Tameside Hospital NHS
NHS Foundation Trust

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Our Ref: KA/PW/AD/JB/Coroner

Your Ref: JSP/KA/00911-2013

Date: 26 March 2014

Strictly Private & Confidential
Mr J S Pollard
Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

RESPONSE TO REGULATION 28 LETTER

Dear Mr Pollard

Thank you for your letter of the 30th January 2014 setting out your concerns under Regulations 28 of the Coroners (Investigations) Regulations 2013.

On the 29th January 2014, you held an Inquest into the death of Leslie Alfred Pates who died on the 2nd April 2013. The medical cause of death was recorded as:

1(a) Sepsis
1(b) Pressure sore
1(c) Immobility/stroke
II Vascular dementia, Chronic Obstructive Pulmonary Disease, Hypertension, Stroke

At the conclusion of the Inquest you set out a number of concerns. These concerns were reported to the Trust and we are now in a position to advise you of what action has been taken to address the issues identified.

1. There has been a complete breakdown in effective communication between the hospital and the family of the deceased.

To improve effective communication between the Integrated Transfer Team and the patients and their immediate carers/family regarding the discharge plan, the following actions are being taken.

Develop a checklist to ensure all members of the Multidisciplinary Team (MDT) have engaged with patients and their family prior to discharge.

The Team leader to ensure through the computer systems between social services and the Trust (IAS/EIS systems) that there is documented evidence that all Integrated Transfer Team (ITT) cases have been discussed with patients and their designated carers.

2. Neither the hospital staff nor the social services staff took any, or any proper, account of the wishes and views of the family prior to the discharge home of the patient.

To ensure the patients and families wishes are fully raised and given full consideration in the discharge process the following actions have been undertaken:

To ensure all patients and families have every opportunity to discuss plans and have a dedicated name and contact number for the social worker managing their discharge.

A Leaflet has been produced and is in publication process for patients and carers about "Leaving our Care".

To ensure all newly appointed staff/agency workers are adequately orientated to the hospital and all procedures and policies are outlined from both Tameside MBC and Tameside Foundation Trust (TFT) to the expected standards of practice.

All temporary workers located within the Transfer Team will have an induction process and complete the induction checklist within one week of commencing role.

Each temporary worker will receive an induction and adequate support and documented regular supervision.

3. The patient who was aged 80 years was sent home with severe pressure sores and without the facility of a pressure relieving mattress.

All patients returning home with care package will have their equipment needs assessed and documented in hospital.

Social workers to communicate effectively with the Nurse Coordinators , so that timely referrals for assessment of equipment needs can be made. The daily length of stay meetings will ensure that the checklist process for discharge is followed.

A complex care plan has been formulated for all parties to agree the patient is supported and fully ready for home.

4. Tameside Social Services failed completely or adequately to consider the views of the family of the deceased before determining and bringing into effect a plan for his discharge.

All plans of care for patients must be shared with the patient and, with patient's consent, their next of kin and agreed before discharge.

Each member of the ITT should ensure all care plans are prepared accurately and presented before being discussed and shared. This will be monitored through regular supervision of Tameside MBC staff and through daily length of stay. The ITT supervisors will monitor documentation via Social worker IAS system.

The Head of Patient Flow and Team Leader for ITT now have transparency and ability to view and monitor all social worker involvement with cases through Tameside MBC IAS system. This is monitored daily for all cases known to the ITT.

5. The required "meeting" between Social Services and the family prior to discharge from hospital, simply never took place.

To improve communication from the ward staff to the ITT through the induction of robust daily SHOP board round.

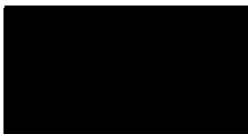
A Pilot of "Sick Patients Home Other Plan" (SHOP) is in progress on two medical wards. This is to be escalated across the trust over the next 3 months and become embedded practice. This will improve ward based communication to the discharge team and is documented. The SHOP process is a full MDT process daily where all patients are discussed and discharge plans agreed daily. This is documented and evidenced by the ITT team.

