NHS
Greater Manchester
Integrated Care

E: [redacted]

Date: 25 November 2024

Private & Confidential

Ms Alison Mutch
Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Sent by email to: [redacted]

Dear Ms. Mutch

Re: Regulation 28 Report to Prevent Future Deaths - George Neville Coulthard

Thank you for your Regulation 28 Report dated 24 September 2024 regarding the sad death of George Neville Coulthard. On behalf of NHS Greater Manchester Integrated Care (NHS GM), We would like to begin by offering our sincere condolences to Mr. Coulthard's family for their loss.

Thank you for highlighting your concerns during the inquest which concluded on the 29 August 2024. On behalf of NHS GM, we apologise that you have had to bring these matters of concern to our attention. We recognise it is very important to ensure we make the necessary improvements to the quality and safety of future services.

During the inquest you identified several causes for concern. I have investigated and my response outlines some background information and then specifically addressed each cause of concern.

Background

Mr Coulthard attended Trafford Urgent Care Centre on 24 October 2023 after a fall. He was seen with his daughter and had sustained an injury to his left lower leg and left hand. At the time of the examinations, he was found to have superficial wounds over his shins. He had x ray of his left lower leg and left hand which did not show any fracture (break). His wound was cleaned dressed, and he was discharged home to be followed up by the district nurses.

Mr Coulthard re-attended the Trafford Urgent Care Centre on 27 October 2023 with increasing pain and redness to his left lower leg wound (shin wound). He felt otherwise well. At the time of examination, the left shin wound appeared swollen and erythematous (red) and suggestive of infected wound. With a likely diagnosis of an infected wound to his left shin (Cellulitis). A wound swab was taken (to check what kind of bacterial infection was present) and what antibiotics should be prescribed, and the wound was redressed.

Mr Coulthard was given antibiotics to take home for treatment of likely wound infection. The antibiotic given at the time was the right antibiotic as confirmed by the swab result.

Mr Coulthard attended the Emergency Department at Wythenshawe Hospital on 8 November 2023. He was assessed with his daughter present. It was noted that over the previous two and a half weeks he had been rapidly deteriorating in terms of his clinical state with reduced mobility and being unable to eat or drink well. He had been referred to the crisis team and to be assessed for having home modification. He had suffered an unwitnessed fall at home the night before and was found on the floor at 06:00 hrs on the morning of the attendance. He had tenderness to the right side of his chest and some tenderness over the region of his pelvis. He was prescribed and administered intravenous fluids, antibiotics and a CT of his head, chest, abdomen and pelvis was completed which did not show anything concerning. Given the above concerns he was admitted under the care of the medical team.

Mr Coulthard remained in Wythenshawe Hospital receiving treatment for various medical conditions. On 18 December 2023, in view of his ongoing physical deterioration with no realistic prospect of improvement, a multi-disciplinary team decision was made that Mr Coulthard's new functional baseline would be hoist transfer from bed to chair. He was also considered medically optimised and discharge planning was initiated. Mr Coulthard remained stable, and plans were made for a transfer to a care home.

I will now address each of the areas of concern as detailed within the Regulation 28 Prevention of Future Deaths Report:

> **Mr Coulthard was assessed as being suitable for discharge on 18 December 2023 . he remained in an acute hospital setting for a further 4 weeks due to challenges in identifying a suitable care home. This was due, the inquest was told, to a shortage of suitable places and the Christmas period. The impact of this on Mr Coulthard was that he remained in an acute setting when the inquest was told the care he required would have been better delivered in a care home / nursing home setting.**

Although Mr Coulthard was medically optimised, he was still receiving therapy input to work with him on his sitting balance from 18 – 23 December 2024.Within this timeframe Mr Coulthard also experienced a short period of feeling more unwell on 20 December 2023, where he was experiencing shivers which recovered after 24 hours. He was also reviewed by the plastics team on 23 December 2023 regarding his complex wound, discussed with Mr Wong, Plastics Consultant, to confirm that further management was via the tissue viability team with twice weekly dressing changes.

