

**GLOUCESTERSHIRE SAFEGUARDING ADULTS BOARD**

**SAFEGUARDING ADULTS REVIEW REPORT DANNY**

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## **1.Introduction**

**1.1** The purpose of this report is to describe the process and recommendations of a Safeguarding Adult Review carried out into the circumstances around the death of an individual, Danny, who was receiving care, treatment and support from organisations in the Gloucester area. Danny had very complex mental health and physical needs throughout his lifetime. Over his final months he experienced numerous episodes of physical ill health, which required admission to hospital. Concerns were raised about the way in which services were provided to him and whether individual practitioners and organisations worked together effectively to ensure his safety and wellbeing. A Safeguarding Adults enquiry was held but the outcome was inconclusive. Whilst many good assessments were carried out and acted upon, there was a lack of co-ordination and issues around obtaining resources to meet additional identified needs. There were failings in the system and Danny may not have received the support he needed, and may not have been cared for in the most appropriate setting during his final months.

**1.2** Gloucestershire Safeguarding Adults Board considered that a referral regarding Danny, submitted to them by a community services manager from 2gether NHS Foundation Trust on 8 December 2016, met the criteria set out in the Care Act 2014 under Section 44 to hold a Safeguarding Adult Review. This states that ‘Safeguarding Adult Boards must arrange a Safeguarding Adult Review when an adult in its area dies as a result of abuse or neglect or has not died, but the Safeguarding Adults Board knows or suspects that the adult has experienced abuse.’ The decision was taken that the criteria were met. In this case, Danny died of natural causes but the circumstances gave rise to concerns that there may have been failures in the systems that supported him.

**1.2** A Review must be carried out in accordance with Gloucestershire Safeguarding Adults Board’s Multi-Agency Safeguarding Adults Policy <http://www.gloucestershire.gov.uk/gsab/i-am-a-professional/multi-agency-safeguarding-policy-and-procedures/multi-agency-safeguarding-policy-and-procedures/>. Each partner organisation must co-operate in and contribute to the carrying out of the Safeguarding Adult Review. The purpose is to identify the lessons learnt from the specific case and to apply these to future cases to prevent such circumstances occurring again.

**1.3** The time period to be covered by the review is 25 September 2015 to 3 November 2016.

## **2. Process of Review**

**2.1** The guiding principles for a Safeguarding Adult Review are set out in the Care Act 2014 and were followed in this Review.

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;

- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith and
- Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

**2.2** An Independent Facilitator was commissioned to lead the process and to write a short report. She had no previous involvement with health and social care organisations or individual practitioners in the Gloucestershire area and has the appropriate skills, experience and qualifications to carry out this process.

### **2.3 Organisations involved:**

London Road Medical Practice (GP)

Eden Futures (Care Provider)

2gether NHS Foundation Trust (Mental Health- health and social care)

Gloucestershire Care Services

Gloucestershire Adult Social Care (Learning Disabilities Social Care and Hospital Discharge)

Gloucestershire Hospitals NHS Foundation Trust (the Hospital)

Gloucestershire Clinical Commissioning Group

### **2.4 Methodology**

There is a range of methods for conducting a Safeguarding Adult Review and it is the responsibility of the Board to determine which method suits the case best, ensuring that it is proportionate and appropriate to the situation and makes effective use of resources. For the situation in respect of Danny, a systems approach was selected, with the additional requirement of a chronology, or timeline, from each organisation. This type of methodology was selected in order to focus on the systems, which underpinned the provision of care and support across organisations for an individual with complex needs.

The review utilised key principles of 'Learning Together', a validated methodology produced by the Social Care Institute for Excellence and in which the Lead Reviewer is trained and experienced.

The Review is not about blame but about learning from experience in order to protect vulnerable people in future. The process is confidential, although the Reviewer reserves the right to raise any issues she believes may result in harm to any individual. Staff participating will be advised to seek support from their organisations if they experience any distress from the process at any stage.

Particularly important to the systems approach is the avoidance of hindsight bias, being wise after the event, as this does not assist the process of understanding the system as it was at the time of the events under review by the people working within it. In order to achieve this, a series of 'conversations' with front line staff and managers was held. The 'conversations' were designed to put the participant at ease as far as possible and to support them in identifying the situation as it was for them at the time.

**2.5** The work of the Review began in September 2017 with a series of 7 'conversations' conducted by the Lead Reviewer with support from the Board Business Manager. This included the GP, Community Nurses, Gloucester and Cheltenham Hospitals, Gloucester Adult Social Care, Eden Futures and 2gether NHS Foundation Trust. Unfortunately, several of the practitioners involved with Danny directly had left their respective organisations and discussions were held with managers or colleagues. This made it difficult initially to gain a picture of Danny as a person but fortunately, Danny's brother was willing to participate in the Review and he provided a rich source of information relating to Danny's past and recent history during a visit to his home.

**2.6** Family involvement is highly beneficial to a Review and expected by the Care Act 2014 if possible. Danny's brother lives at some distance from Gloucester and works abroad but he maintained contact with Danny throughout his life. He was aware that difficulties were arising regarding his brother's care during the Review period and intervened with the practitioners at this time, gaining a very clear grasp of the issues. His views on the services will be considered as part of this Review. It should also be noted that Danny had formed close relationships with his Support Workers in the organisation providing him with care and support over many years. The organisation has participated in this Review and concerns are explored as to whether sufficient credence was given to both family and support workers in making decisions about his care.

**2.7** Following the conversations, a workshop was held with participants from the organisations involved and the Safeguarding Adult Review sub group of the Board. This workshop explored the events leading up to Danny's death and considered the reasons underlying the decisions made. It also considered what learning could be taken from the events and made some recommendations for action.

**2.8** Gloucestershire Safeguarding Adults Board will publish the report and its recommendations in anonymous form once it has been agreed. The report will set out whether there are lessons to be learned about how practitioners and agencies worked together and individually, and how practice will change to improve outcomes for people. This will include identification of practice being shown to have a positive impact for Danny and of failings (at practice and organisational levels), which had a detrimental effect on his health and wellbeing.

### **3. Terms of Reference**

**3.1** The general aims of the Review are set out in the Terms of Reference as follows:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk.
- To review the effectiveness of procedures (both multi-agency and those of individual organisations)
- To inform and improve local inter-agency practice
- To improve practice by acting on learning (developing best practice)
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

**3.2** The specific aims are set out as follows:

- To examine how the circumstances leading up to the death of Danny, who died in hospital on 3 November 2016, were handled and whether the policies and procedures in place across various agencies during that time were followed.
- To consider whether all opportunities to ensure Danny had received appropriate care and support within the overall delivery system were identified up to the time of his death
- To review the effectiveness of multi-agency communications across the many agencies that were involved in his care.
- To review the appropriateness and level of care and support he received as his condition began to deteriorate.
- To review the circumstances surrounding his discharges from hospital and his subsequent re-admission within 24 hours during August 2016 and October 2016.
- To review agencies' approaches to the issue of his mental capacity to make decisions about the management of his diabetes and, professional duty of care.

