Norfolk County Council

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Our ref: LB/MW/LY-Reg28
Date: 29 March 2016

Dear Sir

Re: Lorraine Youngs of Flat 51, Foulgers Opening, Norwich NR1 3AH – D.O.B 05/02/1980
Inquest date: 25/01/2016 to 27/01/2016

I refer to the Regulation 28 Report to prevent Future Deaths dated 1 February 2016 issued to Mr Harold Bodmer, Executive Director of Adult Social Services, Norfolk County Council. I should be grateful if you would accept this letter as providing the response to this report.

The Report identified the following matters of concern:

"The Inquest heard evidence regarding Lorraine Young's care in the community. Evidence was given from Lorraine's social worker that a care package had been agreed in principle at a visit on 12 February 2015. At the time of her death, this had not been implemented. The evidence given was that this had not been followed up. Whilst it could not be said in the context of Lorraine's death whether the delay affected the outcome, I was concerned that a delay in following up implementation of an agreed package could, in different circumstances, affect the outcome for a vulnerable service user. The evidence before the inquest was that there appeared to be no system for following up implementation of an agreed care package."

The response from the local authority is as follows:

At the time of this serious incident in March 2015, social work support to patients in the acute wards at Hellesdon Hospital was provided by the responsible locality mental health social care team. The team responsible for assessment and commissioning social care services for LY was the Norwich locality mental health social care team based at Gateway House, Wymondham.

In May 2015, Norfolk County Council (NCC) made changes to the social care support arrangements to the wards at Hellesdon Hospital. The wards are now served by a dedicated Hospital Discharge Social Care team based on the Hellesdon Hospital site.

Three experienced mental health social worker/Approved Mental Health Professionals based in this team link with the acute wards to ensure early signposting, timely and proportionate needs assessments, multi-disciplinary decision making and discharge planning. This facilitates much closer working arrangements which ensure that patients who are admitted to the ward can be assessed as soon as they are well enough, and arrangements made for their discharge. This means that delays and last minute arrangements are avoided.

The Hospital Discharge Social Care staff cover for one another during any period of absence to ensure that agreed actions are followed up. There is also the back-up of the North locality mental health team duty system, whereby there is a member of staff available every day during office hours to respond to urgent and unplanned requests.

The Hospital Discharge Social Care team is managed by a Practice Consultant (Senior Social Worker) and Team Manager who are also based on the Hellesdon Hospital site. The social care staff in this team receive formal monthly supervision.

The Hospital Discharge Social Care team can refer people to Norfolk First Support if a person has been identified as suitable for re-enablement and may not require care in the longer term. This service provides six weeks re-enablement for people in their own homes, supporting where temporary conditions have reduced the person's ability to care for themselves or to re-enable people to care for themselves as far as they are able e.g. people who have suffered fractures or a short term acute illness.

This service can be arranged at short notice and can support hospital discharge. If the assessment by the hospital discharge social worker indicates longer term needs, the worker instructs the NCC Care Arranging Service to source care services. The Care Arranging Service (CAS) shares the relevant assessment information with the potential care provider to ensure that they are able to meet the person's assessed care and support needs and identifies the date the care package is needed to start. The actions of the Care Arranging Service are recorded on CareFirst, the NCC electronic client based information system.

Having this dedicated team ensures that the care requests are followed up and actioned. CAS keep the social worker informed of their actions and the care they have arranged. If CAS are unable to source the care and support required they inform the social worker and keep an unmet need log.

Once the person is discharged from hospital, the locality social work team becomes responsible for ensuring that the care package continues to meet the needs of the person by carrying out an initial review at four weeks and then at regular intervals.

I trust this response answers your concerns but if you have any further queries, please do not hesitate to contact me.

Yours faithfully

Lorna Bright
Assistant Director, Social Work