11th January 2021

***BY EMAIL ONLY***

HMC Ms Sonia Hayes
Coroners Court
Kent and Medway Coroner's Service
Cantium House
Sandling Road
Maidstone
ME14 1XD

[redacted]
Chief Executive
Maidstone and Tunbridge Wells NHS Trust
Maidstone Hospital
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Dear Madam

**Re: Katherine Mabel Hogan**
**Conclusion of Inquest: 17th July 2020**

I write further to the above matter and the Regulation 28 Report received by the Trust dated 18th November 2020 issued under the Coroners (Investigations) Regulations 2013. I hope that this reply will be helpful in detailing the consideration given and actions taken to address the matters of concern in your report.

First and foremost, I have written separately to the family of Mrs Hogan to offer my sincere condolences.

As the Court will be aware, the Trust carried out an internal investigation as regards the circumstances leading to the fall sustained by Mrs Hogan on 16th August 2019. This internal investigation was provided to the Court and the interested persons. As part of the Trust's continued objective to learn and improve, this internal review was recently re-opened with the investigation scope further extended to cover the overall care afforded to Mrs Hogan, as opposed to focusing on the incident of the fall itself.

In response to the issued Regulation 28 Report, I now respond in turn to the matters of concern raised:

**Concern 1)**
**Staff shortages contributed to the patient being left the clinical decisions area of the unit on a trolley. This was not an area that was suitable to keep a patient overnight. Staff shortages were reported to those responsible for the hospital.**

**Trust Response:**
Staffing levels at the time of the incident ought to have comprised 7 registered nurses and 1 clinical support worker (CSW). Actual staffing levels at the time of the incident were 5 registered nurses and 1 CSW. There were staffing shortages of 1 registered nurse from the start of this shift and at 4am this increased to staffing shortages of 2 registered nurses between the hours of 4am – 7.30am.

The Trust regrets this shortage of staff; this staff deficit was due to one shift not being covered, and a member of the nursing team commencing their shift at an earlier time of 4pm as requested by the

nurse in charge (This led to the nurse finishing her shift at 4am rather than 7am, prior to the index event).

The Court was provided with evidence as to the activity levels in the A&E department on the date of Mrs Hogan's fall. In the 24 hour period starting 15th August 00:01am to 16th August 00:00am the unit was particularly busy with 222 attendances to the department, minimal movement of patients, with many awaiting transfer to beds that were not yet available. Whilst we do not seek to detract from concerns raised, we hope this information assists as regards context.

In light of these facts, and the concern noted within your Report, the Trust has comprehensively considered this matter further. Going forward staff have been reminded that if staffing levels are identified as a concern this should be escalated by the senior nursing team and site practitioner to arrange cover. Staffing concerns must also be reported on the Trust's incident reporting system (DATIX) – so that these levels may be monitored and kept under review.

As standard practice, staffing concerns are escalated at each daily site meeting. The Nurse in charge has the responsibility to discuss / escalate staffing deficits and plans to a Matron. This 'horizon planning' aids early identification of staffing shortages so that temporary / agency staff may be sourced as required. Nursing staff have also been reminded that their twice daily safety huddles in each ward/department should be used to consider all concerns, including any staffing issues. We have also introduced twice daily trust-wide safe staffing meetings, chaired by the Chief Nurse and attended by the Divisional Directors of Nursing and Quality. These meetings are used to understand risks anywhere in the Trust in relation to staffing and identify actions required to mitigate these risks.

The patient was left in the CDU on a trolley due to the historical department protocol not being followed. The patient did not meet the admission criteria for the CDU however was still admitted to this area. As a result of this incident, action has been taken to update the department protocol and admission criteria. The updated department protocol and admission criteria has been disseminated to all staff within the department. The updated department protocol now states that the unit must be closed if there is no suitable staff allocated to the unit.

**Concern 2)**
**Evidence is that the unit has moved and has been reconfigured, however there remains an outstanding request for increased staffing that has not been addressed by the Trust.**

As the Court have noted, the Clinical Decision Unit (CDU) has been reconfigured. In line with this, the Trust now confirms that a Standard Operating Process (SOP) as regards the CDU has been updated and amended. This SOP sets out the intended use of the CDU. The provisions of this SOP include:

- Clarity as regards the purpose of the CDU, in that it is a short-stay clinical assessment area rather than an overnight ward
- The criterion for the use of this unit in respect of treatment, investigations and required interventions prior to discharge
- Patients who require admission should not be placed in CDU for any period. If an inpatient bed is required they should be admitted under the appropriate speciality

- Exclusion criteria as regards the use of the CDU area (includes patients that score on our national early warning system)
- A clear plan documented in the A&E notes with likely discharge within 4 hours as agreed by the named responsible Doctor and Nurse in Charge

Safe staffing levels have been reassessed since the reconfiguration of the department and incorporated into the rotas. These levels also form part of the basis of safe staffing reporting to the Chief Nurse. Senior nursing support has been increased with the successful recruitment of 3 additional Emergency Medicine Matrons. The senior support Matron cover has meant that there is cover 7 days a week on site to support the staff within the department. There is an active ongoing recruitment campaign for Emergency Department nurses with regular recruitment days taking place.

Royal College of Emergency Medicine and Getting It Right First Time recommendations on staffing levels for Emergency Departments were released in September and October 2020 and the organisation is now using these clear staffing recommendations to benchmark safe staffing levels for each shift. This has led to the creation of additional posts within the department which are being substantially recruited to.

The organisation re-opened the serious incident investigation to review the care provided to Mrs Hogan and have created a revised action plan to address all issues identified. The action plan is being finalised with the senior nursing team within the Emergency Department. This should be completed by the end of this month, at which point the re-opened SI investigation report and action plan will be shared with the family for review and input.

As evidenced by the re-opening of the internal review of this regrettable event, we aim to continue to learn wherever possible from concerns raised with the Trust so as to improve the services we offer to all our patients.

Yours sincerely

[redacted]
**Chief Executive**