NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

[redacted]
Chief Executive Officer
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Fountain Street
Ashton-under-Lyne
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[redacted]

9th November 2021

Ms A Morris
HM Senior Coroner
Manchester South Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Morris,

I am writing further to the inquest touching upon the death of Irene Esaw (who died on 11th November 2018) which concluded 9th September 2021 and the subsequent Regulation 28 Report issued to this Trust. This builds on the extensive work undertaken since 2018 to strengthen Safeguarding arrangements across the Trust. I hope to be able to address the issues raised in your report, and set out below my response.

The Trust acknowledge the breadth and complexity of the concerns raised by you in your report and with partners in the local system (Tameside Metropolitan Borough Council) we have considered the concerns. As we demonstrated at the inquest, a Trust wide commitment and focus on these matters has been demonstrated and will continually evolve and remain at the heart of the legacy of the learning from the death of Mrs Esaw. We also acknowledge the time that has passed since Mrs Esaw's care and highlight to you that many of the developments and programmes outlined in this response are continuing to expand and develop, given their scope and multi-disciplinary nature.

Concern 1

Mental Capacity Act project

During the inquest, the Trust were able to present a number of improvements to support the consistent application of the Mental Capacity Act and this included a suite of policies, procedures training and documentation to support the application of mental capacity act in practice.

To enhance further our work in relation to Mental Capacity Act awareness and overseen by the Executive Director of Nursing and Integrated Governance and the Deputy Director of Nursing Professional Standards, Safeguarding and Assurance has reprioritorised resources for funding for a dedicated Senior Mental Health Nurse to take the lead on a revised improvement project focused on the application of the mental capacity act (MCA) in the Trust, this individual is in post. Partnerships have

been developed with Pennine Care Foundation Trust. This post will further promote consent and mental capacity awareness across the Trust footprint and will be part of the integrated safeguarding resource and team, reporting to the Head of Nursing for Integrated Safeguarding. This will impact on the culture of awareness and action.

The revised MCA improvement project has been launched by the Trust in November 2021 and is being supported by the Trust transformation team and being led by the Lead Nurse for Mental Health to ensure consistency in the application of the Mental Capacity Act. This quality improvement programme is building on previous work and will transition into the next phase which will focus on the transfer to and implementation of Liberty Protection Safeguards (LPS). Our current priority and focus is to continually raise awareness and promote a culture where the application of the mental capacity act is our everyday business at every intervention.

In partnership with the Local authority we have taken the lead in establishing a multi-agency group focused on the application of the MCA with a view to a collective review and benchmarking of our policies and procedures in order to develop a multi-agency strategy, policy and training on the application of the Mental Capacity Act across the multiagency system, to promote a shared approach and understanding

The oversight and scrutiny of the MCA Quality Improvement Programme will be by the Trust's Integrated Safeguarding Committee which is chaired by the Executive Lead for Safeguarding. Regular update reports and oversight of the Trust's improvement project will also report to the newly formed Multi Agency Monitoring Group, established to monitor the significant learning and actions from this case.

The project will focus on five core areas:

- Legislation
  Whilst the Trust has a current Mental Capacity Act Policy which is in line with the required statutory requirements and meets regulatory requirements, the Trust is cognisant that the new Mental Capacity Act Code of Practice is due to be published in 2022. In line with this the Trust will review the revised Code to ensure that its policies are aligned. As part of the Trust's response to this the Trust, will develop an audit process and clear audit cycles, this will be aligned to the national implementation of Liberty Protection Safeguards. Our training will be aligned with this.

- Training and development
  The Trust has a focused month on safeguarding throughout the month of November 2021. As part of this whole month of focus there is a Mental Capacity Act Masterclass entitled "back to basics" which will work in parallel with our community and social care partners as a multi-agency plan. In addition to this, a proposal for the inaugural integrated safeguarding conference has also been approved to be held in Spring 2022, hosted by the Trust, with invitations to multi-agency colleagues to promote a culture in which teams collaborate work and learn together.