#### **4. Case Summary: The Facts**

**4.1** This account has been collated from chronologies submitted by the organisations involved and conversations held with key staff and family. The information provided is very detailed and this account attempts to identify the key events and issues arising.

**4.2** Danny was a white British man, aged 64, when he died after a series of hospital admissions relating to his physical conditions, complicated by his learning disabilities, mental health problems and falls. Whilst the period for this Review spans the final 14 months of his life, it is useful to understand the events leading up to this and to learn something about the man behind the issues under consideration. Danny's younger brother was able to provide an account of this, and how Danny's mental illness and learning disabilities impacted on both Danny and his family.

**4.3** Since childhood, Danny was considered 'different'. His family were reluctant to discuss his condition at the time and managed it by trying to exert strong control. He started out in mainstream education but was moved into a boarding school for children with special needs, supported financially by the Army, as his father was serving overseas. He was able to learn to read and write and was assessed as having an IQ of 70, which placed him on the borderline of being considered to have a learning disability.

**4.4** On leaving school, Danny went to an agricultural college for people with learning disabilities. He did well there and found work afterwards as a farm labourer and in factories, cycling miles around the district. He lived at home and liked to spend his money on sweets. His mother took control of his money to prevent this but Danny stole them instead from the local supermarket. His brother intervened to avoid further action. This worked, but did not prevent Danny from repeating the behaviour at other shops. This was the start of a life long series of 'scrapes' from which Danny's brother rescued him, some much more serious than others. On one occasion he ran away to join a circus, ending up being burned in a fire and travelling across London in a dressing gown; on another he heard voices telling him to harm the children of his brother's partner and was admitted to psychiatric hospital; on another he became acutely ill, requiring compulsory admission to hospital under Section 3 of the Mental Health Act 1983.

**4.5** Danny had a determined personality and would not let anything get in his way. He would say to his brother "you can't tell me what to do, you are my younger brother". His brother describes him as childlike in some ways but adult in others, finding some simple things difficult. It is evident that Danny was a much-loved member of the family. Unfortunately his behaviour presented problems to his parents and, despite several attempts to live with them and with his brother, the difficulties became too great.

**4.6** Danny was diagnosed with diabetes in 2001. From this time his mental and physical health needs became complex and difficult to manage. He presented to the Emergency Department on 41 occasions between 2005- 2016. 10 of these were in 2016, and 5 led to inpatient admissions. In addition to this, he was sectioned again in November 2006 with a diagnosis of borderline learning disability and pre-psychotic episodes. A letter from the consultant psychiatrist at that time stated that Danny 'falls between services'. It was agreed by the services at the time that his

care would be managed and funded through the mental health team for working age adults with support from the community team for people with learning disabilities. As he had been on Section 3, Danny was subject to Section 117 of the Mental Health Act 1983. From this time onwards, Danny lived in supported living accommodation, mostly in the Stroud and Gloucester areas.

**4.7** At the beginning of the Review period, Danny was residing in his own rented flat in a property shared with other individuals with similar needs, supported by the same staff group. In April 2016, the landlord sold this property and Danny moved into a ground floor flat in central Gloucester. His care needs and level of support did not change with this move. He was assessed to need 33.25 hours support each week divided into morning and evening visits. Danny had a good relationship with a small team of Support workers. He needed considerable help to maintain his independence, especially with shopping and preparing meals. Support staff would visit twice each day, once in the morning to supervise him getting ready for the day and get his evening meal ready and leave it for him to microwave in the evening, before returning to help him settle for the night. Danny enjoyed reading, drawing and painting, music and browsing charity shops for items of interest. He also owned a cockatoo, called Elvis after his favourite musician.

**4.8** A decline in health was evident from May 2016 onwards. Danny presented to the Emergency Department 7 times, with 6 leading to inpatient admissions. From 4 August 2016 until his death on 3 November 2016, he was only at home for 16 nights. During this period, he received treatment, including surgery, and input from a range of specialists regarding aspects of his conditions. At times he was acutely unwell. He needed considerable support whilst in hospital to manage his behaviour, which included some aggression towards others. At each discharge, Danny was assessed to be medically fit and his ongoing care needs at home were assessed by the Hospital Discharge Team as there were ongoing concerns about the severity of his health problems and the difficulties in managing them. His death was sudden and not expected.

**4.9** The following table sets out the admissions and discharges and brief details of his treatment and discharge plans.

<b>Emergency Dept.</b>	<b>Inpatient Admission</b>	<b>Reason for admission</b>	<b>Treatment</b>	<b>Discharge</b>	<b>Discharge Plans</b>
Tues 3 May 16	Yes Gloucester	Abdominal pain; diarrhoea and vomiting with blood	Symptoms settled. Concerns re blood sugar	Wed 11 May	Liaison with community nurse and diabetic nurse. Appt made for 12 May.
Fri 20 May 16	Yes Gloucester	Abdominal pain; 'unwell diabetic'; blood sugar high	Stabilising blood sugar	Sat 21 May	Liaised with Out of Hours Nursing and Adult Social Care
Wed 3	No	Facial skin infection –			Letter to GP

Aug 16		Danny picking at sore			
Thurs 4 Aug 16	Yes Gloucester	Mental health problems; Shingles; low blood sugar; Eye infection (paramedics)	Antibiotics; dermatology investigations not shingles; dressings to eye;	Fri 12 Aug	Letter to GP- confusion and self neglect; check bloods in 2-3 days
Wed 23 Aug 16	Yes Gloucester	Mental health	Infected sore on face; dressings; IV fluid and antibiotics; MRSA; cellulitis; raised temp and blood sugars; 'apparent lack of support' 'clothes very dirty' 'appears self neglected'; LD Liaison Nurse involved; osteomyelitis; amputation of toe under general anaesthetic; agitated; ward proving extra support;	Tue 20 Sept	Liaison with brother during stay  Discharge planning ...13 Sept but was delayed.  Discharged on antibiotics and with cellulitis. Letter to GP and community nurses re wound care.
Wed 21 Sept 16	Yes Cheltenham	Collapsed in street (paramedics called)	Painful foot/cellulitis; tummy pain and constipation. Acutely unwell; raised blood sugar; embolism - anti coagulant therapy. Second toe amputation. Antibiotics.	Sat 22 Oct	Integrated discharge team involved in discharge planning. Brother looking at residential care in Milton Keynes;  22 Oct – consultant ward round 'for wound review next day'. This review considered he was medically fit for discharge and stable.  Letter to GP to request blood monitoring  Community nurse noted discharge as 'unsafe'; different insulin regime



					and inadequate supplies; no prescription chart or no of units so none given by carers.
Sun 23 Oct 16	Yes Gloucester	Collapsed in flat; confused and had vomited (community nurses present and paramedics called)	Antibiotics – acute kidney injury; fall.  Cardiac arrest but resuscitation failed to restart heart.	Died 3 Nov	Cause of death from Coroner  “Left ventricular failure; hypersensitive heart disease and diabetes mellitus”