The Integrated Team (IDT) would not have seen Mr Coulthard until he was both therapeutically and medically optimised as the therapy information can be crucial when placing someone.

On 23 December 2023, Mr Coulthard was seen by the Specialist Discharge Nurse and he and his family (his partner and daughter) were spoken to regarding options for his discharge. Later that afternoon a best interest decision was made for 24-hour care.

The assessment was not submitted until 27 December 2023 due to the Bank Holiday which meant that the commissioning team was not available until then.

A discharge to assess (D2A) referral form was received from Wythenshawe Hospital, by the Transfer of Care (ToC) Hub, at Stockport NHS Foundation Trust, at 17:34 hours on Wednesday, 27 December 2023 via e-mail. The referral was subsequently triaged at 0The 8:28 hours, on 28 December 2023. It was noted on the referral form that Mr Coulthard lacked mental capacity. Further information was requested via e-

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mail, on 28 December 2023, seeking evidence of Mr Coulthard's Mental Capacity Act assessment and Best Interest decision outcome.

On Friday, 29 December 2023, information was received back from Wythenshawe Hospital. As per commissioning arrangements, a senior multi-disciplinary team triage (Continuing Healthcare (CHC) Lead, Adult Social Care (ASC) Lead and Transfer of Care Hub (ToCH) Operational Lead) confirmed Mr Coulthard did require twenty-four-hour nursing provision and was, therefore, identified as being on a Discharge to Assess Pathway 3. The national definition[1] of Pathway 3 refers to people being discharged from an acute hospital to a new residential or nursing home setting, for people who are considered likely to need long-term residential or nursing home care. The government guidance states that other than in exceptional circumstances, no one should be discharged directly into a permanent care home placement for the first time without first giving them an opportunity to recover in a temporary placement before assessing their long-term needs.

Subsequently, the D2A form completed by Wythenshawe hospital was shared by the ToCH with four nursing homes to consider whether they would accept Mr Coulthard into their care. These were the four nursing homes within the Stockport locality that were outside the Pathway 2 D2A commissioned beds, with capacity that could meet Mr Coulthard's needs at that time.

Between 29 December 2023 and 5 January 2024, three of the four nursing homes declined to accept Mr Coulthard. On 9 January 2024, Hilltop Hall nursing home agreed to accepting Mr Coulthard into their care pending confirmation of the Continuing Health Care (CHC) funding. On 10 January 2024, funding was confirmed with an agreed welcome date of 11 January 2024. Mr Coulthard was discharged from Wythenshawe hospital and transferred to Hilltop Hall nursing home on 11 January 2024.

Mr Coulthard's referral was triaged by a Band 7 nursing team lead within the ToCH to review current needs and establish discharge pathway and provision in community beds where needs could be met. This was actioned within 48 hours including requiring the additional information.

Once a patient is deemed to be medically optimised (to be as well as can be achieved), the aim is either for the patient to be discharged to their home, or for arrangements to be put in place for transfer to an appropriate care setting, able to meet their needs at that time and to support rehabilitation where that is indicated.

Looking at this case, I agree that the time from a decision that Mr Coulthard was medically optimised (18 December 2023) to his actual transfer to Hilltop Hall Nursing Home (11 January 2024) was too long. However, as explained above, it can take time to complete all the necessary formalities to progress a complex discharge.

You refer to information provided at the inquest suggesting that the festive period may have had an impact on the time taken to secure Mr Coulthard's safe discharge. Whilst accepting that this was a complex discharge, and would have taken time to facilitate, the festive bank holiday did impact in that there was a period of three days where the discharge information was available but could not be processed, for which I sincerely apologise.

> **In addition, the inquest heard evidence that it meant that an acute bed required for other patients was not available creating delays in allocating beds to patients requiring admission. The inquest was told that significant delays of this nature occur on a regular**

[1] Hospital discharge and community support guidance - GOV.UK (www.gov.uk)

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basis and are often exacerbated by the Christmas period.