  To further strengthen the existing portfolio of e-learning the Trust will use the masterclass methodology and other learning opportunities, 7 minute briefings, podcasts and animations for example so that there is a continuous program in place to support staff knowledge in identifying, and their application of the MCA. Furthermore the implementation of the joint action plan between the Trust and the Council will minimize the future risk of inadequate multi agency working. Every opportunity will be used to educate and raise awareness.

- Communications

As part of the Trust's broader communications project in which specific topics receive focused exposure during a calendar month, November is 'Spotlight on Safeguarding' month, to coincide with Adult Safeguarding week. This will incorporate the launch of a Mental Capacity Act campaign and encouraged all staff to 'think family' by raising awareness and providing opportunities for learning to support and promote a culture and organisational approach, that safeguarding is 'Our Everyday Business'. The Trust have also developing multimedia resources such as short animations, screensavers, MCA aide memoir cards and coverings to the lift doors to maintain a high profile throughout the organisation. To establish the positive impact upon staff awareness of MCA a short online survey has been developed for use across the Trust. The survey has been circulated prior to the MCA campaign launch and will be repeated In January 2022 to assess knowledge and confidence across the workforce. The results of this survey will be monitored on a scheduled basis via the Integrated Safeguarding Committee.

The first edition of an Integrated Safeguarding Newsletter has been circulated to colleagues throughout the Trust during the November "Spotlight on Safeguarding" month with a focus on application of the Mental Capacity Act, Neglect and 'Bettys' story.

- Ensuring the Trust is demonstrating a consistent application of the Mental Capacity Act

The Executive led Integrated Safeguarding Committee will monitor the progress of the improvement project at each meeting, this will in turn report to the Service Quality and Assurance Group and Quality and Non-Executive led Trust Board Sub Committee, the Quality and Governance Committee. A detailed overview of the project is to be presented on the Safeguarding agenda on 1st December 2021. The Trust audit cycle has been revised to include the multi-agency audit programme rather than individual organisation focus. We will also seek to obtain staff feedback in advance of and following the MCA awareness campaign and relevant training through evaluations, case studies, survey monkey and a competency tool.

- Digital

The Trust have been developing the use of alternative Trust digital platforms to identify and support vulnerable patients, linking dementia to capacity assessments on ward electronic boards. This is explained in more detail below:

As part of the Trust improvement project we have secured a dedicated budget to develop the Mental Capacity Act Campaign, entitled 'MCA it's as easy as ABC' , that will be launched during National Adult Safeguarding week commencing 15th November 2021.

In collaboration with our colleagues in Adult Social Care, the Trust has agreed to present to Tameside Adult Safeguarding Partnership Board (TASPB) on 7th December 2021 and together we will take the lead on establishing a multi-agency group focused on the application of the Mental Capacity Act. There will be a collective review and benchmarking of our repsective policies and procedures in order to develop a multi-agency strategy, policy and training on the application of the Mental Capacity Act across the multiagency system. This will promote a shared approach and understanding.

Electronic systems

At the inquest you raised concerns regarding medical and nursing staff adequately considering and assessing Mrs Esaw's mental capacity to make decisions about her own care needs during her admission. It was considered that this undermined the discharge planning and was one of the key reasons that the discharge was considered unsafe.

You acknowledged the Trusts ongoing work in this area but were conscious that this was a work in progress and that there were some issues remaining, and that the Trust was not completely compliant. In the circumstances, we set out the additional work that the Trust has been undertaken in order to ensure that staff are competent and confident in their ability to assess capacity on an ongoing basis.

The Trust is in the process of transitioning towards electronic patient records in accordance with the NHS commitment to use all electronic patient records. Working closely with our Chief Clinical Information officer in relation to the transition to electronic notes work has progressed with clinical colleagues which has considered the potential to include prompts in relation to mental capacity assessments, in particular when preparing the discharge letter.