**4.10** Concern had existed for some time for Danny’s wellbeing and safety in the community, with 6 referrals to Safeguarding Adults from July 2012. These were concerned with a number of falls and a burglary in July 2015. This raised issues about his vulnerability in allowing people into his flat and management of his money. During the Review Period, on 15 July 2016, the social care support services provider raised concerns about possible financial exploitation. The Police were involved but the case was closed as inconclusive on Danny’s death. However, it did lead to an assessment of his mental capacity, deeming him unable to manage his financial affairs, and a subsequent application by Gloucestershire County Council to the Court of Protection to manage this on his behalf. Unfortunately Danny died before this was put in place.

## **5. Analysis**

**5.1** The analysis of the information gathered through the Review Process aims to answer the concerns raised in the Terms of Reference **(3.00)**

### **5.2.1 Mental capacity to make decisions and professional duty of care.**

In November 2006, Danny was detained in a psychiatric hospital under Section 3 of the Mental Health Act. In a letter from a Learning Disability Psychiatrist to a Mental Health colleague at this time, Danny’s diagnosis is given as Pre-psychotic Episodes and Borderline Learning Disability. His most recent IQ assessment had given a ‘score’ of under 70, the threshold at which learning disability is considered to be present, whereas previous assessments had placed him above that level. Danny was considered to have many difficulties and that he fell between services, being more ‘able’ than most people within learning disability services but more ‘disabled’ by his inability to learn new tasks than most people with mental health problems. He associated better with people with mental health problems than those with a learning disability and he perceived himself as having a mental health problem rather than a learning disability. However, when under stress, the psychiatrist considered he behaved more in keeping with his borderline learning disability than his mental health problem.

**5.2.2** In reviewing the action taken by agencies in respect of the Mental Capacity Act 2005, it is important to understand how Danny processed information. His learning disability made it difficult for him to learn new tasks. Having an IQ of around 70, he would lack the ability to understand and use complex information, impacting on his ability to understand the consequences of some decisions. As we know, capacity to make a decision is specific to the decision so he would have had capacity to make some decisions but not others.

**5.2.3** Personality factors were also involved. Danny's brother said that if you told him not to do something, he would go ahead and do it anyway. He had a determined personality and did not take kindly to being told not to do something he wanted to do. He did not like to follow instructions. Danny's brother said 'it would be like telling a small child' and questions whether his brother could understand the full implications of his actions or his decisions in many areas.

**5.2.4** There is evidence from the records that agencies did apply the Mental Capacity Act 2005 to decisions that needed to be made. He was given as much control over his daily life as possible by support staff, such as choice of clothes or activities but it was recognised and action taken to determine whether he had the capacity to make bigger decisions such as where to live or how to manage his finances. For example, he needed to move accommodation in April 2016 and his social worker completed an assessment, which deemed he did have capacity in this respect. In August 2016, there were concerns regarding his financial affairs, the subject of a Safeguarding Adults Section 42 enquiry, and the same social worker assessed that he did not have capacity regarding his money and was not likely to have it in future. An assumption had been made previously that he did have capacity regarding finance but it is not clear whether any formal assessment was carried out. This assessment resulted in an application to the Court of Protection to authorise Gloucestershire Council Client Affairs to act on his behalf. Unfortunately Danny died before this could be actioned.

**5.2.5** The issue of capacity around eating sweets was raised at a professionals meeting in 2014. A capacity assessment was completed at the time and Danny was deemed to have capacity; keeping a food diary was suggested.

**5.2.6** Danny's brother described him as having a sweet tooth as a child and young adult and that he resorted to stealing to obtain sweet foods when his mother tried to control his purchases. This continued through his life. It was his behaviour prior to his diagnosis of diabetes in 2001 and does not appear to have changed as a result of the diagnosis. Clearly this diagnosis made it critical to his health that he controlled his sugar intake. Danny was provided with information about the effects of excess sugar and was issued with frequent reminders, advice and instructions by health staff and support workers but he continued to go out and buy sugary snacks when he was not under supervision.

**5.2.6** Danny's craving for sweet foods may have been exacerbated by his anti-psychotic medication, a common side effect.

**5.2.7** In May 2016, GP records state that Danny had capacity to make decisions regarding his sugar intake. The GP and practice nurses were in frequent contact with his support workers regarding his blood sugar levels, which were often very high. The issue of diet was discussed at a multi-disciplinary meeting whilst Danny was in hospital on 9 August 2016. It was agreed that his Care Co-ordinator would assess whether he had

the capacity to understand the risks of eating the wrong foods when he was discharged. This does not appear to have happened but he was only living in the community for ten days following discharge before readmission.

**5.2.7** Community nurses expressed concerns when they assessed him following hospital discharge on 12 May 2016. The notes record that Danny 'needs prompting and supervision; not always able to make informed decisions.' They were concerned about his blood sugar. However, his support worker was sure Danny understood the impact of the sugary foods on his diabetes. Danny did not want to change his behaviour in terms of his food choices.

**5.2.8** Danny appeared to understand the impact of eating excess sugary foods at the time he was being told about it but he may have been unable to internalise the information and act upon it when he was alone. It is possible that he had difficulty with abstract concepts such as 'too much sugar will make you ill', especially when he was unaware of any ill effects. He simply continued to do what he had always done throughout his life. Whilst it is not for this Review to make judgements on his likely capacity to make decisions about his diet, it seems probable that he did not have the executive skills to understand fully the implications of eating sweet food and weigh up the information about his condition, compounded by his resistance to following instructions generally.