In addition, the profile of the ITT team is being raised through public awareness and increased visibility and open access

- Creating information boards and posters to display across the wards and departments to raise awareness of the team to allow patients, families and carers to have easy access to the team for support and guidance in the discharge process.
- The team has a social worker available 6 days a week to patients and relatives and a Clinical Discharge Facilitator (CDF) available seven days a week, from 0800-2000hrs to speak with patients, staff and relatives for advice.
- CDF team are providing training to new staff on their Corporate Induction about planning discharges.
- ITT team are training all staff on the Nursing documentation relating to discharge and compiling a data base of all staff trained.

I hope that these reassurances address the issues that have been raised.

Yours sincerely



Interim Chief Executive

In response to Reg 28 (LP)

Tameside Hospital NHS
NHS Foundation Trust

LEAD: [redacted]

Issues	RESPONSIBLE	Actions	Deadline	Progress (RAG)
1. To improve effective communication between the Integrated Transfer Team and the patients and their immediate carers/family regarding the discharge plan.	[redacted]	• Develop a checklist to ensure all members of the MDT has engaged with patients and family prior to discharge • Team leader to ensure through IAS/EIS systems that there is documented evidence that all ITT cases have been discussed with patients and their designated carers	March 2014	
2. To ensure the patients and families wishes are fully raised and given full consideration in the discharge process.	[redacted]	• To ensure all patients and families have every opportunity to discuss plans and have a dedicated name and contact number for the social worker managing their discharge • Leaflet has been produced and is in publication process for patients and carers about "Leaving our Care"	March 2014	
3. To ensure all agency workers are adequately orientated to the hospital and all procedures and policies are outlined from both TMBC and TFT to the expected standards of practice.	[redacted]	• All temporary workers located within the Transfer Team will have an induction process and complete the induction checklist within one week of commencing role. • Each temporary worker will receive an induction and adequate support and documented regular supervision.	Feb 2014	

Tameside Hospital NHS
NHS Foundation Trust

LEAD:

Issues	RESPONSIBLE	Actions	Deadline	Progress (R G)
4. All plans of care for patients must be shared with the patient and with patient's consent their next of kin and agreed before being discharge	TMBC/TFT	• Each member of the ITT should ensure all care plans are prepared accurately and presented before being discussed and shared. This will be monitored through regular supervision of TMBC staff and through daily length of stay. ITT supervisors to monitor documentation via Social worker IAS system. • Head of Patient Flow and Team Leader for ITT now have transparency and ability to view and monitor all social worker involvement with cases through TMBC IAS system. This is monitored daily for all cases known to the ITT.	March 2014	
5. To improve communication from the ward staff to the ITT through the induction of robust daily SHOP board round	ITT TDAG (Transfer and Discharge Group)	• Pilot SHOP (MDT Board round procedure) in progress on two medical wards. To be escalated across the trust over the next 3 months and become embedded practice. This will improve ward based communication to the discharge team and is documented. The SHOP process is a full MDT process daily where all patients are discussed and discharge plans agreed daily. This is documented and evidenced by the ITT team.	May 2014	

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LEAD: [redacted]

Issues	RESPONSIBLE	Actions	Deadline	Progress (R G)
6. To raise the profile of the ITT team through public awareness and increased visibility and open access.	[redacted]	• Create information boards and posters to display across the wards and departments to raise awareness of the team to allow patients, families and carers to have easy access to the team for support and guidance in the discharge process. • The team has a social worker available 6 days a week to patients and relatives. The Clinical Discharge Facilitator (CDF) is available seven days a week, from 0800-2000hrs to speak with patients , staff and relatives for advice. • CDF team are providing training to new staff on their Corporate induction about planning discharges. • ITT team are training all staff on the Nursing documentation relating to discharge and compiling a data base of all staff trained.	April 2014	
7. All patients returning home with care package have their equipment needs assessed and documented in hospital.	ITT	• Social workers to communicate effectively with the link nurses and make timely referrals for assessment of equipment needs. To ensure at daily length of stay meetings that the checklist process for discharge is followed.	Feb 2014	