The Trust uses a clinical portal for completion and storage of electronic notes. This is a live system with the capability to link to the interactive ward whiteboards within the clinical areas. The electronic systems will support early recognition of patients who may lack capacity, have fluctuating capacity or require additional support on discharge through a variety of means. As all records move to be electronic, this can support a discharge tool which alerts the discharging clinician to previous confusion identified through clinical observations, prompting questions about the resolution of this at the point of discharge. This is already in use within the Trust's Emergency Department and Acute Medical Unit (ED and AMU) with the intention that this be rolled out across the hospital throughout 2021 and 2022.

As the system is rolled out throughout the hospital, it will include alert notes for several scenarios. For example, if confusion was to be identified within observations on three or more occasions, this generates a message prompting a capacity assessment. The system has the capacity to make this mandatory and not allow the clinician to move on or complete the entry without completing the assessment. In terms of discharge, this could also generate messages such as "this person has shown confusion during their admission, can you confirm that this discharge is safe". While this is part of an ongoing agenda I would like to assure you that we are currently in the testing stages for some of this technology in anticipation of rolling our across our acute inpatient areas.

Using the Ward whiteboards enables staff to see at a glance any specific needs such as lack of capacity. There are over 40 options, each with their own icon. For example, dementia (forget me not icon), falls risk (falling leaf), safeguarding concerns. The combination of icons in one accessible place will help inform planning both as an inpatient and for discharge. Depending on the icons selected, there are a range of pop-ups which can be generated in order to increase safety. For example "do not discharge without repeat capacity assessment" or "approval needed from safeguarding team before discharge". The system will also generate emails to specific teams such as Safeguarding, Patient Safety, Safer Care, indicating assessments or advice required prior to discharge. An alert can also be automated to the team who will be overseeing the live Trust wide view which will help improve a response in real time and assessments as part of the preparations for discharge or onward care planning.

Betty's story

During the inquest, you were informed of 'Betty's story' and how the Trust has used this to educate staff on capacity assessments and recognising the clinical signs of neglect, which we will address further below.

We have liaised with teams who coordinate multi-professional inductions for staff across the Trust, all have committed to including Betty's story and the learning from this to develop a recurrent programme of training.

The Head of Nursing for Integrated Safeguarding is presenting at the Trust wide, multi professional Grand Round on 17th December 2021. The presentation will build upon 'Betty's Story' has already been presented on 7th July 2021. The aim of this will have a focus on MCA and neglect.

To provide an alternative an innovative method of telling "Betty's story the Trust have commissioned a playwright to develop this into a live play, for sharing across the organisation. The initial planning meetings for this will commence during November 2021.

Concern 2

I understand that you also raised concerns that in 2018 during Mrs Esaw' admission, there was no adequate consideration by the medical or nursing staff that her clinical presentation itself indicated neglect and therefore a safeguarding concern. At inquest, the Trust representatives acknowledged that further work was required around the recognition of the signs of neglect and that this too was an ongoing project.

As part of the Trust's spotlight on "Safeguarding" month in November 2021, a seven minute briefing document will be circulated on 15th November to coincide with Adult Safeguarding week. The staff will be asked to discuss the 7 minute briefing during meetings, ward huddles and provide their reflections and feedback to the Head of Nursing for Integrated, in particular how the learning from this will be applied in their practice and what further support they will need. This feedback will inform further learning opportunities and work plan for the improvement project.

The Trust's Safeguarding Lead, [redacted] has continued to focus on this project with the support of the senior nurse and medical leadership team to ascertain how this can be factored into all areas of clinical practice. In addition to this, the Clinical Director for the Emergency Department is establishing a specialist team to provide advice on the clinical signs of neglect. He has requested a nomination from each Divisional team with the advice and support of [redacted], who is the Clinical Director for Integration and Consultant Geriatrician, building on a model used by paediatric colleagues.

The Trust continues to strengthen the older person's care that is currently provided across its services. There is a real focus on recognizing and understanding frailty syndromes, especially in patients aged 75+, and also exercising greater multidisciplinary scrutiny for patients aged 75+ who are confused or fall.