**5.2.9** A related concern was raised regarding the support worker's practice of leaving Danny in the town alone when his shift finished at the end of the commissioned hours. This had been a regular occurrence, as he liked to explore charity shops. He was able to make his way back to his home afterwards. However, this practice was repeated on 21<sup>st</sup> September 2016, the day after he was discharged from hospital following toe amputation. The support worker tried to persuade him to come home but he refused. As Danny was deemed to have capacity in this previously, the support worker left him in the town centre. He was getting agitated so the support worker considered the best option was to leave him rather than to continue pressing him to go home. He took the shopping back to the flat. Unfortunately Danny collapsed. Staff from the Provider attended swiftly but he required readmission to hospital. An allegation was made that the Care Provider 'lacked common sense' in allowing him to go out in the first place and that they lacked a duty of care in leaving him in town alone. The social worker informed the Care Provider that a Safeguarding Adults concern would be raised if it were ever repeated. The Care Provider considered this to be unfair, given that the commissioned hours were insufficient to cover the whole day and, in addition, Danny was considered to have capacity to choose to come and go from his home when he wanted. However, the Care Provider was clear that the support worker would not have left him in town had the risk to his health been apparent. It might have been appropriate for community staff to re-assess Danny's capacity to make these choices at the point of discharge from hospital if a change to the normal routine was indicated. It is possible that he was unable to weigh up the potential risks of being alone in town at that time. Another option may have been to give the support worker clear instructions on his aftercare and what to do if the situation occurred again at the end of his hours. His capacity to make choices about his diet was re-assessed on discharge,

**5.2.10** During his hospital admissions, Danny had 2 toes amputated. Prior to the first operation on 5 September 2016 the hospital notes state that he 'appears to understand ...the condition of his toe. Patient was able to weigh up decision between surgery and non-surgery management' and a Consent Form 1 completed in accordance with hospital procedures. The records stated that they explained the risks and benefits to Danny's brother. On the following day, it was reiterated that he had capacity. However, on the day of surgery, 7 September, Danny was 'unable to retain

information regarding his foot surgery and stay in hospital' and he was judged not to have capacity at that time. He experienced acute confusion (delirium) and was considered a risk to himself and others. He was acutely unwell at this time. At this point he was re-assessed medically and a capacity assessment completed resulting in the use of the Emergency Sedation Policy to enable the surgery to go ahead. A Best Interests Decision was made but the doctor involved was unable to make contact with Danny's brother in order to consult with him as he was working abroad. Consultation with Danny's support worker might have been possible in place of family, as he knew him well over many years.

**5.2.11** When the second toe was amputated on 1 October 2016, a Consent Form 4 was completed, stating that a Best Interests Decision had been made as Danny was unable to weigh up the information. As for the first amputation, current policy states an Independent Mental Capacity Advocate is not required in these circumstances if a family member is available. His brother was abroad at the time but contactable by mobile telephone. However, there was no evidence from missed calls that any attempts were made. The Consent Form 4 has a duty to consult others.

**5.2.12** An Independent Mental Capacity Advocate was requested by his Care Co-ordinator on 4 October 2016. It is unclear why this request was made given Danny's brother's ongoing involvement. However, it seems likely that this advocacy was in respect to social care assessment and care planning, as he would certainly have been eligible for advocacy for this under the Care Act 2014. This would have been helpful in assessing his needs for 24 hour care and his views on the proposed move to residential care at this time.

**5.2.13 Conclusions.** In summary, there is evidence that the agencies did consider Danny's mental capacity to make decisions about finance, accommodation and surgery and followed the correct procedures, although best practice should have led to the hospital consulting with a relative or other person close to Danny regarding the second toe amputation. There is also evidence that they considered his capacity to buy and consume foods detrimental to his health condition, concluding that he was making informed, if unwise, decisions. His capacity to make decisions about his diet and going out alone required review after hospital discharge.

It may be necessary to repeat capacity assessments if unwise choices continue to be made, with guidance to staff as to when these should be triggered.

When all the information about Danny's mental health, personality and learning disability are taken into account, it seems probable that he may not have understood abstract information and future implications. He may have lacked the 'executive' capacity to make these decisions, which may have been identified with further questioning and challenging by a confident practitioner. It is acknowledged that all the information may not have been accessible in one place to staff undertaking the assessments but it was available readily to this Review. It may also be necessary to explore issues around the quality of life versus the length of life. If Danny was unable to exercise his lifestyle choices and independence, he might have led a longer life but it may not have been happy or fulfilling.

**5.2.14** Danny was not able to leave the hospital at will and would be considered to have been deprived of his liberty. There is no record that his capacity to consent to this deprivation was assessed. Whilst he was not restrained physically, he was prevented from leaving the hospital through distraction and persuasion. Viewed retrospectively, it seems probable that his capacity to consent fluctuated, indicating that a referral to

the Local Authority to consider authorising this deprivation under the Deprivation of Liberty Safeguards 2005 would have been appropriate. This would have involved a qualified Best Interests Assessor.

5.2.15 It should also be noted that, had Danny been assessed as lacking capacity to make decisions to go out shopping independently or pursue any activity which put him at risk, a referral to the Court of Protection should be made to authorise any restrictions placed on him whilst living in the community, either in his own home or in residential care.

### **5.3 Care and support within the overall delivery system**

**5.3.1** Danny had complex and changing needs throughout his lifetime. Over the last 10 years, these needs were met in supported living environments with involvement from community mental health services and primary care. The accommodation from which he had to move in April 2016 appears to have been successful and provided him with companionship from other tenants with similar needs close by and the wider availability of support staff, which provided support to all the tenants in the group of flats. Viewed retrospectively, this move marked the beginning of a decline in his health and wellbeing.

**5.3.2** Danny moved to a ground floor flat in April 2016 located 5 minutes walk from the city centre, on his own. There are conflicting opinions about the quality of this accommodation, from 'dark, damp and dingy' to 'tidy' and 'clean and bright'. He had the continuity of the same number of support hours (33.25 per week) and the same team of support staff from his previous accommodation, one of whom was a man of similar age who had been with him for many years and with whom he built a particularly close relationship. However, he missed the company and the social interaction of his previous accommodation and spent his days in solitary pursuits, painting, reading and watching videos. Danny's brother is clear that this change to his accommodation and lifestyle impacted adversely on his wellbeing.

**5.3.3** Despite the support provided, concern was expressed about his condition. On arrival at the Emergency Department on 23 August 2016, hospital notes stated that his 'clothes are very dirty' and that he 'appears self neglected'. It is not clear why Danny was in this condition when he had a substantial care package to support him and he had sufficient money.

