involved have the information they require to contribute effectively to the transfer process.

13. The LA would expect that the process described above is followed regarding hospital discharge, with information shared about a person's care and support needs prior to any transfer to a different care provision or arrangements (whether at home or in a 24-hour care setting). This includes the care requirements, risk assessment and mental capacity / best interests' information. As explained above, whilst the Local Authority has a clear process in place for arrangements by LA Social Care staff for people moving between care facilities, this was not robust followed in the case of the arrangements for Mrs Spencer and her move to Gladstone Court. This process has been reviewed and improved in order ensure a more robust transfer arrangements process for people requiring this service in the future.

Yours sincerely

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[redacted]
Corporate Director – Adult Social Care and Health
Nottinghamshire County Council