There are other newly appointed leadership roles across the Division of Medicine including a Divisional Director and three Associate Divisional Directions for the operational aspects of the Directorate, and there has also been a change of Clinical Director, who is supporting the Directorate in taking forward

new initiatives within the workforce for medicine. There is an established Medicine Improvement Board chaired by the Deputy Chief Executive which oversees a programme of improvement work which is then taken forward by the Multidisciplinary Team. The Trust has introduced a new Frailty Service that is provided by senior geriatricians and supported by four Trainee Advanced Clinical Practitioners, along with the introduction of a new Clinical Director for integration that works collaboratively with the acute setting and the Tameside & Glossop care homes.

Finally, the Trust also employs Admiral Nurses who support patients with Dementia across the organisation. The Admiral Nurses provide a service across the Medicine Directorate supporting the ward rounds and MDT board rounds to identify patients like Mrs Esaw and their relatives who may require support.

Concern 3

The final concern raised you raised within the report related to multi-agency working. You were concerned that there were assumptions made by the clinical team and the Integrated Urgent Care Team (IUCT) that the other agency was responsible for capacity and needs assessments. This meant that a proper assessment was not undertaken.

The Head of Nursing for Integrated Safeguarding with the Principle Social Worker for Adult Social Care, chaired a multi-agency learning session on 12th October 2021 to reflect on the mechanisms in place for multi-agency working at discharge between the integrated care team, the wards, the medics and the community neighbourhood teams. This was a productive session with commitment from senior colleagues from both organsiations resulting in a shared understanding of this concern and agreement on how this would be addressed. The following themes were identified as areas for development in terms of multiagency working:

- Safe Discharge
- Recognising Adults at Risk
- Roles and Responsibilities
- Application of the Mental Capacity Act

A joint action plan with the Tameside Metropolitan Borough Council has been developed following the meeting informed by the themes and key actions identified to address the concerns that you raised during the inquest. The action plan includes developing the skill and knowledge of the staff involved in hospital discharge in the ward and the community, on what is a safe discharge and who are the adults at risk, through a number of ways such as training, forums, audits and revised procedures. Integral to the joint action plan is ensuring that the multidisciplinary team has a good understanding of each other roles and responsibilities.

The finalised joint action plan will be shared with Tameside Adult Safeguarding Board at the next Board meeting on 7th December 2021. A multiagency action plan will be established to monitor the action plan, this will take place by December 2021. Alongside this a quarterly multiagency working forum will be established as a mechanism to monitor the implementation of the action plan and to support a culture of reflection and learning across the multiagency partnership associated with hospital discharge.

This action plan and improvement work will be monitored by an augmented system with governance arrangements as outlined above and in the action plan, that will promote effective arrangements to ensure cross agency learning, communication and assurance this is embedded in practice. Success will be further monitored by the outcomes of Multiagency forums that will feed internally to the Medicine Management Board and Executive led Integrated Safeguarding Committee as well as externally to

multiagency groups such as Learning and Accountability Group, Tameside Adult Safeguarding Partnership Board and the Domestic Homicide Review Panel. Success will be measured using a range of methodology; informal and formal feedback from the practitioners, surveys, supervision, audit results and case studies.

Conclusion

I appreciate that there is a great deal of information within this letter and many of our responses include work which is continuous and part of our "business as usual". I hope that you will recognise our current process and our intention and commitment to learning from your findings and the care provided to Mrs Esaw. In addition to this, I wish to assure you that the outcome of learning from all incidents, complaints and safeguarding investigations are progressed through the integrated governance work streams, through Divisional Governance Forums and Clinical Leadership Forums, with escalation and oversight of our Executive and Non-Executive Directors. Mrs Esaw's care has been discussed at this most senior level with ongoing oversight and scrutiny of the actions proposed within this letter.