**5.3.4** Concerns were raised at the time of the move by the social worker regarding finances. Whilst he was nominally responsible for his own affairs, the Care Provider managed them on his behalf by assisting him to withdraw funds, using them to purchase essentials and giving him £5 for himself each day. Unspent money was kept in a tin, which was meant to be locked away as Danny was at risk of allowing people into his flat without checking their identity. (This had led to a theft of £5 in July 2015 and a referral to the Police and Safeguarding Adults, which was closed as no significant harm had been caused.) The Care Provider had made several purchases on his behalf, including a toilet seat, wardrobe and blender and equipment, and there were concerns that his money was not being used wisely. There were also concerns that large sums of money were going from his bank account and the Care Provider was using the second bedroom in the flat as an office, although Danny was paying for

all the accommodation. These allegations put considerable strain on the relationship between social worker and provider. They led to an unsubstantiated Safeguarding Adult Enquiry.

**5.3.5** Danny received services from Primary Care in support of his diabetes, attending annual diabetic checks. His GP had little direct contact but had received telephone calls from his support workers regarding blood sugar levels. Community Nurses from the practice had little involvement, as he was able to get into the surgery to see the practice nurses. They did assess him at home following a request from the hospital on Danny's discharge on 12 May 2016 and for some time they provided a telephone service to the Provider to support monitoring of blood sugar, although this was limited in usefulness as only the GP or Diabetic Nurse could authorise a change to his insulin dosage in response to blood sugar level and was stopped when he had regular appointments with the Practice Nurse to ensure his health was monitored. Danny was discussed regularly at the Practice weekly professionals meeting. The District Nurses attended a multi-disciplinary meeting on 9 August 2016 and made a further home visits after discharge on 13 August 2016 and 23 October 2016. They considered the second discharge to be 'unsafe' and he was returned to hospital. Communications between the Primary Health Team members and the hospital were hampered by lack of a joined up system and single point of referral and information into the team.

**5.3.6** Danny received services offered to the general population of his age, including flu immunisation, bowel cancer screening and regular blood pressure checks. He also attended outpatient clinics for ophthalmology.

**5.3.7** It can be seen from the Case Summary (4.9) that Danny presented at the Emergency Department on 7 occasions from May 2016 due to a combination of physical and mental health related issues. These included abdominal pain, diarrhoea and vomiting, concerns regarding blood sugar levels; inflamed and infected sore places on his face exacerbated by self harm and disruptive behavior which drew the attention of the Police. He was admitted as an inpatient on 6 occasions, spending more time in hospital than in his own home from May 2016 until his death.

**5.3.8** During these stays, he was very unwell and required surgery to amputate a toe on 2 separate occasions due to necrosis, cellulitis and infection, the healing process impeded by his picking and banging the wounds. His blood sugar levels were extremely high on most of his admissions but tended to settle once in hospital for a few days. A number of treatment options were discussed with vascular and microbiology specialists. He did not settle easily on general wards. He was often agitated and disruptive, 'shouting out offensive words', lashing out at staff and refusing at times to co-operate with examinations and treatment. Ward staff consulted with the Learning Disability Liaison Nurse for ways in which to support him and utilised additional staff. An acute hospital would not be ideal for Danny once his physical condition had improved.

**5.3.9** Plans to secure support staff known to him to provide support in hospital were unsuccessful. Requests from the hospital were made to Danny's social worker in the 2gether NHS Trust for funding for this (the funding provided for his care in the community was withdrawn on his admissions to hospital). Initially this request was declined in keeping with policy, which expected the hospital to provide any additional care needed for inpatients. When funding was made available for this after further negotiation, the Care Provider declined to offer the service as it was insufficient in their view to cover travel time and costs. Danny's brother offered to pay for this service himself but this was not taken up.

**5.3.10** At the time Danny was sectioned in November 2006, it was agreed between services that he would receive support through mental health services with support from Learning Disabilities, especially around finding suitable accommodation. This situation continued until August 2016 when his psychiatrist decided he should be discharged from Mental Health services, despite the fact that Mental Health Trust was funding his care and he had rights under Section 117 of the Mental Health Act. This gives rise to concern about lack of understanding of the system within the 2gether NHS Trust. A clear multi-agency protocol exists for joint funding, with a process for dispute resolution. Danny was not discharged from the Mental Health Trust and it retained lead responsibility for coordinating his care, with input from other agencies as appropriate.

**5.3.11** It appears that responsibility for funding caused difficulties between agencies. The 2gether social worker asked Adult Social Care to fund reablement services for Danny on discharge as he had balance issues, the protocol being that Adult Social Care paid for needs arising from physical conditions. After assessment by the multi-disciplinary team, the hospital social worker reported that he was not eligible as his mobility had not been affected substantially. This seems to have given rise to some difficulty between staff from these agencies. The hospital social worker stated that funding became the focus, 'the main issue for Adult Social Care was getting Danny out of hospital once he was well enough. The main issue for Mental Health was the funding'. The 2gether social worker's supervisor expressed frustration over the process too, with long delays involved, as cases were often not straightforward. The dispute over who was funding impacted on the relationship between agencies, with information not being shared and meetings not attended.

**5.3.12 Conclusions.** One view mentioned previously was that Danny fell through the gaps between agencies due to his co-morbidities. This was regarding funding and should not detract from the fact that individual organisations provided good care for his physical condition and mental health up to the accommodation move in April 2016 when Danny's needs changed and increased. There was agreement between agencies that his support needed to be increased following discharge but disagreement what this increase should be and responsibility for funding it.

There was a sense of frustration expressed by all at the complexity and length of the processes involved. Severe financial pressures are being experienced in all parts of the health and social care system, with stringent processes for funding authorisation in place in social care. However, some learning about the processes may be required in order to meet with the Care Act 2014 requirement that care services should not be delayed due to funding.

In this case, it appears to have affected relationships and understanding between staff in different parts of the system. It also impacted on Danny's brother, who understood his needs and who became increasingly frustrated with the system's apparent inability to reach a decision to meet them. He felt that nobody was listening to him.

The Care Provider identified that Danny had increased mental health and physical needs which impacted upon each other. It appears that significant weight does not appear to have been given by the commissioners to the views of the Care Provider, who had known Danny over a long period of time. There may have been an undercurrent of concern from commissioners that the Care Provider was seeking self-gain, although this was not expressed openly.

A decision was made eventually to increase the care hours but this still did not cover the whole day. On his last 2 discharges from hospital, incidents occurred on both occasions during the gap in support, causing re-admission.

In terms of his overall care, Danny was very unwell physically and was treated in an appropriate acute hospital setting. His experience in hospital would have been improved greatly with support from familiar people. This may have reduced his lengths of stay in acute care by lessening his distress, agitation and self harming behaviour, increasing his tolerance for some therapies and thereby avoiding infection and sepsis.

Proper arrangements through the Court of Protection for the management of finances should have been put in place at least one year earlier following the Safeguarding Adult referrals, probably earlier. This may have avoided the difficult relationship that developed between the 2gether social worker and Care Provider about the management and use of his money. Danny's brother states that he was unaware of the Safeguarding Adult referrals.