Whenever a patient is medically optimised and no longer in need of care in an acute hospital setting, the aim is for that individual to be discharged safely to their home, or to an appropriate place of care as soon as it can be safely facilitated.

You refer to such delays occurring on a regular basis and often exacerbated by the festive period. The winter period generally is extremely busy with high numbers of patients entering the hospital and needing to be admitted for care and treatment. Whilst every effort is made to appropriately manage the flow of patients to free up beds, there are occasions when delays in discharge do impact on patient flow. This is regrettably not a scenario that is specific to the festive period as such challenges occur throughout the year, but particularly through the winter months. As a system we consistently review discharge processes, alternatives to hospital admission, and patient flow pathways. This is with a view to improving the patient experience and flow through all GM hospitals so that patients can receive the right care at the right time and in the right place.

The lack of effective communication between the discharging team and the community teams meant that it was not understood if Mr Coulthard was on end-of-life care or for rehabilitation. The staff at the first home treated him as end of life / palliative care patient as a consequence even though the paperwork suggested he may be a discharge to assess patient. As a consequence he was moved to another care home for rehabilitation although the evidence was that there was little purpose in the transfer.

The D2A referral form received on Wednesday, 27 December 2023, from Wythenshawe hospital, provided the following information (this was also further discussed with the discharging organisation):

'Pathway 3 - 24 hour nursing care under Discharge to Assess recommended.

Capacity assessment had taken place, referral states fluctuating capacity – currently very sleepy a great deal of the time and has fluctuating capacity due to ongoing delirium. Tissue Viability Nurses management of lower limb wounds now chronic.

Requires: dynamic mattress, static cushion, 2 hourly repositioning. Hoist to tilt in space chair although very fatigued if sat out for long periods.'

As is standard, good, practice, the D2A referral form was shared with the nursing homes in order for them to triage their patient admission and as part of their acceptance process. There was nothing in the referral to imply Mr Coulthard was at the end of his life.

There would be an expectation that the nursing team on the discharging ward would provide a verbal and written handover to the nursing home at the time of discharge to promote continuity of patient care and to ensure that a patient's needs at the time of discharge could still be met.

The hospital team did provide information to Hilltop Hall in written form (Greater Manchester Supported Discharge Referral document) in addition to which the former Manager at Hilltop Hall did speak directly with the ward team and based on the information provided, confirmed that Hilltop Hall could meet Mr Coulthard's needs, formally accepting him to the home as a discharge to assess resident.

The referral document included a detailed medical history, medications and clearly set down current care

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needs. The document advised that Mr Coulthard was 'very sleepy a great deal of the time and had fluctuating capacity due to ongoing delirium'. On arrival to Hilltop Hall nursing home, Mr Coulthard was as described and staff at the home report being surprised that there was a plan for potential rehabilitation.

On 14 January 2024, following admission to Hilltop Hall nursing home, a review was completed by a senior member of the D2A therapy team. On assessment, the therapist found Mr Coulthard's needs to be different from the information on the original D2A referral; they felt that with additional therapy, to improve functional ability, there would be an opportunity for Mr Coulthard to return home. The placement at Hilltop Hall did not offer the daily therapy intervention that the therapist assessed Mr Coulthard to require.

Therapist / Assessor recommended bed based intermediate care, and a bed was sourced at Bramhall Manor nursing home, where daily therapy intervention was available. This decision was reached following a conversation with Mr Coulthard's daughter who agreed the transfer to Bramhall Manor nursing home was in Mr Coulthard's best interest. Mr Coulthard transferred to Bramhall Manor nursing home on 20 January 2024.

On arrival to Bramhall Manor, Mr Coulthard was noted to be very unwell, and it was immediately acknowledged that it was unlikely that he would benefit from rehabilitation. The GP saw Mr Coulthard on 22 January 2024 at which point it was confirmed that he was sadly nearing the end of life. Appropriate anticipatory medications were prescribed to ensure Mr Coulthard was as comfortable as possible. His health continued to deteriorate, and sadly he passed away at Bramhall Manor on 27 January 2024.

