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Mr Tom R Osborne
HM Senior Coroner
HM Coroner's Office
Civic Offices
1 Saxon Gate East
Central Milton Keynes
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Dear Mr Osborne

REGULATION 28 REPORT TO PREVENT DEATHS – Mr John Shrosbree

I am writing in response to your Regulation 28 report following the Inquest held on 25 September 2019 into the death of Mr Shrosbree. I did not receive a copy of the report directly for almost two weeks but accessed it via www.judiciary.uk. The report was covered widely in the local press.

I want to be clear at the outset of my response that I recognise the independent statutory nature of coronial inquests, and the role of Regulation 28 reports. We genuinely value the part that the coronial process plays in 'holding a mirror up' to our services and the care that we provide here in the hospital. Inquests can help us to reflect upon deficiencies in care which we may not otherwise have appreciated, affording us a valuable opportunity to make improvements for the people of Milton Keynes as our future patients.

Whilst I am aware that there were shortcomings in the care that we provided to Mr Shrosbree and that opportunities to potentially alter the course of his illness were missed, I must admit that I was somewhat surprised by the content of your Regulation 28 report, which read as follows:

My concern is that during the evidence it became clear that that the problems encountered in the Emergency Department on 4th June 2019 were mainly brought about by staff shortages. I was told that staff shortages occur on a daily basis and I believe that as a result lives of this citizens of Milton Keynes are being put at risk and the problem should be addressed as a matter of urgency.

Whilst recognising shortcomings in Mr Shrosbree's care, we had not felt at the Trust that

staff shortages *per se* were a significant factor.

I will go on to outline to you how we ensure that staffing levels in the Emergency Department are safe – both in general terms and shift-by-shift. We have a good understanding of our staffing levels in the Emergency Department, and data that evidence the position. I think it is unfortunate that the Trust was not given an opportunity – either prior to the Inquest or between Inquest and issue of the Regulation 28 report – to provide that evidence which offers a significant degree of assurance.

We have invested heavily in clinical staffing levels over the past six years and have measures in place day-to-day in order to ensure that the risk associated with any sub-optimal staffing numbers is spread appropriately across the organisation such that 'sub-optimal' does not equate to 'unsafe'.

I now move on to describe the objective position as it stands (with further qualification around the June 2019 position where appropriate). The staffing establishment (funded and agreed posts) in the Emergency Department is described in the table below:

Role	Establishment / Funded Posts	Vacancy Rate
Band 8A (Matron)	2.0	0%
Band 7 (Senior Sister / Charge Nurse)	9.54	10%
Band 6 (Sister / Charge Nurse)	16.51	3%
Band 5 (Staff Nurse)	47.39	27% (17% in June 2019)
Band 2 (Healthcare Assistant)	24.8	21%
Consultant	10	0%
Middle Grade / Registrar	16	6%
ENP (Emergency Nurse Practitioner)	4.89	0%
Senior House Officer	15	13% (establishment increased in August 2019)

Vacancies (against our agreed establishment) occur for several reasons over and above the number of leavers exceeding those coming into post: for example, parental leave and secondment. In nursing, vacancy rates tend to peak in the late summer / early autumn and reduce as new graduates are available to start work in band 5 entry level posts. Recruitment to nursing roles is ongoing with active and engaging open days in place, in

addition to more passive advertising.

The establishment described in the table above is calculated in order to ensure appropriate ratios for the number and acuity of patients passing through the department. In addition, we can benchmark our staffing levels with other hospitals through use of NHS Improvement's Model Hospital dataset.

The Model Hospital data allow us to compare our local Emergency Department with other organisations nationally, and a sub-set of peer Emergency Departments (selected by Model Hospital on the basis of similarities in organisational size and complexity). The most recent benchmarking data demonstrate that our department is slightly less busy than our peer median but is in all other ways representative. The expenditure on the Emergency Department at Milton Keynes (both crudely and as a proportion of overall expenditure) is greater than the peer median. Our staffing, in terms of whole time equivalent staff, is at the peer median. In terms of breakdown by staff group, more doctors are employed than at our peer organisations (37% over the peer median) and less nurses (13% below the peer median). This variation from peer median represents a relatively small emergency nurse practitioner (ENP) workforce in Milton Keynes. ENPs typically work in the 'ED minors' environment, and in many departments ENPs have replaced a significant part of the non-consultant medical workforce. We do not consider that there is any material difference in nurse staff numbers attending to the needs of patients in the majors and resuscitation environments (where Mr Shrosbree was looked after). The Trust continues to develop the non-medical workforce in the Emergency Department and has recently confirmed plans to train and employ eight advanced nurse practitioners focusing on the emergency care pathway (ED and Acute Medicine).

Where there is a gap on a given shift between staffing establishment and staff on duty, several things are put in place to mitigate risk. These include:

1. identification of additional staff via re-deployment from other areas in the hospital (facilitated via the daily safety huddle attended by all Ward Managers and senior managers, or ad hoc during the day by the site team); and,
2. identification of additional staff to be engaged via staff bank or staffing agencies. The staff bank includes a financial supplement for staff working in ED in recognition of the particular need to ensure good staffing levels there.

Each day, the Emergency Department rota is designed to operate with 15 registered nurses and 5 healthcare assistants. These numbers include a streaming nurse but exclude the Emergency Nurse Practitioners (ENPs) who – as described above – operate semi-autonomously in the management of minor injuries.

During the shift on 04 June when Mr Shrosbree attended, there were 14 registered nurses and 3 healthcare assistants available (1 RN and 2 HCAs below establishment). In addition to this, there was a Band 7 working on a supernumerary basis within the Children's ED and there were 2 ENPs on shift. On the same day, there was a gap of 14 registered nurses and 1 healthcare assistant across the wider hospital in medical and surgical wards.

In terms of general fill rates, ED has had periods over the summer where the rota has had up to 4 RN gaps on a shift. Unless there was a period of significantly reduced activity, the establishment would be supported by other clinical areas, leaving a maximum gap of 2RNs, and only then with Matron's awareness and approval. When the staffing is reduced in this way, the Band 7 Nurse in Charge, with the duty Matron, will determine the most effective and safest use of resources within the geography of the department, based on the acuity at the time.

Having reviewed the data for the day in question (04 June), the Emergency Department was not particularly busy. We have, at our busiest periods, had up to 100 patients in the department. Numbers that day peaked at 61. The waiting times (to be seen by a doctor, following rapid assessment and triage) were not excessive. There were no specific staffing difficulties noted in our site reports.

Time	12:00	15:00	19:00	22:00
Total patients in ED at time	47	58	56	61
Total patients in ED since midnight	73	121	187	221
Waiting time (ED Majors)	1:23	2:40	2:05	2:45
Number of ambulances since midnight	18	29	42	48

Finally I do believe it is important to note that our most recent inspection by our professional regulator, the Care Quality Commission, did not flag any concerns regarding staffing numbers in the ED.

I hope that this comprehensive response provides assurance to you following the concerns which came to light during the Inquest. We do of course acknowledge that at times workload can place significant pressures upon staff: at such times, we are used to making carefully balanced judgements to ensure that our services remain safe for patients at all times.

Given the potential relationship between Regulation 28 reports and public confidence in our hospital and the services we provide, I wonder whether there is a better mechanism

through which the Trust could be alerted to concerns as they emerge such that additional data can be provided in a timely fashion at the Inquest. I would welcome a discussion on this matter.

With kind regards

Yours sincerely

Professor Joe Harrison
Chief Executive

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[redacted], Medical Director
[redacted], Director of Operations