It was not recognised in any of the assessments or noted by the hospital that Danny may have been reaching the end of his life. Although his death was unexpected, the deterioration in his health, necrotic toes in particular, could have been identified as signs that he was in the final stages of his life. During this review, an experienced doctor stated that she would not have been surprised if Danny had passed away within a year of these events. Danny's brother was unaware that his condition was so serious and deteriorating.

#### **5.4 Discharges from hospital and subsequent re-admissions within 24 hours during August 2016 and October 2016**

**5.4.1** The first of these 2 discharges was following an admission on 23 August 2016 to 20 September 2016, almost 5 weeks. The police brought Danny to the Emergency Department – his physical health care needs were observed to be more of a priority than an assessment under the Mental Health Act. He had been found wandering, confused, on a building site and had infected sores on his face. (He had been discharged home from hospital on Friday 12 August 2016, 11 days before). On arrival, his blood sugar level was very high, his temperature slightly raised and his right big toe was in a poor condition, with cellulitis in his right leg. He was assessed for acute infection and sepsis, started on intravenous antibiotics and admitted to a ward. He was very agitated so additional support was requested from his 2gether social worker, with the involvement of the Learning Disability Liaison Nurse.

**5.4.2** During his stay, diabetes treatment was reviewed and a new insulin regime was started due to concerns about previous compliance. He was supported to continue to be independent with this. Numerous medical investigations took place. His condition improved over time and discharge planning commenced on 1 September 2016 in consultation with his brother and a psychiatrist. However, the improvement did not last, particularly regarding his foot. Danny was moved to Cheltenham Hospital on 2 September 2016, eliciting further concerns about his agitation and request for additional support from the new ward to the 2gether social worker. He had surgery to amputate his toe on 7 September 2016 under general anaesthetic. Recovery was not straightforward, as he did not understand that he should not weight-bear. He showed signs of distress, banging and kicking doors, shouting and lashing out. Sedation was needed and one to one nursing was put in place. Gradually the wound



improved but Danny continued to be agitated. Discharge planning began again. His brother considered that the dramatic change in his character was due to his hospitalisation, toe amputation and lack of understanding. The Care Provider informed the 2gether social worker on 12 September 2016 that she had been informed by Danny's brother that he might be discharged the following day. Plans were not in place so the social worker asked for this to be postponed.

**5.4.3** On Thursday 15 September 2016, a Consultant ward round considered Danny appeared 'well and communicating well'. His dressing management was to be reviewed 'on Monday' but he was medically fit for discharge. Over the weekend it was noted that he was not tolerating 'vac therapy' on his toe wound and it was not healing. On Monday, it was considered that he was stable and he was discharged home on antibiotics, with cellulitis still present. 'All clinical information noted within GP's discharge letter. Request for GP involvement and district nurse input in support of wound care'. The District Nurses did not see this information, as they do not use the same system as the GP.

**5.4.4** Hospital social workers (part of Adult Social Care Ongoing Care Team) became involved with Danny on 6 September 2016. An assessment was carried out over several days as it was recognised that his behaviour had altered in hospital and additional care needs were identified. They made attempts to liaise with the 2gether social worker and felt that it was essential for her to visit the ward prior to his discharge to ascertain whether his presentation had changed since admission. She did not come. Frustration was expressed about communications and information was not passed to the hospital discharge staff about his discharge date; different systems were used and they could not access the database held by the 2gether social worker.

**5.4.5** On 14 September 2016, the Care Provider notes that she had been trying all day to contact hospital staff to request a discharge meeting. 'No information from [the social worker] or the hospital as to when Danny might be discharged and what his needs might be and what support would be needed leaving [the support worker] unable to prepare. On 15 September 2016, email correspondence between the brother, social worker, care co-ordinator and the Care Provider stated that the hospital social worker's assessment concluded that Danny was mobile and did not need reablement. The conclusion was drawn that no additional support was required over the previous package. The brother disagreed with this and described the potential poor outcome in terms of physical and mental health if additional support time was not provided to ensure a safe discharge.

**5.4.6** The 2gether social worker contacted the Care Provider at 15.30 on 20 September 2016 to confirm discharge home that day. Danny arrived home alone by taxi at 19.45 with dressings on his head, arm and foot. The Care Provider states that there was no information about managing these dressings. A bag of medication was enclosed and one indicated it should not be taken with insulin. Insulin was therefore withheld. On 21 September 2016, the Care Provider contacted the District Nurses as the hospital, when contacted, had advised that they were expected to change the dressings daily. The nurses were unaware of this and said that he would have to go to the surgery, as he was 'mobile'.

**5.4.7** Later on 21 September 2016, the regular support worker accompanied Danny into town to draw money and buy groceries. He expressed a wish to visit charity shops on his own after his support worker's time was finished. The support worker tried to persuade him to go home but, as Danny had appeared 'normal' and eaten breakfast, it was eventually agreed. At 14.30, the Care Provider manager was contacted by the Police

to assist with Danny, who was 'pale and disorientated' outside the charity shop. Paramedics in attendance refused to take him back to hospital as his physical observations were normal. The Police did not assist as 'it was a mental health issue'. The Care Provider escorted Danny away from the shop but he collapsed to the floor. She called the Ambulance Service again and the Mental Health Crisis Team, both of whom attended. Danny was taken back to hospital. Both agreed that he had declined both mentally and physically.

**5.4.8** On arrival at the Emergency Department, Danny was assessed as being constipated. His blood sugar was slightly raised. He was admitted to Cheltenham Hospital. By 23 September 2016, he was considered 'acutely unwell' with concerns about sepsis and a potential pulmonary embolism, although no evidence found in subsequent investigations. Danny was highly agitated and in pain. Whilst the first toe amputation wound was healing, another was necrotic and needed amputation on 1 October 2016. Discussion about discharge was happening at that time between community and ward staff. The 2gether social worker requested that he transfer to a community hospital to allow time for the wound to heal as district nurses would not visit him at home to manage the dressings. This was denied as Danny did not meet the criteria and was considered independent on the ward. His condition deteriorated again and discharge was postponed.

**5.4.9** A professionals' discharge meeting was held on the ward on 7 October 2016, attended by the Care Provider manager and a support worker, care co-ordinator, lead nurses on the ward and 2gether social worker. The hospital social worker was unable to attend. Danny was said to be medically fit for discharge. The meeting concluded that additional support was needed on discharge due to his increased risk of falls, wandering, diet and pain management, without which he was likely to readmitted again. There was no agreement on funding but the 2gether social worker was to contact Adult Social Care to discuss this. An additional 3.45 hours support was agreed through the Mental Health Panel on 13 October 2016.