The Integrated Safeguarding team is part of the Corporate Nursing and Integrated Governance Team structure, which further promotes and strengthens our governance arrangements. The Nursing and Integrated Governance Team meet weekly for an Executive led meeting to ensure a regular oversight and across all portfolios including Inquests, Complaints, Claims, Incidents, and Safeguarding cases (MICCIS). The purpose of this meeting is for awareness, oversight, insight and foresight into quality, safety and risk issues that is underpinned by a culture of inquiry, triangulation and validation of data. This level of integration further strengthens the safeguarding governance, providing further assurance with a line of sight to the Executive Lead for Safeguarding whom chairs the MICCIS.

I hope you will feel that the Trust has taken appropriate action as a result of your findings, however should you wish to discuss any aspect of this or seek further assurance please do not hesitate to contact me.

Yours sincerely

[redacted]

[redacted] **Executive Director of Nursing and Integrated Governance**

[redacted] **Chief Executive Officer**

Tameside Metropolitan Borough

CHIEF EXECUTIVE

ASHTON-UNDER-LYNE · AUDENSHAW · DENTON · DROYLSDEN · DUKINFIELD · HYDE · LONGDENDALE · MOSSLEY · STALYBRIDGE

[redacted]
Chief Executive, Tameside MBC
and Accountable Officer, Tameside & Glossop CCG
Tameside One, Market Place, Ashton under Lyne, OL6 6BH

[redacted]

Ms Anna Morris
Assistant Coroner
Coroner's Court
1 Mount Tabor Street
STOCKPORT
SK1 3AG

[redacted]

Doc Ref let/sp1211
[redacted]
Date 10 November 2021

Dear Ms Morris

Re: Regulation 28 Report into the death of Irene Ann Esaw (dob 13/11/1934, dod 11/11/2018)

Further to your letter and Regulation 28 Report to Prevent Future Deaths dated 16 September 2021, regarding the tragic case of Irene Ann Esaw please find my response outlined below.

The untimely death of a person is distressing for their family and any others affected by their death and loss, and all the more so if there is any belief that but for the actions of any public sector organisation it could have been avoided.

I would like to record my sincere condolences to the family of Irene Ann Esaw for their loss and I hope through this process they can obtain some closure.

The matters of concern identified by the Coroner and directed to the Chief Executive of Tameside Metropolitan Borough Council were as follows:

1. ***Identifying and Assessing Mental Capacity***
   My findings in relation to Mrs. Esaw's death were that there was a fundamental failure by the local authority staff to adequately consider and assess Mrs. Esaw's capacity to make decisions about her own care needs whilst she was a patient at Tameside General Hospital between 12th September 2018 and the time of her death. This failure in my view, undermined her discharge planning and was one of the key reasons why the discharge was unsafe. I understand that work is ongoing in this area by [redacted] *in relation to prompting and recording of consideration of capacity concerns but, I also have concerns about a lack of professional curiosity by social workers, which I understand is still to be addressed in an ongoing piece of work for the new Safeguarding Lead who has yet to start in post. Therefore, I am concerned that the area of inquiring about and assessing capacity continues to need to be addressed.*

2. ***Multi-agency Working***
   My findings reveal that in the Care assessments of Mrs. Esaw, there were assumptions made by the clinical team and the IUCT that the other agency was responsible for capacity and needs assessments. The effect of this was that there was never an adequate assessment of her needs completed. [redacted]*, the Principal Social Worker for Adult Social Care told me in her evidence that even though IUCT are on the wards at Tameside, there is still further work to be done to understand the roles that the IUCT and the clinical team are undertaking. I am concerned that this continues to need to be addressed.*

Identifying and Assessing Mental Capacity
Since 2019, one of Adult Social Care work force development priorities has been to improve our staff knowledge and application of the Mental Capacity Act.

Tameside MBC has recognised that there is a need to invest in their workforce to ensure that they are appropriately trained and that skills are updated and developed through a number of means.