I am satisfied that staff across the system did act in what they believed to have been Mr Coulthard's best interest when they transferred his care to Bramhall Manor so that he could receive daily therapy input. However, the rapid deterioration in his condition and the fact that he did not benefit from such therapy does lead me to agree that there was little purpose in the transfer to Bramhall Manor.

We strive to provide outstanding end of life care and have only one opportunity to get things right. In Mr Coulthard's case, whilst I acknowledge that there was a delay in recognition that he was entering the end of life stage, I am satisfied that he did receive a high standard of care in his final days of his life.

> **The inquest also heard evidence that the staff at the care home had queried what level and type of care was to be delivered to Mr Coulthard given his overall presentation. However, there was no evidence that the management team had sought to clarify the position to ensure the internal documentation reflected the correct position.**

The ToC Hub is a health and social care team that co-ordinates timely discharges by linking relevant services to prevent avoidable delays in the transfer of care of all patients with complex needs, in the care of an acute trust.

The health and social care team decide / ensure the most appropriate discharge pathway a patient should be placed on, for them to achieve the best possible outcome. It recognises that a whole system approach is key to reduce and prevent un-necessary delayed transfer of care. The ToC team sought further information with regards to Mr Coulthard's needs to ensure the pathway he was placed on would provide the level of care he required.

There would be an expectation that the nursing team on the Wythenshawe Hospital discharging ward would provide a verbal and written handover to the nursing home at the time of Mr Coulthard's discharge, to promote continuity of patient care and to ensure that a patient's needs at the time of discharge could still be met. The team at the Nursing Home would ensure that care / nursing needs could still be met.

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The team at Hilltop Hall acknowledge that they did not attend the hospital to assess Mr Coulthard. Such assessments enable a home team to gain a clear understanding of an individual's current care needs and circumstances. The Home Manager acknowledges that this should have happened and confirms that a change in practice resulting from this case has been that pre-admission assessments are now always undertaken.

> **The evidence before the inquest was that whilst in the community prior to his final hospital admission the access to information and support, from tissue viability and district nursing teams, to care for and treat his wounds was very limited. Better access to wound care would have reduced the risk of further wound deterioration in the community and reduced the risk of him requiring inpatient care for his wounds. However, the demands across GM on TVN and DN services made this difficult to achieve.**

On 31 October 2022, Mr Coulthard's daughter telephoned the Single Point of Access requesting a community nursing visit, as her father had a wound to his right big toe. A domiciliary visit was arranged for the following day and domiciliary wound care visits continued; the wound was noted to be healing well. Domiciliary wound care visits continued from the community team and then Mr Coulthard was transferred to the Stockport Treatment Room service which he visited to have his wound care treatment. It is documented the toe wound had healed and Mr Coulthard was discharged from community services back to own private podiatrist, on 3 April 2023.

There was no further contact with Mr Coulthard, until on 24 October 2023, when Mr Coulthard was re-referred to the community nursing service as he had fallen and sustained wounds to both his legs. A visit was booked for 27 October 2023 as per referral request, Mr Coulthard was required to attend a hospital appointment on this date, therefore, the planned visit was rearranged for 29 October 2023. Community nurses commenced visits to redress wounds to both Mr Coulthard's shins. On 3 November 2023, a Tissue Viability Nursing (TVN) service referral was completed. Community nursing wound care and venepuncture visits continued to be scheduled. On 6 November 2023, there was a virtual review by a TVN and a dressing plan regime agreed. Wound care continued by community nurses up until Mr Coulthard was admitted to hospital, on 8 November 2023, following a further fall. Mr Coulthard was, therefore, discharged from the community nursing service at that time. When a patient is admitted into a hospital, it becomes the responsibility of the ward staff to care for nursing needs, with specialist input requested by the ward staff as required.

I hope the above addresses the concerns raised and that you are assured that as a system we continue to consistently review our admission and discharge processes to ensure that GM patients can access care in our acute hospitals when they need to.

Best wishes

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Interim Deputy Chief Executive Officer and Chief Nursing Officer
NHS Greater Manchester

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