**5.4.10** Once again, Danny did not maintain his improvement and the hospital stay continued. His brother was making plans for him to move into residential care nearer to his home. There were some indications in the hospital social worker's record that discharge was being considered on 21 October 2016 although there was nothing in the hospital notes about this and Danny was still on intravenous antibiotics. On Saturday 22 October 2016, it appears that there were 4 consultant ward round reviews. The first proposed that wound care was to be reviewed the following day. The second promoted limb elevation due to oedema. The third proposes 'step down from antibiotics' and the fourth stated his clinical observations were stable, conversion of intravenous medication to oral and that he was 'medically fit for discharge'. A letter was written to his GP requesting district nurse daily involvement with insulin and dressings to face and foot with ongoing blood monitoring in respect of the antibiotics. A further letter was sent to the Community and Practice Nursing teams and telephone conversations took place. These were not received prior to discharge.

**5.4.11** The 2gether social worker telephoned the Care Provider on 21 October 2016 to confirm that support hours were to be increased to 8.30 per day in total to allow support workers to be present from 9.30 – 12.00 and 2-8pm and it was confirmed that this package could start the following day. No notice had been given to the Care Provider of his imminent discharge the next day prior to this call. The 2gether social worker also stated that she would raise a Safeguarding Adult concern if the support worker left Danny in town at the end of his shift. The Care Provider

reminded the social worker of Danny's previous behaviour and refusal to come home and stated that responsibility could not be taken for him outside of funded hours.

**5.4.12** The Integrated Community Team received a call on 22 October 2016 from the Out of Hours Team to advise them that Danny was being discharged that day and required dressings.

**5.4.13** Danny arrived home and requested a Chinese meal. This was brought for him but discovered not eaten the next day. On 23 October 2016, he was supported to get up. The support worker left at the end of his shift at 12.00 as arranged. On his return at 2pm, Danny was on the floor and refused to get up to go to bed. An emergency ambulance was called as Danny was in pain, had slurred speech, had vomited and been incontinent. The District Nurses arrived at that point to change his dressings and all agreed that he should return to hospital.

**5.4.14** The District Nurse recorded that Danny was sent home from hospital on different insulin, insufficient supplies, no prescription chart or note of dose. The hospital stated later that this was in Danny's bag but this could not be verified. She noted that it was an unsafe discharge.

**5.4.15** On 23 October 2016 Danny was admitted to hospital again after assessment in the Emergency Department. Further treatment was given and plans were progressed by his brother to move into residential care on discharge, but sadly Danny died on 3 November 2016, 'an unexpected death'.

**5.4.16 Conclusions.** In reviewing these admissions and discharges, it is evident that Danny had complex mental health and learning disability needs which impacted on the way in which treatment could be provided to address his physical condition. His condition fluctuated, making it difficult to predict when he was ready for discharge. There were several occasions when plans were progressing and had to be postponed. Some of this planning was good; for example the multi-disciplinary team meeting on 7 October 2016 achieved consensus regarding future needs. However, other aspects were poor and contributed towards rapid readmissions.

These were:

- a) Insufficient notice given to the Care Provider that Danny was being discharged after lengthy stays in hospital, both were less than 24 hours. He received a large package of care, over 8 hours each day, and it is unreasonable to expect them to be able to re-start this delivery this without due notice. It is to their credit that they did manage to fulfil the commissioned care hours using familiar support workers.
- b) Inadequate instructions to the Care Provider about arrangements for care. Danny was discharged with the dressings required but was considered to be able to get to the surgery for them to be done. The Care Provider received criticism that he should not have walked into town on foot on the day after his discharge and that this was a significant factor in his collapse and readmission. Criticism was also made that he was left in town. It is unclear what was expected of the Care Provider given that Danny was assessed to have capacity in respect to going out, reinforced by the instruction from the District Nurses that he was fit to attend the surgery.
- c) The Care Plan did not take into account fully the concerns of both family and Care Provider that it was unsafe to leave Danny alone for part of the day. The risks were articulated clearly at the meeting on 7 October and through numerous emails. Some additional hours were

provided on the second discharge but they still left a gap in the middle of the day. Harm befell Danny during the support workers' absence, as predicted, on both occasions. The views of Danny's support worker were not sought.

- d) The role of the hospital social worker in co-ordinating plans does not appear to be understood by community colleagues or the hospital.
- e) The Hospital Discharge policy for Gloucestershire Hospitals NHS Foundation Trust sets out the importance of discharge planning. It states that premature discharge can result in un-met needs for the patient, a poorly prepared home environment, and likelihood of readmission to the acute sector and use of inappropriate or more costly social care services. Any discharge involving one or more agencies is termed 'complex' in this policy and there is a section about this. A list of organisations is given but very little information as to how to manage the process. It does not mention the role of the hospital social workers. It also states that hospital staff must 'ensure patient (and carer) are equipped with all necessary information' and 'ensure safe practice in relation to the provision of medication on discharge'. The planning and communication had started in a very timely way three weeks prior to discharge with a multi-disciplinary meeting on 7 October 2016, a number of delays occurred to the discharge through Danny's ill health. There is evidence of some communication between the Together Social Worker and the Care Provider on 18 October to update but only 24 hours notice was given to the Care Provider of imminent discharge. The second discharge, on 22 October 2016, was on a Saturday. Hospital discharges take place on any day of the week but many community services do not offer their usual services at weekends which can make continuity and communication less straightforward.
- f) There was a great deal of communication between all parties, most of it timely and effective, with some obvious gaps. However, there was a lack of co-ordination across agencies, some of this being exacerbated by funding disputes and delays.
- g) It does not appear that full and detailed information about medication and dosage was communicated effectively to the provider on discharge, although hospital notes record that they were.
- h) Following such a prolonged hospital stay for a person with such complex needs, a home visit prior to discharge is essential in assessing needs, or at least a visit by a person who knew him well in the community.

## **6 Key Findings**

### **6.1 Good Practice**

This Review has been completed in partnership with representatives of the organisations who provided health and care services to Danny over many years. They have been very willing to engage with the review process and have been honest, self-critical and open to challenge, keen to identify where learning may be identified to improve services in future. Indeed, steps have already been taken to improve the system based on the perceived issues arising from this case (6.2). There are some examples of excellent practice.

- Continuity of care provider and support workers over many years
- Exceptional care shown by the support worker in visiting Danny regularly in hospital, unpaid and in his own time, and giving a long term home to Danny's treasured cockatoo, Elvis.