In order to do this a number of priorities were agreed:

- To improve social work standards and the quality of social work practice, assessment and care planning.
- To ensure the provision of effective support and development to managers and practitioners to develop a skilled and confident workforce which meets the needs of the service and the people it supports.
- To offer high-quality advice, support and consultancy to social work managers to develop social work services locally and with our partners.
- A programme to embed the Mental Capacity Act in practice is underway including Mental Capacity Assessment Forums and Social Work Forums
- A Quality Assurance Framework and a Workforce Development Framework are being developed with the aim to embed professional confidence, curiosity and development in practice.
- Adult Services has registered with Research in Practice for Adults (RiPfA) to support managers and staff
- A Social Work Consultant post has been recruited to. This post does not carry a caseload and does not directly line manage any staff. The purpose of this management level post is to support our professional teams, managers and staff to improve outcomes for individuals through their improved practice.

On the 22 July 2020, a 12 month improvement plan was launched, which incorporates standards of practice, themed audits and themed Continuing Professional Development. The Individual Management Report (IMR) recommendations and action plan are annexed to this report as **Appendix A.**

Some of the work completed has included reviewing the documentation for recording Mental Capacity Assessments and Best Interest decisions. These have been linked to other assessments such as the Needs assessment and Risk assessment to ensure the Mental Capacity Act is at the heart of social work practice with adults. The revised and updated assessments (**Appendix B &C** refers) and Care Act guidance for staff (**Appendix D** refers) are annexed to this response.

A programme of regular training has taken place and will continue as this is an area of law and practice which changes and evolves with the changing nature of practice and case law.

The Safeguarding Lead started in their role on the 13 September 2021, they are responsible for the implementation of the new Safeguarding Policy and Procedure within Tameside Adult Services. One of the priorities that will run throughout all of their work will be to ensure staff feel confident and equipped to be more 'professionally curious'. This is recognised safeguarding training and the toolkit, advises that social workers can become more professionally curious and respectfully uncertain by following the points below:

1) *"Question why someone is behaving in a certain way. Consider what these behaviours could indicate.*
2) *Find out more about someone's personal circumstances. Assess their behaviour in light of what you know about them and their situation.*
3) *Question the motives of anyone who is with the person. Why are they there? What is their relationship to the person? Do they appear controlling? Do they dislike leaving the person alone? Even if they appear kind and supportive, could this be a way of hiding their role in harming the person?*

4) *Recognise when someone is reluctant to provide a full or accurate account of events or is pretending to cooperate to avoid raising suspicions.*
5) *Think outside the box. Consider the person or situation from the viewpoint of other workers. What might they look out for and notice? What would they think about the situation?*
6) *Maintain an open mind. Avoid making assumptions, taking information at face value and jumping to conclusions. Take account of changing information and different perspectives. Consider if you need to adapt your views.*
7) *Ask questions and challenge what you believe to be untrue.*
8) *Notice if you or someone else starts to doubt that someone is a victim – consider the reasons for these doubts. Are they fair? It might be helpful to read more about how victims of exploitation are perceived.*
9) *Trust your instinct and raise concerns if something about someone's behaviour or situation does not feel right.*
10) *Think vulnerability and exploitation – be actively aware of how anyone you come across may be vulnerable and could be experiencing exploitation.*
11) *Think and act outside of your immediate job role – take action to investigate and act on your concerns, even if this goes beyond the immediate remit of your role and responsibilities.*
12) *For example, a professionally curious health professional who is treating someone for physical injuries would also question why these injuries have been sustained and assess the person's wider appearance and behaviour – do they seem distressed? Are they reluctant to say how they received their injuries? Do they seem to be hiding something? Is there anything about them that raises concerns or suspicions?*
13) *If you are concerned about someone, take action to find out more about their situation and protect their safety and wellbeing."*

Within the first month of being in the role, the Safeguarding Lead delivered a session for all social workers and managers on the learning from this case. The session was very well attended with over 100 attendees. Following the event, staff have been asked to discuss the learning in their teams and then share feedback with the Safeguarding Lead on how the learning will be applied in practice and what further support they may need. This feedback will inform their work plan.

The Safeguarding Lead's work plan includes gaining feedback on practice in a number of ways including conducting regular case file audits, learning reviews and consulting with all staff on a regular basis through surveys and forums to ensure that the support provided meets the needs of the organisation and social work standards. This approach aims to improve social worker's confidence, knowledge and skills in safeguarding practice and ensure staff demonstrate professional curiosity in practice.

