8th February 2022

[redacted]
Chief Executive
Maidstone and Tunbridge Wells NHS Trust
Maidstone Hospital
Hermitage Lane
Maidstone, ME16 9QQ
[redacted]

Private & Confidential
Ms Sonia Hayes
HM Assistant Coroner Mid Kent and Medway

Sent via email:
kentandmedwaycoroners@kent.gov.uk

Dear Madam

Response to Regulation 28 Prevention of Future Deaths Report: Mr Terence Talbot (Deceased)
Conclusion of Inquest: 20th – 23rd September 2021

I write further to the above Report dated 3rd December 2021 and detail the Trust's formal response below.

I hope that this reply will be helpful in detailing the actions taken to address the matters of concern in your report.

As you will be aware the Trust provided, and spoke to an Action Plan at the Inquest hearing in September 2021 in response to the issues identified by the Court and the experts you had instructed. These actions have been recorded in the Trust's Incident Reporting system (DATIX), to ensure colleagues are sighted on the changes that have been and are being implemented (please see below). I hope the Court and the family of Mr Talbot take assurance from the commitments set out in the plan as well as those noted below.

In addressing the concerns you have raised, the Trust have also taken additional steps to strengthen our existing multi-professional day to day working with Kent and Medway Social Care Partnership Trust (KMPT). I have set out further detail on the steps being taken as part of our response to this report.

I will now respond in turn to the concerns raised regarding Maidstone and Tunbridge Wells NHS Trust (MTW).

Concern 1: The lack of consideration of specialty dermatology referral with deteriorating severe exfoliative dermatitis in a rare and complex diagnosis.

Response
Awareness and escalation techniques form part of training that is delivered to nursing colleagues. As identified within the hearing, the Trust, (albeit not in a timely manner), did obtain community dermatology opinion and support (the Court will recall that the Trust does not provide dermatology services itself).

With regards to referral pathways and specialty dermatology referrals, the Trust's Clinical Director for specialist medical services has been asked to nominate a lead clinician to review the pathway into

dermatology services for critical diseases, to ensure there is clarity regarding urgent and non-urgent cases. It is expected that the identified clinician will take up this role in by the end of this month. Scoping the option of including/contracting East Kent Hospitals University Foundation Trusts Dermatology Services into our current pathway will form part of this clinicians' commission. Once this has been completed additional training will be commissioned by the Trust to increase the awareness to our staff regarding the services & pathways which are available. The objective of this training will be to ensure that there is Trust wide awareness of available support systems in relation to dermatology.

To further support staff the Trust has Matron cover in place seven days a week, which ensures senior support and presence on site. This role supports staff within departments and includes assistance with referrals and escalation as required.

The dermatology issues identified in this case have been fed back to the dermatology services. In turn, the learning from this case is being used as an educational tool.

Concern 2: There was a lack of regular dietitian input with malnutrition.

Response

The Court received evidence at the Inquest around the patient's engagement with the Trust's dietitians. The Court will recall that Mr Talbot was deemed by our staff to have capacity, however issues around capacity assessments were noted to have contributed to the lack of regular dietitian input.

The Trust recognises the importance of adequate nutrition in order to promote patient recovery. With regards to ensuring vigilance around nutrition, the following summary sets out the Trust's assurance in respect of this concern. The actions noted below have been further captured on DATIX in order to promote awareness and learning and enable monitoring of implementation:

- All patients continue to have a Malnutrition Universal Screening Tool (MUST) score completed on admission and weekly thereafter to detect any deterioration and ensure dietetic intervention;
- An electronic patient records system (Sunrise) was introduced in Summer 2020 with the electronic recording of MUST, this system allows for better monitoring of the findings of the MUST;
- Ward training of nursing staff by the Dietetics Department was suspended during 2020 due to Covid pressures however, the Trust is now recommencing these training sessions;
- Dietitians have been attending Clinical Support Worker (CSW) training days monthly to teach MUST, escalation and outline support available;
- Audits of MUST completion continue to be undertaken. The next one is scheduled to be carried out in March 2022 to ascertain changes to practice and any further training required.
- Ward-based therapy assistants are being recruited. Their focus will also include assisting patients with eating and drinking and speech and language therapy.

In order to ensure comprehensive learning from this matter, and as part of the MDT discussions with our neighbouring mental health Trust, the Trust is committed to ensuring further vigilance with regards to the monitoring of food charts for inpatients with physical and mental health needs.

Concerns 3: The evidence was the focus was on problems relating to discharge rather than treatment during multidisciplinary meetings.

Response

The Trust has explored the improvement of treatment pathways of inpatient care when patients are under dual care of KMPT and MTW. A meeting has taken place between both Trusts to discuss safety

netting, with further meetings planned. To date, the following agreements have been discussed by the medical directors at each organisation:

- The Trust will work with KMPT on an initiative which will aim to strengthen communications and mitigate risks to patients who receive care from both organisations. This initiative will be developed and managed by both Trusts and will provide clarity regarding joint treatment pathways.

- KMPT has signed a service level agreement with MTW to support patients detained under the Mental Health Act receiving treatment at MTW for their physical health needs. A training package is being delivered to MTW ward based nursing and medical staff by KMPT Mental Health Act compliance manager. This will significantly improve the understanding of the needs of patients with complex psychiatric conditions admitted to MTW.

Concern 4: Issues relating to capacity to consent to, or refuse treatment were not all subjected to mental capacity assessments.

Response

The Court is respectfully advised that the Trust has commissioned an audit into its consent and capacity practices. The external Trust Auditor has found that the Trust is broadly performing well. The recommendations from this review have been discussed by the Directorate leads and taken forward as part of the DATIX action plan noted above.

Further, the Trust has introduced a new clinical advisor role as the lead clinician on capacity. The Trust has also appointed a new Mental Capacity Act clinical practitioner who will be available to assist the wards in dealing with complex cases. These leads will strengthen our oversight in ensuring the appropriate considerations around capacity are comprehensively covered.

Along with the above training, the Trust continues to provide tailored, bespoke training sessions to all staff regarding the vital importance of capacity assessments. Again, regular audit and monitoring is being applied Trust wide. Such training is mandatory for each clinical member of staff.

Thank you for bringing your concerns to my attention. Whilst I do not seek to detract from the concerns raised, I hope the above detail provides assurance that the Trust has taken these concerns seriously and will continue to deliver the actions outlined in our response. In addition, the implementation of these actions will be monitored and any lessons learned will be shared in order to improve the services we offer to all our patients.

I am very happy to discuss or clarify any of the above points.

With the Court's permission I would like to share this response with Mr Talbot's family and seek the Court's agreement to this.

Yours sincerely

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Chief Executive