- The Provider's ability to respond with 24 hours notice to hospital discharge in re-instating a large increased care package using staff known to Danny.
- The persistence and determination of the 2gether Trust social worker in identifying and acting upon Safeguarding Adults concerns and Mental Capacity Act issues.
- The Learning Disability Liaison Nurse was able support Danny in hospital and advises ward staff. Although Danny had borderline learning disabilities, she was able to be flexible.
- Hospital Discharge Social Worker care planning carried out carefully (but not linked in with other agencies)
- Discharge planning meeting, albeit 3 weeks prior to discharge with updates needed

## **6.2 Progress since the events leading to the Safeguarding Adults Review**

- A District Nursing Referral Centre is being set up for nursing referrals. The need for this was identified in a previous Review.
- Gloucester Safeguarding Adults Board has put in place a series of six roadshows for staff on the Mental Capacity Act 2005 during 2018. The theme is 'Finding the Balance', keeping adults with care and support needs safe whilst allowing them to feel in control of their lives, as far as possible.

## **6.3 Themes**

1. The current arrangements for funding different aspects of an individual's total care needs by different parts of the social care system, and the financial pressures on each part, may be creating barriers between practitioners and impacting on client care. In this case, funding issues appear to have received greater focus than delivering the right care. Whilst clear protocols for funding appear to be in place between organisations, they are complex and there may be a lack of awareness across the whole system about the protocols and processes involved.
2. Clear and detailed information about the way in which all needs will be met and by whom should be made available and communicated well in advance to the Care Provider and anyone expected to take a key role following discharge. The notice required will depend on many factors, including the complexity of the needs, importance of using familiar staff and the size of care package.
3. Any person with substantial difficulties should have an appropriate professional lead or case manager who is able to co-ordinate the convening of multi-agency meetings and planning of services. This may be the professional who has the most direct involvement and access to other service providers working with the individual. It is incumbent on this person to set out lines of communication and ensure all the pieces of the jigsaw are in place. There needs to be greater awareness that the Community Nursing Service is a separate entity to the GP Practice and communication should be made to each service appropriately.

4. Advocacy should be in place for people with substantial difficulties in order to ensure that needs and wishes are fully identified and taken into account when decisions about the future are made. Individuals without capacity have a right to this under both Mental Capacity Act and Care Act 2014.
5. The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2007 need continued work to embed them fully into practice, including the role of the Independent Mental Capacity Advocate and the role of family and other people close to the individual.
6. The Mental Capacity of people with complex co-morbidities needs review following surgery, other treatment or other changes as the individual's ability to weigh up information and take changes into account may be affected. Practitioners need to be confident in challenging and establishing if the individual has 'executive' capacity.
7. Signs that end of life may be approaching were not identified in assessments. Although Danny was not considered to be reaching the end of his life and his death was not expected so suddenly, there were signs that his physical condition was deteriorating significantly and that his death within a year would not be surprising. In making decisions about care, and restrictions on a person's independence, it is useful to consider probable life expectancy in order to make the balance between a person's quality of life and extending the length of their life.
8. People with substantial difficulties may need additional care and support in hospital. This may be achieved best by using available funding to pay support workers with whom the person is familiar on site during the admission to provide continuity of care and to assure their wellbeing and comfort. Hospital staff need information about the care needs of the person and the proposed discharge environment.

**6.4** Gloucestershire Health and Care services are not unique in finding that the systems in place are not always adequate to meet the changing needs of people with complex co-morbidities. Similar concerns were also identified in two Serious Case Reviews carried out for Suffolk Safeguarding Adults Board in 2014, authored by Margaret Flynn, who also led the Winterbourne View Serious Case Review. An 'overhaul of structures' supporting adults with learning disabilities was recommended which included the following actions, which are equally appropriate for Gloucestershire to consider across all conditions:

- A named Care Co-coordinator for health and social care for each individual
- An annual review, to include CHC
- A joined up system for record keeping and information sharing

**6.5** At a national level, the Learning Disabilities Mortality Review (LeDeR) is a research programme commissioned on behalf of NHS England and run by Bristol University. Started in June 2015 and run over three years, it aims to clarify 'any potentially modifiable factors associated with a

person's death and works to ensure they are not repeated elsewhere.' The LeDeR Programme will also collate and share the anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements. This is a programme in which Gloucestershire Safeguarding Adults Board is participating and will benefit from the finding in any future revision of services.

**6.6** As individuals with multiple health conditions live longer, the challenges to health and social care services increase as individual agencies are required to provide specialist and general interventions and at the same time, work together very closely to co-ordinate care as some conditions impact on the way others are managed. Planning a hospital discharge brings these issues into sharp focus, often against a background of competing pressures to vacate hospital beds and to minimise spending in the community. The example provided by this Review of Danny's situation shows the importance of getting every detail of future care in place and communicated to the right people in advance of discharge. It has been seen that failure to do this can have serious repercussions on the individual and may not make best use of either hospital or community resources.

## **7. Recommendations to Gloucestershire Safeguarding Adult Board**

- 1. The Board should request a review of the Multi-Agency Hospital Discharge Policy to ensure that it sets out best practice in making safe and effective arrangements for people with complex needs. This should include:**
  - The role of the Hospital Discharge Social Worker**
  - Guidance on essential information requirements to ensure continuity of care and treatment and who will be involved in delivering each component of the Care Plan.**
  - Arrangements for monitoring**
  - Expectations on communication and timeliness**
  
- 2. The Board should be assured that multi-agency care planning, including advocacy, is in place for people with complex and deteriorating co-morbidities and that it takes account the views of the Care Provider and family. Funding responsibilities need to be clear in order to avoid delays in services in compliance with the Care Act 2014.**

3. **The Board will request that the Local Authority, Clinical Commissioning Group and Gloucestershire Royal Hospital will explore providing additional support in hospital for people with substantial difficulties from support workers with whom the person is familiar. This will provide continuity of care and contribute towards their wellbeing.**
4. **The Board should be assured that all agencies continue to work towards improving understanding the Mental Capacity Act and Deprivation of Liberty Safeguards and that they are implemented fully. Practitioners need the confidence and support to challenge appropriately to establish capacity when it is unclear or fluctuating, and where ‘unwise choices’ lead to ongoing harm to the individual.**

## **References**

Journal of the Royal Society of Medicine 2012 Jul: 105(7): 279-282

NICE The Care and Support of Older People with Learning Disabilities (draft – final version expected May 2018)

General Medical Council Guidance on Learning Disabilities

Suffolk Safeguarding Adults Board Serious Case Reviews 2014 (website)

Transforming Care – A National Response to Winterbourne View Hospital (Dept. of Health 2012)