The Safeguarding Lead has arranged quarterly Safeguarding Practice Forums. The first of these is planned in December 2021 and the theme will be Domestic Abuse. The ongoing training programme for social workers and managers will be reviewed and developed by the Safeguarding lead ensuring that staff have up to date knowledge and skills in this area of practice. There will be a rolling programme of essential training for all practitioners to complete every 2 years, this includes new and existing staff.

The Principal Social Worker is currently reviewing the implementation of the quality assurance framework for social work practice, the application of the Mental Capacity Act will feature in this work. The aim is that a new framework will be in place from January 2022. Part of this work will include implementing the National Mental Capacity Act Competency Framework, developed by Bournemouth University. A skills and knowledge audit will take place of social workers and managers and the outcome will inform the ongoing training programme.

Multi-agency Working
Tameside MBC and Tameside and Glossop Integrated Care NHS Foundation Trust both received similar Prevention of Future Death reports. In response to this and in line with Tameside MBC's Domestic Homicide Action Plan, a learning meeting took place on the 12 October 2021.

Senior staff from both the Tameside and Glossop Integrated Care NHS Foundation Trust and Tameside MBC met to reflect on the mechanisms in place for multiagency working at discharge between the Integrated Urgent Care Team, the Wards, the Medics and the community Neighbourhood Teams. The meeting was chaired by the Principal Social Worker, TMBC and the Head of Nursing for Integrated Safeguarding, Tameside and Glossop Integrated Care NHS Foundation Trust. The following themes were identified as areas for development in terms of multiagency working:

- Safe Discharge
- Recognising Adults at Risk
- Roles and Responsibilities
- The Application of the Mental Capacity Act

A joint action plan for the Tameside and Glossop Integrated Care NHS Foundation Trust and Tameside MBC has been developed, which includes developing the knowledge and skills of all the staff involved in hospital discharge on the ward and in the community on '*What is a Safe Discharge?*' and '*Who are the adults at risk?* ' through a number of ways such as training, forums, audits and revised procedures. The joint action plan is also annexed to this response – **Appendix E** refers.

Integral to this, is ensuring that the multidisciplinary team have a good understanding of one another's roles and responsibilities. Work will take place to ensure that this is embedded in practice. This will include ensuring that roles and responsibilities feature in the induction of all staff, in ongoing clinical supervision and in multiagency procedures and standards. A multiagency review and refresh of the Mental Capacity Act procedures and training regarding adults with care needs on discharge, will take place.

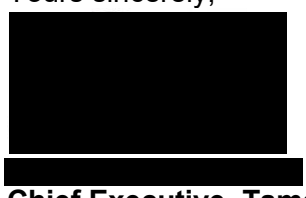
The finalised joint action plan will be shared with Tameside Adult Safeguarding Board at the next Board meeting in December 2021. A Multiagency Action Plan Group will be established to monitor the action plan, this will in place by December 2021. Alongside this a Quarterly Multiagency Learning Forum will be established as a mechanism to monitor the implementation of the action plan and to support a culture of reflection and learning across the multiagency partnership associated with hospital discharge.

Conclusion
Tameside MBC trusts that these actions and proposals are sufficient to satisfy that Coroner that the Council does take these concerns seriously, and that there is a continuous programme in place to support staff knowledge in identifying and their application of the Mental Capacity Act. Furthermore that the implementation of the joint action plan between the Council and Tameside and Glossop Integrated Care NHS Foundation Trust will minimise the risk of inadequate multi agency working.

I hope that we have provided you with the necessary assurances in relation to your concerns.

Please contact me if you require any further information or if I can assist further in any way.

Yours sincerely,



Chief Executive, Tameside MBC/Accountable Officer, Tameside & Glossop CCG

Attachments:

Appendix A	IMR Recommendations with Action Plan
Appendix B	Mental Capacity Assessment